COMMONWEALTH OF PENNSYLVANIA

Michael Tyson	:	State Civil Service Commission
	:	
v.	:	
	:	
Torrance State Hospital, Department of Human Services	:	Appeal No. 29726

Jerome J. Kaharick	Taylor Nicholas
Attorney for Appellant	Attorney for Appointing Authority

ADJUDICATION

This is an appeal by Michael Tyson challenging his two one-day suspensions without pay from regular Forensic Registered Nurse employment with the Torrance State Hospital, Department of Human Services. A hearing was held October 25, 2017, at the Torrance State Hospital in Torrance, Pennsylvania before Commissioner Odelfa Smith Preston.[1]

The Commissioners have reviewed the Notes of Testimony and exhibits introduced at the hearing. The issue before the Commission is whether the appointing authority had good cause to issue both of appellant's one-day suspensions without pay.

[1] Odelfa Smith Preston's service as a Commissioner ended March 21, 2019, before this adjudication was issued.

FINDINGS OF FACT

1. By letter dated August 13, 2017, appellant was issued a one-day suspension without pay from his position as a Forensic Registered Nurse, regular status, effective with the start of his shift on Wednesday, August 16, 2017. The appointing authority charged:

> The reason for this suspension is: Failure to Follow Procedures (as defined by DHS 7174). Specifically you tightly wrapped a strongly adhesive tape in three layers directly to the skin of the upper thigh of a patient in order to hold a Foley in place. This resulted in tears to the patient's skin upon removal.

Comm. Ex. A-1.

2. By letter dated August 13, 2017, appellant was issued a one-day suspension without pay from his position as a Forensic Registered Nurse, regular status, effective with the start of his shift on Thursday, August 17, 2017. The appointing authority charged:

> The reason for this suspension is: Failure to Follow Procedures (as defined by DHS 7174). Specifically, you did not administer required medications, Haloperidol and Benztropine, to a patient [on] July 13,

> 2017, on the C2 unit of the Forensics Center and did not report the error. These actions are violations of Nursing Policy 85-88: Medication Administration Checklist and Mediation/Treatment Administration Guidelines.

Comm. Ex. A.

3. This appeal was properly raised before this Commission and was heard under Section 951(a) of the Civil Service Act, as amended.[2]

4. On December 7, 2015, appellant began his employment as a Registered Nurse with the appointing authority. Comm. Ex. E.

Foley Catheter Tube:

5. Patient Mr. S. has a Foley catheter. A Foley catheter has a tube that goes down the patient's leg and is secured to the patient's thigh. N.T. pp. 18, 41, 43.

6. On or about June 28, 2017, during the afternoon shift, Mr. S. reported to a Forensic Security Employee (hereinafter "FSE") he was in pain and discomfort caused by the Foley catheter tube, which

[2] Appellant's request for a hearing under Section 951(b) was denied.

was taped to his right thigh. The FSE reported the information to Registered Nurse Lance Updegraff. N.T. p. 19.

7. Updegraff told Registered Nurse Tara Barnhart Mr. S. was reporting pain and discomfort in the area of the Foley catheter tube. Updegraff also stated there was tape applied tightly to the patient's leg. N.T. pp. 19-20.

8. Updegraff also notified Forensic Registered Nurse Supervisor Lisa Conrad who arrived on the floor. N.T. pp. 20, 69.

9. When Conrad and Updegraff went to Mr. S.s' room, Conrad saw there were three layers of half inch-wide silk tape wrapped tightly around Mr. S.'s leg. One layer of tape was directly on Mr. S.'s skin; the other two layers were wrapped over the first one. N.T. pp. 56-57, 62-63, 70-71.

10. Appellant had utilized silk tape when he attached Mr. S's Foley catheter tube to Mr. S.'s leg. N.T. p. 171.

11. The skin around the silk tape was bulging because the tape was wrapped too tightly. N.T. p. 58.

12. Barnhart was near Mr. S.'s doorway when the tape was removed; she saw the last layer of tape being removed. N.T. pp. 48-49.

13. Updegraff removed the tape from Mr. S.'s leg; the process of removal left a few small skin tears. N.T. pp. 22-23; AA Ex. 1.

