STATE OF WISCONSIN PERSONNEL COMMISSION

LYNN HINTZ,
Appellant,

v.

Secretary, DEPARTMENT OF CORRECTIONS,
Respondent.

Case No. 97-0079-PC

FINAL DECISION AND ORDER

A proposed decision and order (PDO) was mailed to the parties on April 1, 1999. The appellant filed written arguments. The Commission considered the arguments raised by the parties and reviewed the hearing record. The Commission did not disagree with the credibility assessments of the hearing examiner. Also, with a few minor exceptions (addressed below), the Commission agrees with the proposed findings of fact. However, the Commission redrafted the PDO to add a number of findings, and to expand on some of the findings made in the PDO. This has been done to address more fully the issues in this case and the parties' contentions. The Commission also has redrafted the proposed opinion for the same reasons.

This is an appeal pursuant to §230.44(1)(c), Stats., of a suspension and a demotion. The following findings of fact are based on the hearing record, and any findings of fact in the discussion are adopted as such.

FINDINGS OF FACT

1. Appellant, Lynn Hintz, was hired by the Department of Corrections (DOC) as a registered nurse at Oshkosh Correctional Institution in 1991. Two years later, she transferred to Oakhill Correctional Institution and then, a year later, to Waupun Correctional Institution (WCI), where on February 24, 1994, she was promoted to Health Services Nursing Supervisor 1 for the WCI infirmary. Her supervisor at WCI as of December 1993, was Kathleen Berkley, Health Services Nursing Sector Chief.

2. DOC made a decision to create a new infirmary at the Dodge Correctional Institution (DCI). The patients from the WCI infirmary (hereafter, the "Old Infirmary") were transferred to the DCI infirmary (hereafter, the "New Infirmary") on November 1, 1995. The appellant competed and was appointed as the day-shift supervisor of the New Infirmary. Kathleen Berkely was appointed as the Health Services Nursing Sector Chief at DCI and still functioned as the appellant's supervisor.

3. The *planned* organizational structure of the New Infirmary is shown by the chart attached to the appellant's position description (PD) which she signed on July 10, 1995 (Exh. A-8, p. 10). Ms. Berkley, as the Sector Chief, had direct supervisory responsibility over the New Infirmary's day supervisor (the appellant) and over the New Infirmary's night supervisor. The appellant had direct supervisory authority of the daytime staff which consisted of 5 registered nurses (RNs), a physical therapist, a program assistant 2, three licensed practical nurses (LPNs) and five nursing assistants (NAs). The night supervisor position was to have direct supervisory authority of the nighttime staff which consisted of four RNs, four LPNs and seven NAs.

4. The planned organizational structure was incomplete for most of the time appellant worked at the New Infirmary. In particular, the night shift supervisor position essentially remained vacant the entire time. The night supervisor position first was occupied on October 30, 1995, but that person left in December 1995. The position remained vacant until August 1996, but the new incumbent was rarely present and left in November 1996. The position then remained vacant until William McCreedy was hired as the night supervisor in March 1997. The appellant was expected to perform the duties of both positions, including supervision of permanent staff on all shifts (as noted in the prior paragraph), as well as several limited term (LTE) positions (LPNs or NAs) and inmate workers (cleaning swampers, laundry swampers and public service workers). The LTE positions were added in response to appellant's repeated requests for additional staff. Even with these additions, it was

appellant's opinion that the New Infirmary was understaffed. Ms. Berkley also thought the New Infirmary was understaffed and provided the following additional testimony:

> Before we even opened, Sharon (Zunker, Director of the Bureau of Health Services) had expressed the fact that she knew there wasn't enough positions for the infirmary and had requested additional positions to cover for vacations and those kinds of things and it was turned down before we even opened.

5. The appellant regularly put in long hours (more than 40 hours a week) to get her work done. She and Ms. Berkley were required to be available by pager 24 hours a day, 7 days a week.[1] The protocol was for staff to page the appellant first and to page Ms. Berkley only if staff could not reach the appellant.

6. Ms. Berkeley's job duties at the New Infirmary were as shown in the PD marked as Exh. R-5, pp. 396-403. It is not evident from the PD itself but it is true that Ms. Berkley performed those duties not only for the New Infirmary but also for another institution. Her job duties included responsibility for supervising the appellant (and others), as well as managerial responsibilities including helping to establish formal policies and procedures for the New Infirmary.

7. The appellant's job duties at the New Infirmary were described first in a PD which she signed on her first day of work (on 7/10/95) (Exh. A8), and later described in a PD which she signed on June 14, 1996, in relation to a planned reallocation of her position (Exh. A7). She was responsible for the day-to-day supervision of the New Infirmary, including supervision of health care provided to the inmate patients and the establishment of formal policies and procedures for the New Infirmary.

8. DOC suspended the appellant without pay for 10 days, and demoted her to a nursing position at an institution other than DCI. This was the first discipline

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[1] The hours appellant worked are noted in Exh. A-4. During the period from January through March 1997, the appellant worked an average of 49.46 hours per week. During the same time period the number of hours she worked a week ranged from 43 to 55 ¼.

imposed in her career with DOC. She was informed of the disciplinary action by letter dated July 21, 1997, the text of which is shown below in relevant part:

