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LUCREATIA FORD

v.

Docket No. 91-H-096

WEST VIRGINIA DEPARTMENT OF HEALTH/
WELCH EMERGENCY HOSPITAL

DECISION

Grievant, Lucretia Ford, is employed by the West Virginia Department of Health (WVH) as a Health Service Worker (HSW) at Welch Emergency Hospital (WEH). She initiated a grievance at Level I December 3, 1990, protesting her three-day suspension without pay. Her supervisor was without authority to grant relief and at Level II, Stephen Shride, WEH's Administrator, found the evidence in support of one particular part of the charges against the grievant to be insufficient but denied the grievance on the basis that others were supported. The grievance was also denied at Level III following a hearing held February 19, 1991.¹ Appeal to Level IV was made March 11, 1991, and a hearing was held May 30, 1991. The parties submitted proposed findings of fact and conclusions of law by July 10, 1991.

¹The transcript of this proceeding is part of the record herein.

I.

Many of the facts surrounding the case are not in dispute. The grievant began her employment with WEH in 1984 as a HSW in its Long-Term Care (LTC) unit. This unit serves elderly clients who, due to physical or mental infirmities, are unable to function adequately in their own homes.² The duties of HSWs in the unit generally parallel those of orderlies in regular hospital settings.

Although no personnel evaluations were offered in evidence, it appears WEH had no complaints about the grievant's work performance until early 1990. On January 11, 1990 an LPN discovered patient H.B.³ on the floor of her room. Upon investigation it was determined that the patient had been attempting to get from her bathroom to her bed unassisted and had fallen. The fall caused H.B. some pain but she sustained no serious injuries. The LPN filed an incident report on the matter which eventually reached Diane Jeffries, WEH's Patient Advocate,⁴ who subsequently

²While the record is somewhat unclear, it appears that long-term encompasses more than the services typically found in nursing homes. Apparently, at least some of the patients in this unit require close medical attention for a part of their stay at the hospital.

³There being no need to use the names of patients, they are identified herein by initials.

⁴While Ms. Jeffries is an employee of WEH and reports directly to Mr. Shride, she essentially functions as ombudsman for the patients. Most, if not all, of her duties relate to the investigation of allegations of patient abuse.

made a further investigation which included discussions with H.B. and the grievant. In a January 16, 1990 Patient Advocate's Report, Ms. Jeffries advised Mr. Shride, Head Nurse Linda Evans, and Director of Long-Term Nursing Eugenia Burroughs that she had determined that H.B.'s fall was the result of the grievant's negligence. Specifically, she explained that her inquiry indicated the grievant had assisted H.B. to the bathroom and onto the commode and then left the room to obtain a clean gown for the patient. According to the report, H.B. then attempted to reach her bed and fell. Ms. Jeffries recommended verbal and written warnings for the grievant, noting that she "should not have left this patient alone for any reason in the bathroom." There is nothing in the record which indicates that the grievant was ever given the recommended discipline.

On April 26, 1990, while making her regularly scheduled rounds, Ms. Jeffries was approached by patient B.S. who angrily complained that she had not been showered for two weeks. In an April 26, 1990 memorandum, Ms. Jeffries advised Ms. Burroughs that her examination revealed that the patient's last documented shower was on April 1, 1990 and was administered by the grievant. She also explained that since that date B.S. had been one of the grievant's assigned patients on ten days. In an April 27, 1990 Patient Advocate's Report Ms. Jeffries made no conclusions about the grievant's culpability in the matter but noted that she had held a conference with the grievant during which she stated that she had "an unresolved problem dealing with the residents following the death of her mother." Ms. Jeffries concluded her

report by remarking, "Following the discussion it was decided upon by administration to afford [the grievant] time to work out her problem, seeking active treatment with a psychologist of her choice and temporarily transfer her to Med./Surg. 3-11 shift with goal to reassign back to the [long-term] unit." The transfer was effected shortly thereafter but again the record contains nothing to show the grievant then received a warning, verbal or written, concerning her care of B.S.

During the course of Ms. Jeffries' investigation of B.S.' complaint, she also discovered that HSWs S.K., L.V., B.A., and E.S. were also responsible for the patient's care for certain periods of time between April 6, 1990 and April 26, 1990. Ms. Jeffries subsequently held conferences with those employees and, in a May 3, 1990 memorandum to Ms. Burroughs, explained that they all reported they had not showered B.S. during the shifts in which the patient was in their care because their assignment sheets did not require them to do so. Ms. Jeffries further advised Ms. Burroughs that "It was explained that this was not acceptable though it may be true, a new shower chart was posted on 4-4-90 showing that this patient is to be bathed on the 3-11 shift." None of these HSWs were disciplined for their care of the patient.