14. After the tape was removed, Updegraff secured the bag with a catheter holder[3] on the unit. N.T. p. 54; AA Ex. 2.

15. After the tape was removed, Mr. S. did not complain about any additional pain. N.T. pp. 53-54, 77; AA Ex. 2.

16. On July 26, 2017, appellant attended a Pre-Disciplinary Conference (hereinafter "PDC") to respond to the charges related to Mr. S.'s Foley catheter tube. AA Ex. 6.

17. During his PDC, appellant stated the tape had not been wrapped tightly, but he did wrap the tape around Mr. S.'s leg at least two times. N.T. p. 112; AA Ex. 6.

[3] A catheter holder is a sticky patch with clip that is used to hold a Foley catheter tube in place; it is safer for the skin than tape. N.T. pp. 24, 43.

Administering Medication:

18. On July 13, 2017, Barnhart was administering her 4:00 p.m. medications and was informed by an FSE that patient Mr. C. had not received his morning medications. N.T. p. 30.

19. When Barnhart spoke to Mr. C., he said he must have slept through the morning medication distribution. N.T. p. 30.

20. Barnhart reviewed Mr. C.'s Medication Administration Record (hereinafter "MAR") and realized he was to receive two medications at 8:00 a.m. N.T. p. 30; AA Ex. 3.

21. Barnhart looked in the drawers next to Mr. C.'s bed and found a medicine cup containing both of his morning medications. N.T. p. 30.

22. Mr. C. stated he did not see the medication cup until she showed it to him. N.T. p. 30.

23. When Barnhart spoke to appellant, he stated he did not know the patient missed his morning medications. N.T. p. 35.

24. Barnhart told appellant Mr. C.'s medications were in his drawer and Mr. C. reported he had not received them. Appellant replied, "Well, I must have missed them [the medications] then." N.T. p. 35.

25. Barnhart reviewed Mr. C.'s MAR in more detail and saw only one medication was circled, indicating it had not been administered. N.T. p. 35; AA Ex. 3.

26. Appellant had not provided any indication on the MAR that Mr. C.'s second medication was not administered at 8:00 a.m. The MAR is initialed, indicating the dose was administered to the patient. N.T. pp. 37-38; AA Ex. 3.

27. If a medication is not administered to a patient, the nurse must use the back of the patient's MAR and write down the reason the medication was either missed or not administered. Appellant had not written anything on the back of Mr. C.'s MAR. N.T. pp. 34-35, 60-61; AA Ex. 3.

28. Barnhart informed Registered Nurse Diana Gricar about the medication error. N.T. pp. 83-84.

29. Gricar completed Medication Variance Report (hereinafter "MVR") indicating appellant had omitted two medications for a patient. She then sent the MVR to the nursing office. N.T. pp. 36-38, 89; AA Ex. 3.

30. On July 26, 2017, appellant attended a PDC to respond to charges related to the medication error. N.T. p. 101; AA Ex. 6.

31. During his PDC, appellant stated he did not realize at the time that he had missed the patient's medications and admitted he had not reported any missed medications. N.T. pp. 101, 117; AA Ex 6.

DISCUSSION

At issue before the Commission is whether the appointing authority had good cause to issue appellant both of his one-day suspensions without pay. The appointing authority charges appellant with failure to follow procedures by tightly wrapping a Foley catheter tube directly onto a patient's skin, resulting in tears to the patient's skin upon its removal. The appointing authority also charges appellant with failure to follow procedures pertaining to the administration of required medications.

In an appeal challenging the suspension of a regular status employee, the appointing authority has the burden to present sufficient evidence to demonstrate the suspension was for good cause. *White v. Commonwealth, Department of Correction*s, 110 Pa. Commw. 496, 532 A.2d 950 (1987); 71 P.S. §§ 741.803, 741.951(a); 4 Pa. Code § 105.15. Good cause must relate to an employee's competence and ability to perform his job duties, *Department of Corrections v. Ehnot*, 110 Pa. Commw. 608, 532 A.2d 1262 (1987), or must result from conduct which hampers or frustrates the execution of the employee's duties. *McCain v. Department of Education*, 71 Pa. Commw. 165, 454 A.2d 667 (1983).

