COMMONWEALTH OF PENNSYLVANIA

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| Theresa R. Zajac | : | State Civil Service Commission |
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| v. | : | |
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| Department of Human Services, Danville State Hospital | : | Appeal No. 29745 |

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| Bruce K. Anders, Peter C. Wood, Jr. | Peter J. Garcia, Robert M. Miller, Jr. |
| Attorneys for Appellant | Attorneys for Appointing Authority |

## ADJUDICATION

This is an appeal by Theresa R. Zajac challenging her suspension pending investigation and subsequent removal from regular Registered Nurse employment with the Danville State Hospital, Department of Human Services. Hearings were held May 3-4, 2018, at the Danville State Hospital in Danville, Pennsylvania before Commissioner Gregory M. Lane.

The Commissioners have reviewed the Notes of Testimony and exhibits introduced at the hearing,[1] as well as the post-hearing Briefs submitted by the parties. The issues before the Commission are: 1) whether the appointing authority had sufficient cause under the Civil Service Act to support its decision to

[1] At the hearing, the presiding Commissioner noted that, on Motion from Counsel, the Commission had agreed to adopt, in our consideration on this Appeal, the record compiled in a prior hearing (*Zajac v. Department of Human Services*, SCSC Appeal No. 29734) involving the same parties. N.T. pp. 15-16. In this Adjudication, any references to the earlier matter will be preceded by the designation "Appeal No. 29734."

remove[2] appellant from her position; and 2) whether the decision to remove appellant was affected by discrimination violative of the Civil Service Act's prohibition of discrimination.

## FINDINGS OF FACT

1. By letter dated August 28, 2017, appellant was advised that she had been suspended, effective August 26, 2017, pending investigation of her "actions on August 21, 23 and 25, 2017." Comm. Ex. A, p. 1.

2. By letter dated September 21, 2017, appellant was advised that she was being removed, effective at the close of business, September 26, 2017. Comm. Ex. C.

[2] When an appointing authority suspends an employee pending investigation and subsequently removes the employee, the period of suspension will be deemed part of the removal action. *Woods v. State Civil Service Commission (New Castle Youth Development Center, Department of Public Welfare)*, 865 A.2d 272, 274 n. 3 (Pa. Commw. Ct. 2004); 4 Pa. Code § 101.21(b)(2). Appellant having been suspended, effective August 26, 2017, pending investigation, and having remained on suspension until her removal by letter dated September 21, 2016, we consider appellant's removal, effective as of the date of suspension, to be the sole personnel action to be reviewed through this appeal.

3. The September 21 letter stated:

> The reason for this removal is: "Failure to Follow General Instructions or Procedures" as defined in DHS Human Resource Policy 7174.

Comm. Ex. C, p. 1.

4. The September 21 letter additionally noted that a five-day disciplinary suspension "issued on August 21, 2017," was considered in establishing the level of the current discipline.[3] Comm. Ex. C, p. 1.

5. The appeal was properly raised before this Commission and was heard under Sections 951(a) and 951(b) of the Civil Service Act, as amended. Comm. Exs. B, D, E, F, G, H.

6. Appellant was employed by the appointing authority as a Registered Nurse for approximately seventeen years—the most recent twelve years were at the Danville State Hospital (hereinafter "the Hospital"); she was initially employed at the Harrisburg State Hospital until it closed. N.T. pp.

[3] The noted suspension is the subject of the previously cited SCSC Appeal No. 29734.

253, 304-305. The Hospital is a residential psychiatric facility. Appeal No. 29734, N.T. pp. 42, 71.

7. Effective July 20, 2017, appellant was suspended from her Registered Nurse employment at the Hospital. By letter dated August 18, 2017, appellant was ordered to return to work "on Monday, August 21, 2017, at 0645." Appeal No. 29734, Comm. Ex. A, p. 1.

8. On the day of her return, appellant was provided a copy of the August 21 letter; the August 21 letter served as a written statement formally notifying appellant that although she had been absent for twenty-two working days, she would "be made whole" for all but the five days designated as a period of suspension. N.T. pp. 19-20; Appeal No. 29734, Comm. Ex. A, p. 1.

9. The August 18 letter stated the suspension was due to charges of:

> 1. Falsification of an Official Record or Document as defined in DHS Human Resource Policy 7174.
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> * * *

> 2. Negligent Individual Abuse as defined in DHS Human Resource Policy 7178.
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> * * *
>
> 3. Failure to Follow General Instructions or Procedures as defined in DHS Human Resource Policy 7174.

