BEFORE THE PERSONNEL APPEALS BOARD

STATE OF WASHINGTON

MARLENE WESTFALL, Appellant, v. DEPARTMENT OF SOCIAL AND HEALTH SERVICES, Respondent.	Case No. DISM-99-0063 FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER OF THE BOARD

I. INTRODUCTION

1.1 **Hearing.** This appeal came on for hearing before the Personnel Appeals Board, WALTER T. HUBBARD, Chair; GERALD L. MORGEN, Vice Chair; and LEANA D. LAMB, Member. The hearing was held at the Frances Haddon Morgan Center in Bremerton, Washington, on May 23 and 24, 2001.

1.2 **Appearances.** Appellant Marlene Westfall present and was represented by Anita L. Hunter, Attorney at Law, of Parr and Younglove, P.L.L.C. Janetta E. Sheehan, Assistant Attorney General, represented Respondent Department of Social and Health Services.

1.3 **Nature of Appeal.** This is an appeal from the disciplinary sanction of dismissal for neglect of duty, insubordination, gross misconduct and willful violation of published employing agency rules or policies. Respondent alleged that Appellant released a confidential document without authorization; behaved in an unprofessional manner; failed to follow verbal instructions; and failed to report a medication error.

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1.4 **Citations Discussed.** WAC 358-30-170; Baker v. Dep't of Corrections, PAB No. D82-084 (1983); McCurdy v. Dep't of Social & Health Services, PAB No. D86-119 (1987); Rainwater v. School for the Deaf, PAB No. D89-004 (1989); Countryman v. Dep't of Social and Health Services, PAB No. D94-025 (1995); Skaalheim v. Dep't of Social & Health Services, PAB No. D93-053 (1994).

II. FINDINGS OF FACT

2.1 Appellant Marlene Westfall was a Licensed Practical Nurse (LPN) 2 and permanent employee of Respondent Department of Social and Health Services (DSHS) at the Frances Haddon Morgan Center (FHMC). Appellant and Respondent are subject to Chapters 41.06 and 41.64 RCW and the rules promulgated thereunder, Titles 356 and 358 WAC. Appellant filed a timely appeal on December 6, 1999.

2.2 Appellant began employment at FHMC in December 1990. After approximately 3 years, she left FHMC for employment with the Department of Veterans Affairs at the Retsil Veterans Home. After working at Retsil for approximately 2 1/2 years, she returned to FHMC in June 1996. Appellant was aware of the FHMC policies and procedures. On December 23, 1997, Appellant signed a statement during her annual review that confirmed she was aware of all procedures, understood that client records were confidential, and that she would not divulge, publish or make known to unauthorized persons or the public any information which could identify a resident. Appellant also confirmed that she, "recognized that unauthorized release of confidential information may subject [her] to civil liability under provisions of state law."

2.3 By letter dated November 5, 1999, Carol Kirk, Superintendent of FHMC, informed Appellant of her dismissal for neglect of duty, insubordination, gross misconduct and willful

violation of the published employing agency or Department of Personnel rules or regulations. Ms. Kirk alleged that Appellant:

- Between November 9, 1998 and November 20, 1998, took a confidential emergency room report from a client's file and sent it to the Washington State Nursing Care Quality Assurance Commission;
- Engaged in a pattern of unprofessional conduct toward Registered Nurse (RN) 2 Sherri Wilson;
- Failed to follow RN Wilson's directives; and
- After discovering a medication error made by RN Wilson, failed to initiate an incident report, complete an error form, and notify the highest level of authority in the work area.

2.4 Appellant's supervisor was Alleen Witte, RN 4. Appellant's co-worker was Sherri Wilson, RN 2. RNs are responsible for overseeing and directing daily patient care activities. LPNs are expected to follow and comply with the directives given by RNs.

Release of a Confidential Medical Document:

2.5 On August 3, 1998, a resident of the FHMC passed away. This was the first death to occur at the facility and the incident was upsetting to all the staff. During the incident, staff attempted to administer CPR to the client, the medics were called and the client was transported to Harrison Memorial Hospital for emergency treatment. The client did not have a "do not resuscitate" directive in his file, but RN Witte, his case manager, felt that the situation was probably hopeless and decided to discontinue CPR.

2.6 Following this incident, the hospital sent FHMC a copy of the Emergency Room Report. When the report was received, Appellant presented it to Dr. Lila Aflatooni for her review and initials. Appellant expressed her concerns to Dr. Aflatooni about how the incident was handled.

2.7 Sometime between November 3 and 20, 1998, a copy of the report was sent anonymously to the Washington State Nursing Quality Assurance Commission. The copy contained handwritten notations by Appellant including the name of RN 4 Alleen Witte and the notation "~~O~~ Code Status that not to continue life support."