> This is official notification that you are suspended without pay for 10 working days, effective July 25, 1997, through August 7, 1997, and demoted from Health Services Nursing Supervisor to Nurse Clinician 2. You are suspended and demoted for violating the (DOC) Work Rules:
>
> A1. Insubordination, disobedience, or failure to carry out assignments or instructions as described in the Health Services Nursing Supervisor, Infirmary Position Description and BHS (DOC's Bureau of Health Services) Policies;
> A4. Negligence in performance of assigned duties as described in the Health Services Nursing Supervisor, Infirmary Position Description and BHS Policies;
> A21. Failure to comply with or violating any rule, regulation or order of a professional licensing agency when the license is related to the employee's position, namely Wisconsin Administrative Code, Chapter N6, Standards of Practice for Registered Nurses.
> A6. Falsifying records, knowingly giving false information or knowingly permitting, encouraging, or directing others to do so. Failing to provide truthful, accurate, and complete information when required.
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> On March 11, 1997, John[2] was admitted to the Health Services Unit, Infirmary, Dodge Correctional Institution, with a reaction to psychotropic medication. As the Infirmary's Health Services Nursing Supervisor, you were responsible for directing the health care that John received and ensuring that the health care met AMA Standards: 151 Infirmary Care (Essential) and the Nurse Practice Act. John was a patient at the HSU - Infirmary from March 11 to March 19, 1997. During this time, John's medical condition suffered decompensation that was directly attributable to inadequate patient evaluation, a lack of consistent and qualitative documentation in the charts/records of the inmate, and a failure to subsequently treat and manage his special medical needs.
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> On March 19, 1997, John was transferred on an emergency basis to the UWH&C with Malignant Neuroleptic Syndrome. Had you adequately

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[2] John is not the inmate's true name. It is used in this decision as a pseudonym.

> carried out your responsibilities as the Infirmary's Health Services Nursing Supervisor, John's medical condition would not have deteriorated to the point that his life was in danger.
>
> The seriousness of your failure to adequately perform your responsibilities as the HSU supervisor is exacerbated by your callous indifference to John's suffering. While an inpatient at the DCI HSU, John urinated and defecated in his room, and, because of his immobility and instability, found himself in his own waste. When John was removed from his cell on March 19, he was wet and dirty from his own urine and feces.[3] While under your medical care, John lost 19 lbs. and was admitted to the UWH&C undernourished and dehydrated. You not only ignored John's plea for help as evidenced by your March 17, 1997, directive to security and subordinate nursing staff to leave John on the floor without having done a nursing assessment but at an investigatory meeting you denied having given the directive which five staff members heard you give.
>
> The DCI Infirmary was opened on November 1, 1995. You were appointed Health Services Nursing Supervisor on February 24, 1994, to ensure when the Infirmary opened necessary policy and procedures would be in place. As of March 19, 1997, this had not been done. Changes affecting unit operations are made frequently, often through simply verbal/oral directives. Your failure to establish unit health care priorities and standards of performance expectations for subordinate staff, has generated confusion on the part of the professional staff, and has adversely affected the delivery of health care to inmates.
>
> A complaint will be filed with the Department of Regulation and Licensing regarding this incident.

<u>Policies and Procedures</u>

9. One reason given for the discipline was the appellant's failure to develop policies and procedures. The relevant portion from the disciplinary letter is repeated below.

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[3] Respondent is incorrect that John was lying in his own feces. RN Gould, who treated him on March 19, 1997, recorded that he was found incontinent of urine. She made no mention of feces. Further, the UW Hospital reported that John was constipated when he arrived at the hospital.

> The DCI Infirmary was opened on November 1, 1995. You were appointed Health Services Nursing Supervisor on February 24, 1994, to ensure when the Infirmary opened necessary policy and procedures would be in place. As of March 19, 1997, this had not been done.

DOC is incorrect in saying that the appellant was hired for the New Infirmary position on February 24, 1994. In February 1994, she was hired with supervisory duties relating to the Old Infirmary (see Exh. A-10), at which time she knew she also would be expected to help hire and train staff at the New Infirmary. Her actual hiring date at the New Infirmary on or about July 10, 1995.[4] DOC expected the appellant to perform duties related to the New Infirmary, such as hiring (which was done in October - December 1995), training the staff and developing policies and procedures for the New Infirmary before it opened. However, DOC also expected the appellant to continue to perform her duties in the Old Infirmary so the time available for working on New Infirmary tasks was limited.

10. Policies and procedures existed for the New Infirmary but had not been formalized (with the exception of two policies that had been formalized). There was a checklist for nurses to follow for newly admitted patients. Every position in every shift had its own post orders (including for the inmate workers) telling staff what they were to do during the shift. There also was a black ring binder containing a manual with job instructions that was kept at the nurses' station.

11. Ms. Berkely was aware that the policies and procedures were not all in place and were not put in formal format as required by DOC's Bureau of Health Care Services. Ms. Berkely did not fault the appellant for this because she recognized that the appellant did not have the time available to get the job done in light of other tasks which Ms. Berkley helped the appellant to prioritize.

12. Ms. Berkley assessed the appellant's work performance at the New Infirmary on two occasions. The first assessment covered the period from February 20, 1995 through February 19, 1996 (Exh. A-12). The second assessment covered the

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[4] The incorrect date also was recited inadvertently in the PDO.

period from February 23, 1996 through February 22, 1997 (Exh. A-13). Both evaluations specifically noted that formal policies and procedures were not done and yet Ms. Berkley gave the appellant positive performance evaluations

13. DOC conducted an investigation into the care and treatment of John. The investigative report (Exh. R-5, pp. 15-64) includes the following criticisms (as relevant to policies and procedures) of Ms. Berkley's performance of duties assigned in her PD:

> Kathleen Berkley has not met the requirements in the Health Services Sector Chief Position Description as follows:
> - Did not interpret and put in effect administrative policies established by the Bureau.
> - Has not determined the amount and how to deliver inmate care services in the infirmary for inmates in program segregation status, clinical observation status and the mentally ill inmate . . .
> - There is no evidence of organized inmate care services to delineate authority, functional responsibility, lines of relationship and communication to provide safe and therapeutically effective services at DCI Infirmary.
> - No evidence of DCI Infirmary programs being reviewed . . .
> - There has been no analysis of inmate care services to improve quality of care and maximum utilization of staff.
> - Ineffective supervision of Lynn Hintz, as evidenced by her actions in handling the health care of John.
> - Has not identified clinical indicators to measure and evaluate quality care.
> - Has not prepared manuals, guidelines or procedures to be used in the Infirmary.
>
> There is inconclusive evidence to suggest if the above facts would reach the threshold of work rule violations rather than indicators of unsatisfactory work performance.