Foley Catheter Tube:

We begin with the appointing authority's charges related to Mr. S.'s Foley catheter tube. The appointing authority presented the testimony of Registered Nurse Tara Barnhart, Forensic Registered Nurse Supervisor Lisa Conrad, Nurse Manager Jillian Kimberlin, and Human Resource Analyst Stephanie Varholak. Appellant testified on his own behalf.

Barnhart provided testimony about Mr. S. and how the incident came to the attention of staff. Specifically, Barnhart testified that on June 28, 2017, Mr. S. complained to a Forensic Security Employee (hereinafter "FSE") he was in pain and discomfort because of his Foley catheter tube. N.T. p. 19. The FSE informed Registered Nurse Lance Updegraff about Mr. S.'s complaint. Updegraff provided the information about Mr. S.'s pain and discomfort to both Barnhart and Conrad. When Barnhart, Conrad, and Updegraff went to Mr. S.'s room, they noted three layers of half inch-wide silk tape wrapped tightly around Mr. S.'s leg, one layer of which was directly on his skin. N.T. pp. 56-57, 62-63, 70-71. In addition, the skin

around the silk tape was bulging because the tape was wrapped too tightly. N.T. p. 58. The process of removing the tape caused a few small skin tears on Mr. S.'s leg. N.T. pp. 22-23; AA Ex. 1. After the tape was removed, Updegraff secured the catheter bag with a catheter holder located on the unit. N.T. p. 54. Mr. S. did not complain of any additional pain. N.T. pp. 53-54, 77; AA Ex. 2.

Barnhart provided additional information about why the process appellant used to attach the Foley catheter tube was not proper and provided an alternative method. Barnhart testified the tape should not be applied directly to a patient's skin because it can cause the skin to breakdown. N.T. p. 25. In addition, Mr. S. had hair on his legs, which could make removal of any tape very painful. N.T. p. 25. In this instance, Mr. S. had three layers of tape on his leg and it appeared his circulation was starting to get cut off. N.T. p. 25. She explained appellant could have shaved the area of Mr. S.'s leg, applied adhesive remover, and then utilized catheter holders to hold the Foley catheter tube in place. N.T. pp. 25-26, 43-45. Conrad and Barnhart both testified silk tape is not intended to be used for Foley catheters or Foley catheter tubes because it has a very strong adhesive and does not stretch. N.T. pp. 57, 76.

Conrad and Kimberlin explained an alternative method appellant could have used to secure the Foley catheter tube. Specifically, there were elastic bands on the catheter bag appellant could have used to secure the Foley catheter tube to Mr. S.'s leg. N.T. pp. 71, 120. Kimberlin explained if appellant had properly used the existing elastic bands, he would not have had to use any tape on the patient's leg. N.T. pp. 121-122. Kimberlin testified the proper equipment would have been made available if appellant had asked. N.T. p. 120.

Kimberlin testified about the PDC related to Mr. S.'s incident. During his PDC, appellant admitted wrapping the tape around the patient's leg twice but indicated he had not wrapped the tape tightly. N.T. p. 112; AA Ex. 6. During the PDC, appellant tried to justify his actions, but did not deny taping Mr. S.'s leg and never stated it had been taped by another employee. N.T. p. 112. Varholak testified she reviewed the minutes from appellant's PDC and the appointing authority's Disciplinary Policy; she then determined a one-day suspension was the appropriate level of discipline to recommend. N.T. pp. 133-134; AA Ex. 7.

In response, appellant testified he was assigned to place a Foley catheter in Mr. S. N.T. p. 143. Appellant admits he used tape on the patient's leg to hold the Foley catheter tube but is not sure if he wrapped the tape around Mr. S.'s leg two or three times. N.T. pp. 147, 172. He also admits he did not shave Mr. S.'s leg first. N.T. p. 168.

Appellant explained he knows the catheter clips procedure for securing a Foley catheter tube. N.T. p. 143. He testified he would have used a clip, but there were none available on the ward. N.T. p. 144. Appellant asserts he checked both supply rooms in the building and asked another nurse; the proper equipment was not available. N.T. pp. 144, 168. In addition, he used tape instead of seeking a catheter clip because Mr. S. had previously complained of discomfort and possible injuries from the movement of the Foley catheter tube and appellant wanted to relieve the pulling. N.T. p. 145.