During the grievant's assignment in WEH's Medical/Surgical Unit she was at times responsible for the care of patient I.C. whose family also provided privately-paid attendants. One of the attendants, Linda Mitchell, made a complaint against the grievant on June 20, 1990. The only written account of the complaint and

the action taken thereon in the record is contained in a memorandum from Head Nurse Randy Smith to Med./Surg. Nursing Director Lana Kibbey, which in its entirety states:

A conference was held on June 21, 1990 with Lucretia Ford, Health Service Worker at 2:30 PM regarding a complaint by Linda Mitchell, a hired sitter, for patient I.C.

ISSUE:

Ms. Mitchell states that on June 20, 1990 that Ms. Ford accused "someone" of moving the linen saver pad from under the patient's buttocks. Ms. Mitchell states that since she and her daughter were the only people in constant attendance to the patient and the tone of voice along with the body movements Ms. Ford used that this was directed toward her. Ms. Mitchell reports Ms. Ford also stated "I'm tired of changing all this linen at one time." (The patient had been incontinent of stool.)

Ms. Mitchell feels Ms. Ford inappropriately directed her anger and frustration toward her. Ms. Mitchell also reports Ms. Ford was untidy and left a soiled towel in the floor after cleaning up the patient.

RESPONSE:

Ms. Ford states she did not direct her remarks to Ms. Mitchell. She states she was more or less thinking aloud. Ms. Ford also states that sometimes people mistake her tone of voice for one that is accusatory or abrasive in nature. She states she had no intent of insulting Ms. Mitchell and if Ms. Mitchell took offense at her comments she was sorry. As to being untidy, Ms. Ford states Lena Lundy, LPN was assisting her with cleaning up Ms. C. and thought Ms. Lundy had picked up all the linen.

RESOLUTION:

Ms. Ford was advised to be careful about what she says in the presence of sitters and families. She stated she would be more careful in the future. In addition, Ms. Ford's assignment will be adjusted to where she will not be involved in Ms. C.'s care.

The grievant returned to the LTC unit on August 2, 1990. On November 1, 1990 Ms. Jeffries informed Ms. Burroughs that she had learned the grievant had verbally abused patient M.W. In her

memorandum on the matter Ms. Jeffries reported that she had been informed that M.W. had asked the grievant for assistance and the grievant replied "I will when you learn to talk." Ms. Jeffries went on to advise Ms. Burroughs that she had talked to M.W. and had concluded the allegation was true. Ms. Jeffries asked Ms. Burroughs to advise her as to what disciplinary actions would be taken against the grievant.

By letter dated November 13, 1990, Mr. Shride advised the grievant that she was suspended for three days without pay for "continued negligence and lack of concern in [the] provision of health care to the patients at Welch Emergency Hospital." Mr. Shride gave the following specific reasons for the action:

1. On January 16, 1990, a complaint was filed by a volunteer relative to your inadequate patient care to patient "A" on January 11, 1990. It was reported that you assisted the patient to the bathroom, left the patient to obtain a gown and the patient fell trying to return to bed unassisted. You were given a warning relative to this incident of endangering patient safety.

2. On April 26, 1990, patient "C" complained that she had not been showered in two weeks. A review of the patient chart revealed on 4-26-90 that patient "C's" last documented shower was 4-6-90 by Lucretia Ford. You were one of four (4) employees who had been assigned to this patient. The other employees involved were disciplined and no further incidents have occurred. As a result of this complaint and during a counselling session, you stated that you had unresolved problems dealing with the residents following the death of your mother. You also indicated that you were aware of your attitude change. It was decided that, in an effort to assist you with your problems, you would be temporarily transferred to the Medical/Surgical Unit on the 3-11 shift and you would actively seek treatment with a psychologist of your choice. This transfer was made effective May 2, 1990 and was for a period of ninety (90) working days.

3. On June 31, 1990, a conference was held with you regarding a complaint filed by a hired sitter for

Medical/Surgical patient "D". The complaint consisted of the inappropriate remark made "I'm tired of changing all this linen at one time." Patient "D" was incontinent of stool. It was also reported that you were untidy and left a soiled towel on the floor after cleaning the patient. In response to the complaint you indicated that you were not directly your remarks to anyone that you were more or less thinking aloud. You also stated that you had been assisted by another employee and felt that she had picked up the linen.