14. DOC did not impose discipline on Ms. Berkley for the shortcomings identified during its investigation. Nor did DOC refer Ms. Berkley to the licensing board. Instead, DOC treated the problems as an indicator of unsatisfactory work performance and, accordingly, did not give her a discretionary award for 1997.

Nurse Charting and Assessments

15. Nurses are trained in charting and performing nursing assessments as part of their professional training. The appellant included these topics as part of the orientation training for New Infirmary staff. The appellant's expectation was that a nursing assessment would be done when a patient was admitted to the infirmary, that 3 assessments would be done daily for the patient's first three days at the infirmary and that an assessment would be done once a week thereafter (or more frequently if the inmate's medical condition changed). Initially, the appellant delegated to RN Sue Ward the task of double-checking to ensure that care plans had been developed. RN Ward left the New Infirmary (date unknown in this record) and no one else was assigned the task of ensuring that care plans had been developed.

16. The appellant was aware as early as January 1997 that a problem existed with nurses who were not doing charting and were not documenting assessments as they had been trained to do. The appellant included this as an area for improvement on the nursing evaluations she did in January and February 1997.

17. That a problem existed with nurse charting and assessments was reinforced on February 3, 1997, when Ms. Berkley (who also functioned as chair of the Bureau of Health Care's mortality committee) told appellant that such problems existed in regard to the treatment of a different inmate in September 1996. The appellant discussed the issue at a staff meeting on February 13, 1997.

The Care and Treatment of Inmate John

18. John was incarcerated at WCI. On March 11, 1997, Dr. Yogesh Pareek, psychiatrist, assessed John at WCI. His resulting treatment plan is shown below (Exh. R-6, p. 86):

> The patient at this point is having excessive drooling, decreased sleep and restlessness, but I do not think at this point that this is related to his medication as he is not taking them regularly. He said that he has been taking these medications since December and these things started only nine days ago. Because patient is complaining of weakness and not eating, I will discuss with Dr. Belgado about sending him to the

> infirmary for a few days and offer him IV therapy. I will discontinue the Paxil and the Artane and reduce Haldol to 5 mg . . . for four days and then discontinue. At this point I would like to observe him without any medications. I will see him when he comes back to the infirmary.

Dr. Belgado assessed John at DCI the same day. The relevant portion of his progress note is shown below (Exh. R6, pp. 11-11A):

> Subjective: Very weak, unable to walk, take care of himself, constipation and not able to get to the toilet causing him to have bed and pants wetting.

Dr. Belgado agreed that John should be sent to the New Infirmary for observation and contacted the appellant. The appellant's documentation of this phone call is shown below (Exh. R6, p. 11A):

> Telephone call from Dr. Belgado reports inmate unable to walk for 9 days & incontinent of bowel and bladder. Questionable reaction to psychotropic meds, decreased. Needs to be monitored.

19. A daily summary of the care and treatment of John at the New Infirmary from March 11 through March 19, 1997 is provided in the following paragraphs. Although not evident from the summary, respondent faulted nursing staff for failing to review or recognize the charting which was done (in varying degrees of completeness) by the NAs in regard to information such as the amount of food John was or was not consuming.

20. On **March 11, 1997**, John arrived at the New Infirmary at 2:57 p.m. RN **Cindy Gould** initiated but did not complete his admission assessment. She did not develop a care plan. She noted that John was able to walk to his cell (quite a distance) but had an unsteady gait. She noticed he was drooling. He complained of muscle rigidity and twitching in his legs and abdomen. She saw him bend over in his cell to pick his food tray off the floor and to hand it through the trap door. Psychologist **Joseph Grochowski** visited John on the same date and conducted an assessment through the cell door without reading the inmate's medical chart. He found John to be

alert but unresponsive and without further assessment concluded that John "was refusing to see me." An RN on each shift was assigned to give care and treatment to John and was expected to perform a nursing assessment. The incomplete admission assessment was the only nursing assessment done for John this day.

21. At 8:45 a.m. on **March 12, 1997**, John was evaluated by **Dr. Elsa Horn** with **Heidi Blair**, RN, present. John told Dr. Horn that he had not eaten for 6 days, that his legs were shaky with tremors and that he could not get up. Dr. Horn noted that the inmate could open his hand but reluctantly, "appears stiff." The inmate said he could not touch his nose with his finger, yet he drank water from a cup without difficulty. Dr. Horn's conclusion recorded in the progress notes was that John was experiencing a "psychiatric problem with possible drug reaction." She further noted that his condition was difficult to assess medically "because of psychiatric overlay" (Exh. R-5, p. 118). The appellant consulted with Dr. Horn after Dr. Horn saw the inmate. Dr. Horn reported to the appellant that there were no abnormal physical findings. Dr. Horn said she was concerned with the "psychiatric overlay" and the appellant replied that she had contacted Clinical Services the previous day to arrange for a psychiatric visit but the psychiatrist was unavailable until Thursday. Dr. Horn did not order any lab work, medical monitoring or follow up visits to address the inmate's complaint of not eating. **Dr. Grochowski** again assessed the inmate through the cell door this day. At about 6:15 p.m., Linda Edmunds, NA, recorded that the inmate could walk. An RN on each shift was assigned to give care and treatment to inmate John and was expected to perform an assessment. No nursing assessment was done this day. The charting (by either LPNs or NAs) indicated that John refused breakfast, ate 10% of his lunch and 75% of his supper.