As to his selection of silk tape, appellant testified he did not check for different types of tape on other wards because he felt it did not matter what type he used. N.T. p. 171. Although he could have called down to the nursing office and

asked them to check in other buildings, it would have taken two hours to get the proper supplies to him. N.T. p. 145. Thus, he retrieved the silk tape from the medication room. N.T. p. 171. According to appellant, by using the silk tape instead of waiting an extensive period of time for the proper supplies, he exercised "the best nursing judgement I could make" to assist Mr. S. N.T. p. 156.

Upon review of the record, the Commission finds the appointing authority has presented sufficient evidence to support the charges related to improperly securing Mr. S.'s Foley catheter tube. Specifically, we find Barnhart and Conrad credible[4] that Mr. S. complained of pain related to the silk tape wrapped three times around his leg. Appellant acknowledged using silk tape instead of a catheter clip or paper tape to secure Mr. S.'s Foley catheter tube to his leg. He also admits wrapping the silk tape around the patient's leg at least two times. Barnhart credibly testified appellant could have used catheter holders or a different type of tape. N.T. pp. 25-26, 43. Barnhart and Conrad credibly testified about why using silk tape is improper: it does not stretch, has a stronger adhesive than other types of tape, and caused Mr. S. pain when it was removed. N.T. pp. 56, 76. Kimberlin credibly testified that if appellant had asked, the proper equipment would have been made available. Appellant's deliberate decisions not to seek the proper supplies, using silk tape, and wrapping the patient's leg more than once caused pain and injury to Mr. S., displays a callous disregard for Mr. S.'s care and comfort, and is clearly a negative reflection on his competence and ability to perform his job duties as a nurse. *Ehnot, supra*.

[4] The Commission has the inherent power to determine the credibility of witnesses and the value of their testimony. *McAndrew v. State Civil Service Commission (Department of Community and Economic Development)*, 736 A.2d 26 (Pa. Commw. 1999)

Administering Medication:

We next discuss the appointing authority's charge related to the administration of medication. The appointing authority presented the testimony of Barnhart, Kimberlin, Varholak, and Registered Nurse Diana Gricar.

Barnhart explained how she became aware of the medication administration error. She testified that on July 14, 2017, when she was administering her 4:00 p.m. medications, she was informed by an FSE that Mr. C. had not received his morning medications and had slept through the administration process. N.T. p. 30. Barnhart reviewed Mr. C.'s Medication Administration Record (hereinafter "MAR") and then spoke to Mr. C., who stated he had not received his morning medications and must have slept through the administration process. N.T. p. 30. Barnhart opened the drawer next to Mr. C.'s bed and saw a medicine cup with his medications in the front of the drawer. N.T. pp. 30-31.

Barnhart explained the proper procedures for administrating medications and documenting a dose that is not administered to the patient. A patient's MAR must be signed off and initialed on the front when medication is administered. N.T. pp. 31-32. In addition, the employee administering the medication must initial the back of the MAR. N.T. pp. 31-32. If a medication on an MAR is circled, it indicates the dose was held or not administered. N.T. p. 35. Whenever the employee circles the medication, he must indicate on the back of the MAR why the medication was missed or not administered. N.T. p. 35. Appellant had circled the medication on the MAR but did not put any information on the back

to indicate why the one medication was not administered to the patient. N.T. pp. 37-38; AA Ex. 3. With respect to the second medication, the MAR is initialed, indicating the dose was administered to Mr. C. AA Ex. 3.

Gricar and Barnhart provided testimony about nursing policy. Barnhart testified that performing medication passes is one of a Registered Nurse's essential job duties and responsibilities. N.T. pp. 32-33. Gricar stated the responsibility to administer medication rests with the licensed employee assigned to the task; appellant was assigned to administer medications to Mr. C. N.T. p. 87; AA Ex. 4. Gricar explained the nursing policy provides the MAR must be initialed or signed immediately after the medication is administered to the patient. N.T. p. 88; AA Ex. 4. Gricar and Barnhart testified if the nurse failed to administer medication to the patient, it is a violation of the policy. N.T. pp. 38, 88; AA Ex. 4. In addition, the failure to document that a patient did not receive his medications is a violation of nursing policy. N.T. pp. 38, 89; AA Ex. 4.