4. On November 1, 1990, after your return to Long Term, it was reported that you were verbally abusive to patient "D" when the patient asked you for assistance, you reportedly replied "I will, when you learn how to talk". Patient "D" has difficulty speaking and your reply to her embarrassed and upset her.

II.

WVH maintains that the evidence presented establishes that the grievant was guilty of the charges against her. The agency also asserts that the disciplinary action was properly taken in accordance with its applicable personnel policies and those of the West Virginia Division of Personnel (Personnel).

The grievant contends the evidence fails to show that she committed any infractions of WEH policy relating to the care of patients or was guilty of incompetence or negligence in the performance of her duties. She also alleges that the other HSWs responsible for B.S.'s care received no discipline and WEH engaged in discrimination against her.⁵ For reasons hereinafter

⁵The grievant is black. The races of the other HSWs are not known to the undersigned since they did not appear at Level IV and the Level III evaluator made no findings on this point. The grievant did not, however, make any claim that the
(Footnote Continued)

discussed, the undersigned concludes that the agency has not met its burden in the case.

III.

PATIENT H.B.

The evidence on the incident involving this patient establishes that the grievant escorted her from a recreational activity room to the bathroom and assisted her onto the commode and, in doing so, the patient's gown got wet. It also establishes that the grievant instructed the patient to stay seated until she returned. The record does not reflect how long the grievant was gone but there was no assertion on the part of any witness called by the agency that she was gone longer than necessary to obtain a clean gown. Finally, the evidence concerning this particular incident reveals that H.B. was anxious to return to the recreational activity in which she had been involved and was most likely not trying to go to her bed when she fell.

(Footnote Continued)

difference in treatment was race-motivated. Given the absence of such a claim, the grievant's discrimination-related assertion must be analyzed herein as simply a charge of improper disparate treatment.

PATIENT B.S.

The evidence on the incident involving this patient is rather confusing but it does establish several facts. First, during the period of time in which B.S. was one of the grievant's assigned patients, her assignment sheets, which were rather specific as to her responsibilities, did not direct her to shower the patient. Second, a nursing station bulletin board contained a list of patients who were to be showered on designated shifts and B.S.'s name was so designated during at least some of the days and shifts she was in the grievant's care. Third, the record reflects that there was confusion among many, if not all, of the HSWs in the long-term care unit during April 1990 over whether they were to follow their assignment sheets, the shower chart or both. Fourth, the record, or more specifically B.S.'s medical chart, reveals that from April 1, 1990 to April 16, 1990, the patient bathed herself on ten different days and that HSWs bathed her on five of the remaining six days. Finally, the evidence concerning this patient establishes that neither the grievant nor any of the HSWs named in Ms. Jeffries May 3, 1990 memorandum bathed or showered the patient from April 6, 1990 to April 25, 1990.⁶

⁶During her Level III and Level IV testimony, Ms. Jeffries made rather vague assertions that B.S. reported to her that she had asked the grievant to shower her. These assertions are not supported by the record. Significantly, Ms. Jeffries never made such statements in her written reports concerning the patient to Ms. Burroughs
(Footnote Continued)

PATIENT I.C.

The only evidence offered by the agency on the incident involving this patient was Mr. Smith's June 21, 1990 memorandum and his testimony concerning his conference with the grievant. It was the grievant's testimony that she did verbally express some distress over having to change the patient's bed linens but her comments were not directed at the patient or her private attendant. She denied that her statement to the effect that "someone" had removed the linen protector was directed toward anyone in the room. As to the soiled towel left in the room, the grievant explained, as she did to Mr. Smith, that she thought Ms. Lundy had retrieved it.

PATIENT M.W.

WEH's evidence related to the alleged verbal abuse of this patient consists of the testimony of Ms. Jeffries and LPN Judy Camp and a handwritten, undated statement made by LPN Francis Roberts. In her statement Ms. Roberts related that she was called to M.W.'s room and discovered her crying. According to Ms. Roberts, when asked why she was crying, M.W. responded that

(Footnote Continued)

and no mention of such a request on the patient's part was made in the letter of suspension. For these reasons it is concluded that no such request was made and Ms. Jeffries' statements were the result of poor recollection. In any event, since the suspension letter was very specific as to the incident involving B.S. and no reference to her asking for a shower was made therein, any evidence that she did so must also be deemed irrelevant.

the grievant refused to give her a diaper. Ms. Roberts also stated that M.W. told her the grievant said she needed to talk plain.