22. John was observed on **March 13, 1997**, at times able to walk and stand on his own and at other times able to walk only with assistance. He was seen standing by himself at the toilet. At other times he was incontinent of urine. An RN on each shift was assigned to give care and treatment to John and was expected to perform an assessment. No nursing assessment was done this day. Psychiatric consultant, **Dr. J.**

R. Musunuru, saw John this day. He noted the inmate was feeling restless and had an urgent need for movement. He ordered lab work. The appellant discussed John's condition with Dr. Musunuru. The appellant was concerned about the apparent contradictory behaviors reported to her such as John's ability to walk and to go to the bathroom on his own. Dr. Musunuru told the appellant that he planned to evaluate this. NAs recorded that they were unsure if he ate breakfast, that he ate 10% of his lunch and 75% of his supper this day.

23. On **March 14, 1997**, John continued to exhibit contradictory behaviors. At 7:15 a.m., the progress notes indicate that John positioned himself for breakfast and medications. At 8:15 a.m., Sherri Knaup (LPN), found the inmate on the toilet. He told her that he could not get back to bed. She responded by telling him that he was "very capable of getting back to bed." She left his line of sight and returned finding him back in his bed in a sitting position. The progress notes indicate that LPN Knaup informed a RN and the doctor (but no names given). A progress note at 7:30 p.m. by LPN Guest indicates that the inmate was standing at his cell door drooling. He was unable to tip his head back far enough to take medication on his own. He was unsteady on his feet and trembling slightly. He answered questions appropriately. She informed RN Vick. At 7:30 p.m., NA Edmunds recorded in the progress notes that she offered John ice and juice. The inmate said, "look at my bed, it's all wet and so am I. I need to be changed." She entered the cell (with security staff) and changed the bed. She gave him clean clothes. After leaving the cell, she observed John remove his soiled clothes and put on clean clothes. NAs recorded that John appeared confused and delusional. No nursing assessment was done this day.

24. On **March 15, 1997**, a RN (name illegible) entered a progress note indicating that John had called out to a security officer making rounds. The RN found the inmate lying perpendicular across his bed, body rigid, saying that he needed help, that he would like to get his head up off the bed rail. The RN noted drool down his head and that he was incontinent of urine. The RN felt he was in danger of harming self due to his inability to do things for himself. The RN cleaned up and left him with a

urinal and instructions on how to use it. The RN's recorded plan was to monitor the inmate every 30 minutes. No documentation exists to show that this was done. No nursing assessment was done. A progress note indicates that at 11:00 a.m., John was seen standing in front of his door looking down at the floor. He was seen by **Dr. J.R. Musunuru**, psychiatrist, who recorded that the inmate is "showing more of malingering than any other problems at this time."

25. On **March 16, 1997**, a NA recorded that John ate no meals, had a depressed attitude and was incontinent 7 times. No nursing assessment was done.

26. On **March 17, 1997**, at 12:30 a.m., **Mark Oddsen**, RN, heard John calling for help and found him in bed incontinent of urine. Nurse Oddsen concluded that that the inmate was "non-compliant in willingness to do self cares." He left a gown and clean bed linens on the trap door and instructed the inmate how to use bed controls to assist himself up and how to use the call light rather than shouting. One hour later, RN Oddsen recorded in the progress notes that he found John still lying in bed "refusing to attempt self cares." RN Oddsen (and security staff) entered the cell and assisted John to the toilet. John was told to clean himself up. RN Oddsen then records that John was "unable" to clean himself. LPN Knaup wrote a progress note at 11:30 a.m. indicating that John had been found lying on the floor and "refused" to put himself back into bed. He was incontinent of urine. LPN Knaup (and security staff) entered the cell and changed his bed linen which was wet from urine. It took a gait belt and 3 people to place him back in bed. LPN Knaup reported that John was later observed standing at his sink. At 1:45 p.m., Officer Lesperance was making his initial rounds on the unit and saw John lying on his cell floor. Officer Lesperance asked the inmate if he was hurt. John replied he was not hurt but he needed help to get back to bed. Officer Lesperance notified Sergeant Otto and nursing staff. The appellant told Sergeant Otto <u>not</u> to go into John' cell due to the fact that he was capable of walking on his own and also because he was not injured. When Officer Lesperance heard about the appellant's instructions to Sergeant Otto, he filed an incident report (Exh. R-3). Later, NA **Linda Edmunds** saw John lying on the floor. She knocked at his cell door

but he didn't get up. She reported this to RN **Sherri Sayles**. They both went to **Officer Lesperance** to make arrangements to enter John' cell. Officer Lesperance said they could not enter the cell per instructions from the appellant. At 2:00 p.m., a shift report occurred. **William McCreedy** who was recently hired as the night supervisor attended. He heard the appellant instruct staff to leave John on the floor for awhile to teach him that we are not going to play that game (or words to that effect) and he memorialized the comment in notes he kept for his own use (Exh. R-4). RN Gould wrote a progress note at 7:40 p.m., saying that John had been lying on the floor the entire shift. She notified Lieutenant Koening. After Lieutenant Koening arrived at John's cell, John threatened to harm himself. Lieutenant Koening made the decision to remove John from his cell and to place him in observation due to the threats of self-harm. **RN Gould** evaluated John at 8 p.m., after he was placed in observation. John was unable to raise his legs. He had a pressure area on his left calf caused by lying on a bolt used to hold the railing down by the toilet in his cell. He told RN Gould that he did not want to live anymore. She cleaned him up. John ate no food this day. He was depressed and confused. He was not offered water from the time he was placed in observation until the end of the day.