Appeal No. 29734, Comm. Ex. A.

10. On the day of her return, appellant met with the Hospital's Nurse Manager (Jill Temple), who informed appellant that she would be receiving additional training and that she would have to perform three medication administrations (also referred to as "med passes") under observation to determine her competency. N.T. pp. 20-22, 32-33, 313, 325.

11. Temple also provided copies of Policy and Procedure Statements—addressing Administration of Medication (AA Ex. 1), Administration of Insulin (AA Ex. 2), Administration of a Controlled Substance, Blood Glucose Monitoring, Hand Hygiene, Documentation (AA Ex. 3)—in use at the Hospital. Temple advised appellant that she would be "expected to follow the polic[ies] as written." N.T. pp. 20-21.

12. On August 21, 2017, appellant met with the Hospital's Registered Nurse Instructor (Julie Raup) and was given an opportunity to review Hospital policies and procedures; she and Raup proceeded to Unit 312 where Raup observed appellant's actions. N.T. pp. 53, 127.

13. On August 21, Raup observed the following issues she deemed significant:

    a. appointing authority policy directs that the employee read the MAR[4] and compare it with the label on the medication

       — when appellant opened medications, she had to be reminded multiple times to recheck them with the MAR (N.T. pp. 54-55);

    b. appointing authority policy directs that the employee, after giving medication, sign for each medication administered

       — when appellant saw the next patient[5] approaching, she would frequently prepare for that patient but fail to finish signing the record for the current one (N.T. pp. 55-56);

[4] The medication administration record (customarily referred to as the "MAR") is a written listing of all medications prescribed for a patient

[5] Throughout the record, the terms "consumer," "resident" and "patient" have been used interchangeably.

c. appointing authority policy directs that patients receiving medications be identified twice

— on at least one occasion, appellant failed to access a second identifier and as a result began to give a patient the wrong medications (N.T. pp. 59-62);

d. appointing authority policy directs that after dealing with one patient, gloves be removed before working with another

— after using a finger stick to check a patient's blood sugar, appellant failed to remove her gloves before starting to work on the next patient (N.T. pp. 66-67);

e. appointing authority policy directs that insulin pens be cleaned with alcohol before attaching a needle

— appellant failed to do so on at least one occasion (N.T. pp. 67-68).

N.T. pp. 54-68; AA Ex. 5, pp. 1-2. Appellant failed to successfully complete the assigned med pass on Monday, August 21. N.T. pp. 64, 132.

14. Appellant was additionally trained on Wednesday, August 23, 2017 by being assigned to observe an 8:00 a.m. med pass conducted on the same Unit by

another nurse. Appellant was also given the opportunity to review her Monday performance with Raup. N.T. pp. 76, 285-286.

15. Appellant, was assigned to perform a med pass on Wednesday August 23, 2017. N.T. pp. 76, 287. Appellant successfully performed all procedures during the Wednesday observation. N.T. pp. 76-79, 287; AA Ex. 5, p. 4. Appellant was next assigned to perform two med passes on Friday, August 25—at 8:00 a.m. and at noon. N.T. pp. 79-80.

16. To prepare for the Friday, August 25, 8:00 a.m. medication administration, appellant, as part of her preparation of medications for each patient, included a color-coded system of reminders. N.T. pp. 82-83; 289-292. The inclusion of the reminders took more time during the med pass. N.T. p. 81.

17. During the Friday, August 25, med pass, Raup observed the following:

    a. appellant was not consistent in double and triple-checking the medications with the medication administration record before administering to the patient (N.T. p. 83);

b. during the two-hour period[6] for the 8:00 a.m. medications, appellant was able to complete only six of the sixteen patients scheduled for the 8:00 a.m. administration of medication (N.T. pp. 83-84);

c. appellant provided Tylenol to a patient but failed to immediately note it on the MAR (N.T. pp. 85-86);

d. appellant misidentified a patient until corrected by the observer (N.T. pp. 87-88);

e. appellant inadvertently discarded unused medications (N.T. pp. 89-90);

f. appellant failed to provide all medications required for one patient until corrected by the patient (N.T. pp. 90-91).