2.8 Debra Evans of the Commission received the report and contacted FHMC. Ms. Evans was concerned that someone had removed a confidential medical report from a client's file.

2.9 Gurgis Hafzalla, Developmental Disabilities Administrator 2, discussed the situation with Ms. Evans. He asked Ms. Evans about the envelope in which the report was received. She recalled that it was a non-state envelope, that it contained no return address, and that the handwriting on the envelope was the same handwriting as the notations on the report.

2.10 On December 4, 1998, a Personnel Conduct Report (PCR) was initiated against Appellant. The PCR was investigated and misconduct was found.

2.11 Although Appellant denied mailing the report to the Commission, in a Complaint for Sexual Harassment and Wrongful Termination that she filed on September 28, 2000, in Kitsap County Superior Court, Appellant states that she believed she had an ethical duty to report the circumstances surrounding the death of the patient.

2.12 We find that a preponderance of the credible evidence establishes that Appellant took confidential information about the deceased client and sent it anonymously to the Commission.

2.13 FHMC Policy 602, Client Confidentiality, states, "No employee may permit the use of information or material from either records or computerized programs for any purpose other than

the performance of the employee's official duties. . . . No information may be copied and/or released to any public or private agency without a signed release from the individual, their parent, guardian, or authorized legal representative of the individual who has custody of the individual."

2.14 DSHS Administrative Policy 6.04, Standards of Ethical Conduct for State Employees, prohibits DSHS employees from disclosing "confidential information to any person not authorized to receive the information."

Unprofessional Conduct:

2.15 Appellant and her coworker, RN Wilson, had opposing communication and working styles, which cause them to have stressful working relationship. Respondent was aware of the problems and employed a facilitator to help them understand each other's style and improve their ability to work together.

2.16 Ms. Kirk orally counseled Appellant on May 14 and 28, 1998 and instructed her to cease her unprofessional behavior toward RN Wilson. On June 1, 1998, Ms. Kirk provided Appellant with a memorandum that instructed her to keep her conversations respectful.

2.17 On October 31, 1998, Appellant was given a letter of counseling from Ms. Kirk. Ms. Kirk issued the letter after another situation during which Appellant engaged in inappropriate interactions at work, including gossiping and disrespectful conversation about other staff. Ms. Kirk informed Appellant that gossiping was inappropriate under any circumstances and instructed her to treat coworkers with respect. Ms. Kirk warned Appellant that she could receive disciplinary action if she continued to engage in unprofessional behavior.

2.18 On November 6, 1998, RN Wilson submitted a letter to Ms. Kirk alleging that Appellant was engaging in a pattern of harassment toward her in the workplace. A PCR was initiated against Appellant on November 20, 1998. The PCR was investigated and misconduct was found.

2.19 A preponderance of the credible testimony and evidence establishes that Appellant engaged in numerous incidents of inappropriate communication and disrespectful behavior targeted at RN Wilson. For example, she told another coworker that RN Wilson was lazy, she wrote inappropriate comments in the daily logbook, she left her confidential, personal notes containing unsubstantiated allegations about RN Wilson in an area that was accessible to other staff, and she erroneously reported to her supervisor that RN Wilson had failed to do her job.

2.20 The FHMC Non Discrimination Policy Statement prohibits employees from abusing other employees through insulting or degrading remarks or conduct, and informs employees that they are responsible to maintain an environment free from all forms of harassing conduct. The policy warns employees that violating the policy could result in disciplinary action, up to an including dismissal.

Failure to Follow Instructions:

2.21 RN Wilson was the shift charge during Appellant's work shift. FHMC Policy 320 confirms that the shift charge is designated to direct the work of others during the shift. Appellant was aware of her responsibility to take work direction from RN Wilson.

2.22 In February 1998, RN Wilson assigned Appellant the task of collecting client data including information on weights, sexuality programs and self-medication. Appellant refused to do the task. Appellant testified that she refused because she was on light duty in accordance with her doctor's orders. We do not find Appellant's testimony credible. In her Complaint for Sexual Harassment and Wrongful Termination, Appellant states that she was injured on March 26, 1998, and on May 5,

1999. Appellant's injuries occurred after her refusal to perform the tasks assigned to her by RN Wilson.

2.23 On October 27, 1998, a series of events occurred during which Appellant failed to follow RN Wilson's directions. In the morning, Appellant was escorting client K.S. to the bus stop. Melanie Giordano, Attendant Counselor (AC), was also escorting clients to the bus stop. Escorting clients to the bus is a responsibility of the ACs but other staff help when they have the time. When Appellant was nearing the bus stop, she received a radio call from RN Wilson. RN Wilson told her that client J.V. was in crisis and needed a helmet and pads. Ms. Giordano heard the call and told Appellant that she would finish escorting K.S. to the bus. However, Appellant continued to escort K.S. to the bus stop.