27. On **March 18, 1997**, John was not given water all day. At 4:42 p.m., **RN Vick** recorded that John said he was hungry. A "bag supper" was left on the trap door, but John did not get up to retrieve the food. RN Vick recorded in the progress notes at 5:30 p.m., that John was lying on his mattress and had urinated on the floor, but the mattress was dry. RN Vick thought that John must have sat or stood up to urinate without hitting the mattress. RN Vick concluded that John was non-compliant. No nursing assessment was done this day. **Psychologist Grochowski** again observed the inmate through the cell door. Dr. Grochowski told staff that John appeared catatonic. Dr. Grochowski told staff that he would work on getting John transferred to the Wisconsin Resource Center (WRC) on an emergency basis. Later, Dr. Grochowski spoke with staff at the WRC and was learned that the transfer would not occur. Dr. Grochowski failed to inform staff at the New Infirmary that the transfer would not

occur. **Dr. Musunuru** saw John after he was placed in clinical observation. He thought John was exhibiting psychotic behavior. He ordered that the inmate be given Haldol and Artane in liquid form.

28. On **March 19, 1997**, at 1:45 a.m., John yelled for help. There is no documentation of what assistance was provided (if any). At about 6:00 a.m., John was incontinent of urine. There is no documentation to indicate whether he was cleaned up. At 7:12 a.m., John asked for help and a nurse was notified. There is no documentation of who responded (if there was a response). A shift report occurred at 3 p.m., at which time **Cindy Gould**, RN, was informed that John had not eaten or drunk for 3-4 days. She contacted security staff to prepare to enter his cell. The cell entry occurred at 4:00 p.m., at which time RN Gould found John lying in urine which was a very dark amber color and odorous. It took four security offices to get the inmate into a standing position. The inmate, room and mattress were cleaned. RN Gould performed a nursing assessment, noting that he had lost 19 pounds while at the New Infirmary. She noted drooling as well as a spot on his buttocks where the skin had broken down from being left lying the same position for an extended period of time. He was "very rigid" especially his arms and legs. She was concerned that he was dehydrated. He drank 4 glasses of water and then felt nauseous. She obtained a physician order to start an IV. John agreed to the IV but said he did not want to take his medications because they "will hurt me." She was unable to insert the IV. At 6:00 p.m., RN Gould instructed Thomas Schmidt, LPN, to give John the Haldol and Artane elixir prescribed by Dr. Musunuru. Dr. Tregoning was informed of the inmate's condition at about 6:35 p.m. Dr. Tregoning authorized transferring the inmate to a local hospital. The local hospital indicated the inmate should be sent to the UWHC in Madison. At 8:25 p.m., John was transferred to the UWHC. UWHC emergency physicians saw John at 12:30 a.m. and their diagnosis was severe dehydration and malnutrition, as well as "probable" Neuroleptic Malignant Syndrome (NMS). He was admitted to the geriatric ward where

he remained for about six days. His discharge diagnosis included NMS (Exh. R-6, p. 45).[5]

29. NMS usually occurs in reaction to psychotropic medications. This condition is characterized by autonomic dysfunction (excessively rapid heartbeat, unstable blood pressure, profuse perspiration, a sense of difficulty in breathing, and urinary incontinence), extrapyramidal dysfunction (manifested by catatonic behavior, dystonia, generalized muscle rigidity and pseudo-parkinsonism), high body temperature and fluctuation in levels of consciousness (ranging from being alert to being in a coma). The overall mortality rate is 20 percent. (*Harrison's Principles of Internal Medicine*, 12th Edition, R #5)

The Investigation

30. At some point during this period, appellant's supervisor, Health Services Sector Chief Kathleen Berkley, informed the Bureau of Health Services (BHS) Director Sharon Zunker, her supervisor, about John's case. Zunker instructed Berkley to have the p.m. supervisor, Bill McCreedy (who was still in training status), review the medical records and prepare a report.

31. After receiving McCreedy's report and a response from Berkley, Zunker reported the matter to Kenneth Sondalle, the Administrator of the Division of Adult Institutions. Afterward, an investigation was commenced.

32. On March 26, 1997, under the direction of respondent's Office of Audit, Investigation and Evaluations, BHS Medical Director, Dr. Daley, BHS Sector Chief Dale Poliak (RN) and WRC (Wisconsin Resource Center) Deputy Warden Steve Casperson were assigned to investigate the health care received by John.

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[5] The appellant contended that respondent failed to establish that John had NMS. The medical records from the UW Hospital and Clinics were reliable and provided the basis for finding that John did have NMS. Even if the diagnosis of NMS were considered as incorrect, the outcome of this case would not be affected. The fact would remain that John was dehydrated and malnourished when admitted to the UW Hospital. The fact also would remain that the appellant failed to ensure that nurses were charting and completing assessments, as detailed in the Opinion section of this decision.

33. The particular subject matter under investigation was: a) the nursing care given to John at the DCI infirmary from March 11, 1997 to March 19, 1997; b) the medical care given to John during the same period; c) the psychiatric care given to John during this same period and d) the management of health care delivery at the New Infirmary.

34. Twenty-three staff members of the New Infirmary were interviewed during the investigation including 12 nurses, 3 doctors, 3 correctional officers, 2 psychologists, 1 social worker, 1 practical nurse and 1 nursing assistant. Appellant was among the nurses interviewed.