Ms. Jeffries testified that HSW Evelyn Swiney brought the matter to her attention and when she subsequently asked M.W. if anyone had made any comments about her speech, the patient began crying. Ms. Jeffries further testified that M.W. was embarrassed and told her she could not help the way she talked. Ms. Jeffries stated she also talked to Ms. Camp and Ms. Camp essentially advised her that the patient had told her the same thing.

Ms. Camp testified that she responded to a call from M.W. and found her crying when she arrived at the room. Ms. Camp's account of what the grievant reported to her is as follows:

And she said that the girl that was taking care of her wouldn't put a diaper on her. I asked her why and she said because that the doctor hadn't written up no orders for her, so I couldn't put one on her because she was her patient, you know, and the patient started crying and said that when, that Lucreatia told her that when she could learn to talk she would wait on her, you know, take care of her. So I went out and I was, you know, upset and I told Francis Roberts about it and Francis went in and talked to her about it because I didn't want to discuss it. I thought the LPN, you know, should take care of it and I told her and she went in and she put a diaper on her.

Ms. Camp also stated that she never discussed the incident with Ms. Jeffries. Ms. Jeffries, Ms. Camp and Ms. Roberts did not take any notes on their conversations with the patient or ask the patient to make any type of written statement.

The grievant categorically denied she made any derogatory remarks to the patient. She stated that M.W. was normally an agreeable patient but that when angered she was prone to make

false accusations against WEH staff. The grievant represented that M.W. often specifically requested that she be assigned to her care. She offered the testimony of a co-worker who confirmed that M.W., on several occasions, had refused her assistance and asked for the grievant. In an April 22, 1991, written statement HSW Mary Hamilton also relates that on a few occasions M.W. had requested that the grievant be assigned to her care.

IV.

In disciplinary matters the burden of proof is upon the employer. Davis v. Dept. of Motor Vehicles, Docket No. 89-DMV-569 (January 22, 1990). The agency's evidence in support of the charges against the grievant is very much like that presented in Dilley v. W.Va. Dept. of Health/Pinecrest Hospital, Docket No. 90-H-520 (July 18, 1991), a case in which allegations of abuse and negligent care of patients on the part of a HSW were also made. There, as is the case here, the agency's evidence was largely hearsay statements and the charges were deemed unsubstantiated.

There is no firsthand evidence of record that the grievant made an improper or accusatory remark to patient I.C. or her attendant. Mr. Smith's testimony and his June 21, 1990 memorandum merely confirm that the attendant had assumed that the grievant's remarks were directed at her. The attendant did not testify at any level and the grievant was therefore never afforded the opportunity to question her on the grounds for the

assumption or otherwise confront her about what she reported to Mr. Smith. Also, the grievant's testimony on what occurred was credible. Her version must, therefore, be accepted. Accordingly, it is concluded that the agency has established that at most the grievant exercised poor judgment in expressing her distress vocally about the task of having to change the linens. While this behavior was worthy of admonishment, it cannot provide the basis for a suspension. Moreover, it appears from Mr. Smith's memorandum that this is precisely what he deemed appropriate. The import of his comments is that he considered the grievant's statement that she was sorry if she had offended anyone and the adjustment in her assignment to be a sufficient resolution of the matter. As a general rule, behavior which is deemed corrected or for which discipline has been administered should not later be made the basis for other action. See Duruttya v. Mingo County Board of Education, Docket No. 29-88-104 (February 28, 1990).

As previously noted, the record reflects that the grievant did indeed leave patient H.B. unattended while she went to obtain a clean gown for her. There is, however, no evidence whatsoever that such action was adverse to WEH policy or practice concerning patient care. It may be that certain patients in the LTC unit, including H.B., require constant observation and the uninterrupted attendance of a HSW but the record does not so establish. Absent some showing to that effect, it cannot be concluded that the grievant was guilty of negligence in her care of the patient.