2.24 After she left K.S. at the bus, Appellant proceeded to the medical office to retrieve the helmet and pads, which were kept in a locked cabinet. Appellant did not have a key so she asked for assistance from maintenance to remove the lock. While she was waiting for the lock to be removed, RN Wilson radioed her and directed her to copy client B.W.'s chart because he needed to go to the emergency room. Appellant indicated that she could not comply because she was waiting for the lock on the cabinet to be removed.

2.25 Because Appellant did not copy the B.W.'s chart, RN Wilson was required to do so. This delayed B.W.'s transport to the emergency room by approximately 20 minutes.

2.26 Later, Appellant questioned RN Wilson's decision to take B.W. to the emergency room and said his symptoms were "just medication withdrawal." Appellant made this comment in front of the physician. Although RN Wilson felt that Appellant's comment negatively impacted her reputation

with the physician, no evidence or testimony was presented to establish that RN Wilson's professional reputation was harmed by the comment.

2.27 These incidents were included in RN Wilson's November 6, 1998, letter to Ms. Kirk and were investigated as part of the PCR initiated against Appellant on November 20, 1998.

2.28 Because Ms. Giordano was available to escort K.S. to the bus stop, the need to provide the helmet and pads for J.V. was more important and Appellant should have immediately complied with RN Wilson's request. Even though J.V. was self-injurious and needed the helmet and pads to protect him from injury, Appellant was aware staff was available to care for him until the helmet and pads were delivered. The need to transport a client to the emergency room takes precedent over tasks such as retrieving a helmet and pads. Therefore, when Appellant got the call to copy B.W.'s records, she should have immediately complied with the request. Based on a preponderance of the credible testimony we find that Appellant failed to follow RN Wilson's instructions in regard to J.V. and B.W.

Failure to Report a Medication Error:

2.29 Appellant's regularly scheduled work shift was Monday through Friday from 6:30 a.m. to 3:30 p.m. On Friday, September 25, 1998, Appellant signed off shift at 3:50 p.m. RN Wilson's regularly scheduled work shift was Monday through Friday from 7 a.m. to 4 p.m. On Friday, September 25, 1998, RN Wilson was the shift charge until she signed off shift at 4 p.m.

2.30 On Friday, September 25, 1998, RN 2 Charlett Nelsen, signed on shift at 3:45 p.m. RN Nelsen was not Appellant's supervisor/shift charge or lead worker.

2.31 Shortly after 3:45 p.m. Appellant and RN Nelsen were in one of FHMC's living units. Appellant noticed a pill in the medication cabinet that RN Wilson had failed to give to a client. Appellant told RN Nelsen that she had found the pill. Because it was near the end of Appellant's shift, RN Nelsen said that she would write the incident report.

2.32 FHMC Policy 320 requires that an incident report be written for medication errors. The policy also requires that the employee discovering the incident "shall make an immediate verbal report of any incident to the person with the highest level of authority in their work area (supervisor/shift charge/lead worker) and fill out a FHMC Incident Report form as applicable."

2.33 Appellant did not initiate the incident report as required by the policy. In addition, Appellant did not make a verbal report of the incident to the shift charge, RN Wilson, as required by the policy.

2.34 This incident was also included in RN Wilson's November 6, 1998, letter to Ms. Kirk and was investigated as part of the PCR initiated against Appellant on November 20, 1998.

2.35 Ms. Kirk was responsible for determining the appropriate level of discipline to impose. Prior to making this determination, she reviewed all of the investigative documents, considered the supported and unsupported allegations, reviewed Appellant's personnel file and discussed the available options with personnel. In reviewing Appellant's personnel file, she found that Appellant had received two reductions in salary while she was working at Retsil. One was the result of failing to adequately document an incident and failing to conduct and document an assessment of a resident, and the other was for failing to order medications.

2.36 Ms. Kirk determined that in regard to these incidents, Appellant was aware of the policies and of her duty to follow the policies. Ms. Kirk found that Appellant failed to comply with the policies and neglected her duty when she failed to maintain client confidentiality, failed to follow the directives of RN Wilson, engaged in a pattern of unprofessional conduct, and failed to initiate and report a medication error. Ms. Kirk also found that Appellant was insubordinate when she failed to comply with her oral and written counselings to cease inappropriate behavior and when she refused to follow the directives given to her by RN Wilson. Ms. Kirk concluded that Appellant's misconduct rose to the level of gross misconduct because it was contrary to the mission of agency, placed the safety of clients a risk and negatively impacted client care.