35. On May 20, 1997, a report of the investigation, prepared by Daley, Casperson and Poliak, was submitted to Gloria Thomas of the Office of Audit, Investigation and Evaluation.

36. Next, after holding several meetings discussing the report, respondent assigned a panel to conduct pre-disciplinary hearings. As a result of the pre-disciplinary hearings, respondent imposed discipline on appellant and several other DCI infirmary staff.

Other Staff Disciplined

37. **Dr. Elsa Horn**, physician, received a one day suspension and was referred to the Department of Regulation and Licensing (DRL). The letter of discipline (Exh. A-3, pp. 41-42) contained the following explanation:

> This action is being taken based on the care and treatment of John from March 11, through March 19, 1997, in the (New Infirmary). During this time, you failed to recognize the serious medical decompensation of John from March 11, to March 19, 1997; performed a cursory examination of John on March 12, 1997, which resulted in an order for Clonidine for his slightly elevated blood pressure. John stated to you that he had not eaten for six days. You did not order any lab work, daily weights, monitoring for nutritional intake, or physician follow-up; you indicated that the medical diagnosis of John was difficult because of his "psychiatric overlay." You could not assess his gait because he would not stand up. You did not notice any drooling or muscle twitching when you saw the inmate on March 12; you did not confer/consult with a

> psychiatrist when you were unable to differentiate between medical and psychiatric symptomataology in John. These actions and inactions contributed to the decompensation of John and resulted in his hospitalization in the University of Wisconsin Hospital and Clinics (UWHC).

38. **Cynthia Gould**, RN, received a one-day suspension and was referred to the Department of Regulation and Licensing (DRL). The letter of discipline (Exh. A-3, pp. 37-38) contained the following explanation:

> This action is being taken based on the care and treatment of John . . . During this time, you omitted the bowel and bladder evaluation, psycho-social functioning and neurological portion of your admission nursing assessment performed on John on March 11, 1997; did not develop a plan of care for John following your March 11th nursing assessment; did not act on the abnormalities detected as a result of the nursing assessment performed on John on March 11, 1997, notable, the pulse rate . . . the blood pressure . . . and his slurred speech; allowed Mr. Schmidt, LPN, to give John Haldol on March 19, 1997, even though John told you that the medication was making him sick, thus causing further harm to him; on March 19, 1997 at 16:00 hours, identified an abnormal pulse of 127 and an O2 saturation of 92% and failed to provide any further monitoring of these conditions for 4.5 hours while awaiting the transfer of John to the (UWHC).

39. **Sherri Sayles**, RN, received a written reprimand and was referred to the Department of Regulation and Licensing (DRL). The letter of discipline (Exh. A-3, pp. 49-50) contained the following explanation:

> This action is being taken based on the care and treatment of John . . . in the (New Infirmary). During this time, you failed to recognize the serious medical decompensation of John; did not perform a nursing assessment, even though you should have been aware of the abnormal nutritional intake of John as indicated on flow sheets from March 14, 15, and no nutritional intake on March 16, 17, 18, and 19, 1997; failed to act on the fact that the flow sheets indicated incontinence of urine and/or bowels twelve times on the days you were scheduled to work between March 11 and 19, 1997; you did not report the abnormal nutritional intake and incontinence to the Unit Physician; failed to act on information provided to you by Ms. Knaup on March 14, and March 17,

1997, regarding John's deteriorating condition and failed to pursue your concerns regarding John with your supervisor or the sector chief. This resulted in John experiencing serious medical decompensation from March 17, to March 19, 1997, resulting in his hospitalization at the (UWHC).

You will also be referred to the Department of Regulation and Licensing regarding this incident.

40. **Joseph Grochowski**, psychologist received a verbal reprimand. (Exh. A-3, p. 138).

41. **Mark Oddsen**, RN, received a verbal reprimand. (Exh. A-3, 0. 138).

42. **Gwendolyn Vick**, RN, received a verbal reprimand. (Exh. A-3, p. 139).

43. **Heidi Blair**, RN, received a verbal reprimand. (Exh. A-3, p. 139)

44. **Dr. J. R. Musunuru**, psychiatrist, was terminated. The termination letter (Exh. A-3, pp. 39-40) contained the following explanation:

> During the investigation interview on April 18, 1997, you indicated you were not responsible for the psychiatric care of infirmary inmates. The psychiatric position description states that the psychiatrist tends to the mental needs of inmates, diagnosing, treating, and presenting a plan of care, ordering laboratory work and diagnostic tests, provides exams, monitors care plans for inmates in the infirmary. A review of your contacts with John shows you failed to identify a malignant neuroleptic syndrome and in fact, on March 18, 1997, you ordered Haldol, a drug that could have caused or aggravated such a condition. You continued to deny the presence of this syndrome even after receiving notes from UW Hospital relating to the inmate's hospitalization where such syndrome was diagnosed. You also failed to make any notes in the inmate's medical record that would prevent the medication from being prescribed in the future with the risk of exacerbation of the syndrome.
>
> Your medical notes dated 3-15-97, transcribed on 4-7-97 state that the inmate was eating and drinking well yet by March 19, he had lost 19 pounds.
>
> Several sets of dictation to be transcribed were received in the transcription center covering the period of 3-13-97 to 3-29-97. The

> dictation, with overlapping dates, was received on 3-18-97 and 4-2-97. On 4-17-97, you changed your dictation transcribed on 4-15-97. You were asked during the investigation if there was only one set of transcribed dictation. You said there was only one, when in fact there were at least two.
>
> Your failure to diagnose the inmate's serious condition, to adequately treat it, and the alteration of records pertaining to your care, presented a danger to the health and safety of your patient and constituted unprofessional conduct.
>
> Therefore, though the work rule infractions occurred in your contract position at the DCI, your ability to provide proper psychiatric care to inmates at WCI, and the confidence of other practitioners and program managers in your ability to perform, has been destroyed.