The agency's evidence in support of the charge concerning patient B.S. is similarly lacking. The confusion over which set

of directions HSWs were to follow as to what patients were to be showered and when was the fault of the hospital. It might have been prudent for the grievant to deviate from her rather specific assignment sheets and inquire about a shower for the patient but the agency has not shown that it was her responsibility. Again, a charge of negligence cannot be sustained upon evidence which does not clearly establish that the grievant had some duty either expressly set forth in hospital policy or that under the circumstances some duty was implied by past practice or standards of reasonable care.

Moreover, it appears the grievant's claim of disparate treatment among those responsible for B.S.'s care is well-founded. While the agency contends the grievant and the other HSWs were not similarly-situated in that she was responsible for the patient's care on more shifts than the others, this assertion is not persuasive. If the grievant had some duty to abide by the shower charts during the period in question, then the other HSWs did also. Accordingly, it is concluded that the grievant has shown that the reason offered for the difference in treatment was pretext. Notwithstanding the conclusions made herein regarding the sufficiency of the agency's evidence, the grievant would be minimally entitled to some relief on the basis of this finding.

What actually occurred with patient M.W. is more difficult to discern. Significantly, the patient was never asked to reduce anything to writing or otherwise attest to what if any remarks were made to her by the grievant. Further, the accounts of Ms. Camp, Ms. Jeffries and Ms. Roberts as to what the patient

reported to them not only constitute hearsay evidence but are conflicting. Notably, Ms. Camp was the only witness who recalled that M.W. remarked that the grievant refused her a diaper because the doctor had not ordered one. This and other inconsistencies, although more minor, are sufficient to deem all but the grievant's denial of the charges unreliable hearsay evidence. Accordingly, it is concluded that the agency has failed to prove that the grievant verbally abused the patient.

In addition to the foregoing, the following findings of fact and conclusions of law are made.

FINDINGS OF FACT

1. The grievant has been employed by WEH as a HSW since 1984.

2. On January 11, 1990, after assisting patient H.B. to the bathroom, the grievant left her unattended to obtain her a clean gown. In her absence the patient fell and sustained minor injuries.

3. On April 26, 1990, WEH Patient Advocate Diana Jeffries received a complaint from patient B.S. to the effect that she had not received a shower for two weeks. Upon investigation it was determined that B.S. was an assigned patient of at least four HSWs, including the grievant, for the period in question.

4. During April 1990 there existed considerable confusion among HSWs in WEH's LTC unit as to whether they were to follow directions contained on their individual assignment sheets or seek directions elsewhere.

5. The grievant's assignment sheet for the period in dispute did not direct her to shower B.S. Her failure to do so was cited as one of the reasons for the disciplinary action against her. The other HSWs received no discipline.

6. On June 20, 1990 a private attendant to patient I.C. reported that the grievant inappropriately accused her of removing a linen saver pad from I.C.'s bed.

7. On November 1, 1990, patient M.W. reported to several persons that the grievant had verbally abused her.

8. The grievant was dismissed for three days without pay on November 13, 1990. The above alleged incidents were the grounds cited.

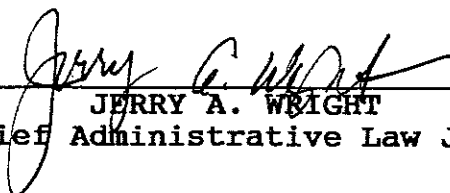
CONCLUSIONS OF LAW

1. Pursuant to W.Va. Code §29-6A-6 the burden of proof in disciplinary matters rests upon the employer. The standard of proof is by a preponderance of the evidence. Dilley v. W.Va. Dept. of Health/Pinecrest Hospital, Docket No. 90-H-520 (July 18, 1991).

2. The agency failed to prove by a preponderance of the evidence that the grievant engaged in the conduct that formed the basis for her suspension.

Accordingly, the grievance is **GRANTED** and Welch Emergency Hospital is hereby **ORDERED** to compensate the grievant for the loss of pay she incurred, restore to her any attendant benefits which she may have lost and remove any and all reference to the suspension from her personnel file.

Any party or the West Virginia Division of Personnel may appeal this decision to the "circuit court of the county in which the grievance occurred," and such appeal must be filed within thirty (30) days of receipt of this decision. W.Va. Code §29-6A-7. Neither the West Virginia Education and State Employees Grievance Board nor any of its Administrative Law Judges is a party to such appeal and should not be so named. any appealing party must advise this office of the intent to appeal and provide the civil action number so that the record can be prepared and transmitted to the appropriate court.



JERRY A. WRIGHT
Chief Administrative Law Judge

Dated: January 17, 1992