Kimberlin testified about appellant's PDC. During his PDC, appellant stated he did not realize at the time he had missed the patient's medications and admitted he had not reported any missed medications. N.T. pp. 101, 117; AA Ex 6. When appellant filled out his witness statement, he did not take responsibility for the error; he felt other staff did not bring Mr. C. to the medication window and, therefore, the other staff members were to blame for the patient not receiving his medication. N.T. pp. 102-103.

Kimberlin noted appellant had a prior medication error which had resulted in reeducation, but not disciplinary action.[5] N.T. pp. 108-109; AA Ex. 7. She also testified appellant documented administering one of the medications to Mr. C. when, in fact, he had not done so. N.T. p. 109; AA Ex. 3.[6] The PDC panel reviewed the types of medications involved, the severity of a missed dose, the appointing authority's Disciplinary Chart, and the prior similar incident. N.T. pp. 109-111; AA Ex. 7. The PDC panel findings were submitted to the Chief Nurse as well as Human Resource Analyst Stephanie Varholak. N.T. p. 110. Varholak determined a one-day suspension was the appropriate disciplinary action to recommend. N.T. pp. 131-133; AA Ex. 8.

In response to the charge, appellant testified Barnhart informed him in the evening that Mr. C. had not received his morning medications. N.T. pp. 160-161. Appellant admits Mr. C. did not receive his morning medications. N.T. pp. 159, 174-175. Appellant explained he relies on the staff to bring the patients to the medication line and Mr. C. either slept through the medication time or was groggy and went back to bed. N.T. pp. 159-160. However, appellant also provided contradicting testimony. Appellant testified he placed Mr. C's evening medications in the patient's drawer, as per his own routine, so they would be ready to be administered later in the day. N.T. p. 162. Appellant provides no explanation as to why he would have been in Mr. C.'s room to place evening medications, but simultaneously expecting Mr. C. to be brought through the morning medication line.

[5] Appellant acknowledges his previous medication error and testified he signed off on a "reorientation" process on August 4, 2017, after the medication error at issue occurred. N.T. pp. 163-164.

[6] Kimberlin did not provide any testimony about whether the PDC panel considered that appellant initialed Mr. C's MAR, indicating a different medication had been administered to Mr. C. at 8:00 AM, even though it had not been provided to Mr. C.

Appellant testified he understands medication errors can be very serious and deserve very serious punishment. N.T. p. 177. However, according to appellant, during his PDC he stated he was "appalled" he would receive discipline for a medication error as they are supposed to be used as a learning tool. N.T. pp. 176-177.

Upon review of the record, the Commission finds the appointing authority has presented sufficient evidence to support the charges related to the medication error. Appellant admits he did not administer the morning medications to Mr. C. We find his attempt to shift the blame onto other staff to be nothing more than an effort to minimize the severity of his mistake. Further, we find appellant's contradictory testimony about expecting Mr. C. to be on the medication line, yet somehow placing Mr. C.'s evening medications in the drawer, not credible. We find Barnhart and Gricar credible that failure to administer medications and failure to properly document the non-administration of medications violates policy. Appellant's inability to properly administer a patient's needed medication clearly reflects negatively upon his competency and ability to perform his job duties as a nurse. *Ehnot, supra*. In summation, the appointing authority has presented sufficient competent evidence to support the charges related to Mr. S.'s Foley catheter tube and the failure to administer Mr. C.'s medication. Accordingly, we enter the following:

CONCLUSION OF LAW

The appointing authority has presented evidence establishing good cause for both suspensions under Section 803 of the Civil Service Act, as amended.

ORDER

AND NOW, the State Civil Service Commission, by agreement of two of its members,[7] dismisses the appeal of Michael Tyson challenging both of his one-day suspensions without pay from regular Forensic Registered Nurse employment with the Torrance State Hospital, Department of Human Services and sustains the actions of the Torrance State Hospital, Department of Human Services in both of the one-day suspensions without pay of Michael Tyson from regular Forensic Registered Nurse employment, effective August 16, 2017 and August 17, 2017.

State Civil Service Commission

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Gregory M. Lane
Commissioner

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Bryan R. Lentz
Commissioner

Officially Mailed: September 3, 2019

[7] Chairman Teresa Osborne was appointed after the record was closed and did not participate in this decision.