CONCLUSIONS OF LAW

1. This matter is properly before the Commission pursuant to §230.44(1)(c), Stats.
2. Respondent has the burden of proof.
3. Respondent has sustained this burden of proof by establishing there was just cause for imposing discipline.
4. The demotion imposed as discipline was not excessive.
5. The 10-day suspension imposed as discipline was not excessive.

OPINION

The issue in this case is:

> Whether there was just cause for the disciplinary action (suspension and demotion) imposed. Sub-issue: Whether the amount of discipline imposed was excessive.

The particular questions to be answered are: 1) whether the greater weight of credible evidence shows that the appellant committed the conduct alleged by respondent in its letter of discharge; 2) whether the greater weight of credible evidence shows such chargeable conduct, if true, constitutes cause for imposition of discipline; and 3) whether the imposed discipline was excessive. *Mitchell v. DNR,* 83-0228-PC, 8/3/84.

The respondent charged in the letter of discipline (see ¶8 of the Findings of Fact) that the appellant failed in her duties relating to the delivery of quality health care in the infirmary, and that, as a result, inmate John was given poor health care and suffered a deterioration of his condition while at the New Infirmary. This charge was proven with the exception of a few minor aspects. A second charge was that the appellant failed to have formal policies and procedures in place at the New Infirmary. This charge was true (with the exception of 2 formal policies). A third charge in the letter of discipline was that the appellant instructed staff on March 17, 1997, to leave John on the floor. This charge was true.[6] The final charge in the letter of discipline was that the appellant provided false information during respondent's investigation when she denied telling staff to leave John on the floor. This charge was true.

We now address the question of whether the conduct engaged in by the appellant constitutes "just cause" for imposing discipline. In *Safransky v. Personnel Board*, 62 Wis. 2d 462, 474, 215 N.W.2d 379 (1974), the court held (citing *State ex.rel. Gudlin v. Civil Service Comm.*, 27 Wis. 2d 77, 87, 133 N.W.2d 799 (1965)) that "just cause" exists when "some deficiency has been demonstrated which can reasonably be said to have a tendency to impair his [her] performance of the duties of his [her] position or the efficiency of the group with which he [she] works."

There can be no question in this case that respondent established just cause pursuant to the *Safransky* standard. Appellant's failure to adequately manage and supervise the New Infirmary led directly to the inadequate nurse charting and nurse assessments for John which contributed to the deterioration of his medical condition. The failure to formalize policies and procedures was a factor in the poor health care given to John, and was inimical to the New Infirmary's mission of providing quality

[6] The appellant denied that she told staff to leave John on the floor. Such denial was not credible. Two different individuals recorded that the appellant's instructions were for staff to leave John on the floor. Each individual recorded the comment that was heard in writing and the written recording was made shortly after the comment was heard. The Commission was persuaded that the two written recordings were trustworthy

health care. The appellant's specific instructions to leave John on the floor, without first have a nursing assessment done as to his then-current medical condition was inconsistent with the responsibilities of a health care supervisor and provided a poor role model for her subordinates. Finally, the appellant's lack of candor about her statement to leave John on the floor, was inconsistent with the honesty respondent should be able to expect from supervisory or line staff.

The next question is to determine whether the discipline imposed (demotion and 10-day suspension without pay) was excessive. In *Kleinsteiber v. DOC*, 97-0060-PC, 9/23/98 (p. 12), the Commission addressed factors to consider in determining whether the discipline imposed was excessive as follows:

> If just cause is shown, the focus of the inquiry shifts to the question of whether the discipline imposed was excessive. Some factors which enter into this determination include the weight or enormity of the employee's offense or dereliction, including the degree to which, under the *Safransky* test, it did or could reasonably be said to tend to impair the employer's operation; the employee's prior record (*Barden v. UW*, 82-2237-PC, 6/9/983); the discipline imposed by the employer in other cases (*Larsen v. DOC*, 90-0374-PC, 5/14/92); and the number of the incidents cited as the basis for discipline for which the employer has successfully shown just cause (*Reimer v. DOC*, 92-0781-PC, 2/3/94).

A mitigating circumstance exists in regard to the appellant's reliance on informal policies and procedures. Specifically, Ms. Berkley helped to prioritize the appellant's workload and, in fact, condoned that the policies were not formalized yet. Another mitigating circumstance is that the night supervisor position was vacant essentially for the entire period at issue in this case. Another consideration in the appellant's favor is that she had no prior discipline.

However, as early as January 1997, the appellant knew that the informal procedures proved insufficient for nurse charting and nursing assessments. She also knew by this time that her prior random check of medical records was insufficient to ensure that nurse charting and assessments were being done. In January and February 1997, she did remind nurses of her expectations in the areas of charting and

assessments (in performance evaluations and at a staff meeting). What she did not do (and what she should have known needed to be done) was to institute a procedure to ensure nurses did in fact chart and assess as expected.

The demotion was not excessive. The appellant no longer could be a proper role model for the staff in the New Infirmary because of her instructions to leave John on the floor without first ensuring that a nursing assessment was done as to his then-current medical condition. Her untruthfulness during the investigation further eroded any notion that it would have been reasonable to leave the appellant as a supervisor at the New Infirmary. Also, the seriousness of the deficiencies in the care and treatment of John and the degree to which the appellant's conduct contributed to those deficiencies militate against keeping the appellant as a supervisor of the New Infirmary. Simply stated, the respondent should not be required to give the appellant another chance in the same position when the potential consequence of repeated error is as serious as occurred here and the appellant's deficiencies were so pronounced.