2.37 Ms. Kirk felt that termination was the appropriate disciplinary sanction because she could no longer trust Appellant with the security and confidentiality of client records. She also felt that Appellant's pattern of behavior negatively impacted productivity and created morale problems among other employees. As a result, by letter dated November 5, 1999, she informed Appellant of her termination.

III. ARGUMENTS OF THE PARTIES

3.1 Respondent argues that Appellant neglected her duty when she released a confidential client document in violation of policy. Respondent further argues that Appellant engaged in a pattern of unprofessional behavior and misconduct, was derogatory towards RN Wilson, and was insubordinate, disruptive and negative in the work place, which adversely affected client care. Respondent contends that Appellant violated her oath, violated her responsibility and put patients in jeopardy. Respondent further contends that any sanction other than dismissal would have given Appellant continued access to client records and would have left her in a position of providing client care, which was unacceptable given her repeated pattern of neglecting her duty, engaging in insubordination and willfully violating policy.

3.2 Appellant argues that she has a right to report patient abuse but asserts that Respondent has no proof that she was responsible for the release of the client's record. Appellant contends that this disciplinary action is the result of RN Wilson's over magnification of events between two people, Appellant who was an active, eager nurse and RN Wilson who did only what was required to get by. Appellant contends that her main concern was for the clients. Appellant asserts that RN Wilson did not like Appellant watching her and as a result, she took everything that Appellant said as a criticism. Appellant contends that it was RN Wilson who was unprofessional and inappropriate in the work place. Appellant argues that Respondent has failed to meet its burden of proof and that the disciplinary sanction should be overturned.

IV. CONCLUSIONS OF LAW

4.1 The Personnel Appeals Board has jurisdiction over the parties hereto and the subject matter herein.

4.2 In a hearing on appeal from a disciplinary action, Respondent has the burden of supporting the charges upon which the action was initiated by proving by a preponderance of the credible evidence that Appellant committed the offenses set forth in the disciplinary letter and that the sanction was appropriate under the facts and circumstances. WAC 358-30-170; Baker v. Dep't of Corrections, PAB No. D82-084 (1983).

4.3 Neglect of duty is established when it is shown that an employee has a duty to his or her employer and that he or she failed to act in a manner consistent with that duty. McCurdy v. Dep't of Social & Health Services, PAB No. D86-119 (1987).

4.5 Insubordination is the refusal to comply with a lawful order or directive given by a superior and is defined as not submitting to authority, willful disrespect or disobedience. Countryman v. Dep't of Social and Health Services, PAB No. D94-025 (1995).

4.6 Gross misconduct is flagrant misbehavior which adversely affects the agency's ability to carry out its functions. Rainwater v. School for the Deaf, PAB No. D89-004 (1989).

4.7 Willful violation of published employing agency or institution or Personnel Resources Board rules or regulations is established by facts showing the existence and publication of the rules or regulations, Appellant's knowledge of the rules or regulations, and failure to comply with the rules or regulations. A willful violation presumes a deliberate act. Skaalheim v. Dep't of Social & Health Services, PAB No. D93-053 (1994).

4.8 In regard to the allegation that Appellant engaged in unprofessional conduct, Respondent has met its burden of proof. However, Appellant and RN Wilson were each responsible for the deterioration of their working relationship. While Appellant behaved inappropriately, as her superior, RN Wilson should have appropriately addressed concerns as they arose. Instead, RN Wilson waited until she felt that the situation was intolerable before she reported her concerns.

4.9 Respondent has proven that more likely than not, Appellant released a confidential document without authorization to do so, engaged in unprofessional behavior, failed to follow RN Wilson's instructions, and failed to properly document and report a medication error. Respondent has met its burden of proving that Appellant's misconduct constituted neglect of duty, insubordination, gross misconduct, and willful violation of agency policies. Appellant was aware of agency policies and was given oral and written notice of her duty to behave in a professional, respectful manner. Yet, Appellant failed to abide by policies, was disrespectful, and refused to

comply with her superiors' directives. Respondent has proven that Appellant's behavior was contrary to the FHMC mission of providing client care and therefore, rose to the level gross misconduct.

4.10 Under the totality of the proven facts and circumstances, dismissal is appropriate and the appeal should be denied.

V. ORDER

NOW, THEREFORE, IT IS HEREBY ORDERED that the appeal of Marlene Westfall is denied.

DATED this _____ day of _____, 2001.

WASHINGTON STATE PERSONNEL APPEALS BOARD

_____
Walter T. Hubbard, Chair

_____
Gerald L. Morgen, Vice Chair

_____
Leana D. Lamb, Member

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