The 10-day suspension was not excessive. The suspension was not needed to correct the appellant's deficiencies as a manager because the demotion effectively removed managerial tasks from her. However, she continues in respondent's employment as a registered nurse. The imposed suspension was reasonable to stress upon her the importance of performing nursing assessments and charting, the inappropriateness of leaving a patient lying on the floor without first performing a nursing assessment and the importance of being honest. All these factors are pertinent and important to her continued employment with respondent as a nurse.

It cannot be denied that the appellant was not the only person whose performance deficiencies contributed to the decline in John's medical condition while he was at the New Infirmary. The Commission reviewed the discipline (or lack thereof) which respondent imposed on other staff. Respondent did not impose discipline on employees who were in training status at the time John was at the New Infirmary and this was a reasonable approach to take. In addition to the appellant's performance failures there also were failures on the part of Ms. Berkley (see ¶14 of the Findings of

Fact), other nurses (see ¶¶ 20-28, 38-39 and 41-43 of the Findings of Fact), and physicians (see ¶¶37, 40 & 44 of the Findings of Fact), as well as the staff psychologist.

Ms. Berkley received no discipline. This is troublesome to a degree. Respondent, however, did recognize her performance deficiencies (as noted in ¶13 of the Findings of Fact) when she was not granted a discretionary award for 1997. Further, distinctions exist between the performance failures of Ms. Berkley and the appellant. Ms. Berkley did not lie during the investigation. Also, it was the appellant as the day-to-day supervisor of the New Infirmary who (at least as early as January 1997) should have known that steps needed to be taken to ensure that nursing assessments and charting were done according to expectations.

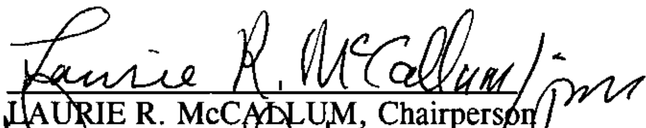
Staff nurses who were disciplined received less discipline than the appellant. Unlike the appellant, the staff nurses were not responsible for the day-to-day supervision of the New Infirmary and they did not lie during the investigation. Under these circumstances, the Commission cannot conclude that the lesser discipline received by other nurses is a valid basis to find that the discipline imposed on the appellant was excessive.

ORDER

Respondent's decision of July 21, 1997, demoting appellant from Health Services Supervisor to Nurse Clinician 2, is affirmed; respondent's decision to suspend the appellant for 10 days without pay is affirmed.

Dated: August 2, 1999.

STATE PERSONNEL COMMISSION


LAURIE R. McCALLUM, Chairperson

DONALD R. MURPHY, Commissioner

JUDY M. ROGERS, Commissioner

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NOTICE
OF RIGHT OF PARTIES TO PETITION FOR REHEARING AND JUDICIAL REVIEW
OF AN ADVERSE DECISION BY THE PERSONNEL COMMISSION

Petition for Rehearing. Any person aggrieved by a final order (except an order arising from an arbitration conducted pursuant to §230.44(4)(bm), Wis. Stats.) may, within 20 days after service of the order, file a written petition with the Commission for rehearing. Unless the Commission's order was served personally, service occurred on the date of mailing as set forth in the attached affidavit of mailing. The petition for rehearing must specify the grounds for the relief sought and supporting authorities. Copies shall be served on all parties of record. See §227.49, Wis. Stats., for procedural details regarding petitions for rehearing.

Petition for Judicial Review. Any person aggrieved by a decision is entitled to judicial review thereof. The petition for judicial review must be filed in the appropriate circuit court as provided in §227.53(1)(a)3, Wis. Stats., and a copy of the petition must be served on the Commission pursuant to §227 53(1)(a)1, Wis. Stats. The petition must identify the Wisconsin Personnel Commission as respondent. The

petition for judicial review must be served and filed within 30 days after the service of the commission's decision except that if a rehearing is requested, any party desiring judicial review must serve and file a petition for review within 30 days after the service of the Commission's order finally disposing of the application for rehearing, or within 30 days after the final disposition by operation of law of any such application for rehearing. Unless the Commission's decision was served personally, service of the decision occurred on the date of mailing as set forth in the attached affidavit of mailing. Not later than 30 days after the petition has been filed in circuit court, the petitioner must also serve a copy of the petition on all parties who appeared in the proceeding before the Commission (who are identified immediately above as "parties") or upon the party's attorney of record. See §227.53, Wis. Stats , for procedural details regarding petitions for judicial review.

It is the responsibility of the petitioning party to arrange for the preparation of the necessary legal documents because neither the commission nor its staff may assist in such preparation.

Pursuant to 1993 Wis. Act 16, effective August 12, 1993, there are certain additional procedures which apply if the Commission's decision is rendered in an appeal of a classification-related decision made by the Secretary of the Department of Employment Relations (DER) or delegated by DER to another agency. The additional procedures for such decisions are as follows.

1. If the Commission's decision was issued after a contested case hearing, the Commission has 90 days after receipt of notice that a petition for judicial review has been filed in which to issue written findings of fact and conclusions of law. (§3020, 1993 Wis. Act 16, creating §227.47(2), Wis. Stats.)

2. The record of the hearing or arbitration before the Commission is transcribed at the expense of the party petitioning for judicial review (§3012, 1993 Wis. Act 16, amending §227.44(8), Wis. Stats.)

2/3/95