N.T. pp. 83-91; AA Ex. 5, pp. 5-6. The 8:00 a.m. medications were not completed until 9:45 a.m.; due to the delay, prescribing physicians had to be contacted to determine whether noon medications should be administered. N.T. pp. 92-93.

18. Appellant did not successfully complete the 8:00 a.m. medical administration. N.T. pp. 94, 121. Raup advised her superiors of the 8:00 a.m. med

[6] As policy directs that prescribed medications be administered to patients during a two-hour period extending from one hour prior to the scheduled medication time to one hour after. N.T. pp. 83, 324.

pass. N.T. pp. 93-94. Appellant did not perform the noon med pass. N.T. p. 92. Raup offered appellant the opportunity to come to her office to discuss the med pass; appellant did not act on the offer. N.T. pp. 95-96.

19. During a pre-disciplinary conference, appellant stated she had not done anything wrong, but, when confronted with discrete procedures, acknowledged her errors. Examples discussed included:

    a. appellant acknowledged incorrectly administering insulin injections. N.T. p. 176.

    b. appellant admitted failing to wipe the end of an insulin pen prior to administering an injection. N.T. p. 176.

    c. appellant acknowledged that she had to call a patient back after failing to provide her all required medications. N.T. p. 177.

    d. appellant admitted that she had failed to immediately sign off on medication after administration. N.T. p. 177.

N.T. pp. 176-177. After the PDC, appellant was suspended pending investigation. N.T. p. 178.

## DISCUSSION

The current action was brought before this Commission as a challenge to the appointing authority's decision to remove appellant from regular Registered Nurse employment; the challenge was brought as an appeal under Sections 951(a) and 951(b) of the Civil Service Act (71 P.S. §§ 741.951(a), 741.951(b)). Comm. Exs. B, D. In an appeal brought under Section 951(a), the burden of proof is for the appointing authority to present evidence at a hearing to establish that the adverse personnel action was imposed for cause sufficient under the Civil Service Act; under Section 807 of the Act, a regular status employee may only be removed for "just" cause. *Pennsylvania Department of Corrections v. State Civil Service Commission (Clapper),* 842 A.2d 526, 531 n. 8 (Pa. Commw. Ct. 2004) citing *State Correctional Institution at Graterford, Department of Corrections v. State Civil Service Commission (Terra)*, 718 A.2d 403, 408 n. 4 (Pa. Commw. Ct. 1998); 71 P.S. § 741.807; 4 Pa. Code § 105.15. Accordingly, the initial matter before the Commission is to determine whether the removal was for just cause.

To meet its burden, an appointing authority is expected to introduce evidence sufficient to prove the charges stated in the written notice provided the appellant, as bases for its action. *Long v. Commonwealth, Pennsylvania Liquor Control Board*, 112 Pa. Commw. Ct. 572, 535 A.2d 1233 (1988). The written notice received by the current appellant states:

> The reason for this removal is: "Failure to Follow General Instructions or Procedures" as defined in DHS Human Resource Policy 7174.
>
> Specifically on Monday, 8/21/2017, you returned to work for remedial education regarding proper Medication Administration and documentation. Upon completion of education, you completed an observed medication pass,

> but did not successfully pass the medication administration observation. You received additional 1:1 education regarding medication administration both on Monday, 8/21/2017, and on Wednesday, 8/23/2017. However, on 8/25/2017 you again completed an observed medication pass, but did not successfully pass the medication administration observation. You were unable to successfully pass 2 of 3 medication administration observations. The ability to administer medications is an essential function of the Registered Nurse position.
>
> This is contrary to the following DHS Policy/Procedures:
>
> - AD101.306 Administration of Insulin
> - AD101.301 Administration of Medication
> - AC101.207 Documentation, Nursing

Comm. Ex. C. The appointing authority presented five witnesses in support of its action—Jill Temple, Julie Raup, Dawn Buckles, Diane Dalberto and Thomas Burk; appellant was the sole witness to testify on her behalf.

Jill Temple, a Nurse Manager at Danville State Hospital, testified she met with appellant on Monday August 21, 2017. N.T. p. 19. Appellant had been directed to report to Temple's office on her return to duty that date following a prior suspension. N.T. p. 19. During that meeting Temple told appellant:

> That we actually were going to have her work with Julie Raup, the Nurse Instructor. And she would be expected to pass three medications --- she would be observed by Julie for three medication administrations to determine competency. And that we would work with her as needed.

N.T. p. 21. Temple testified, "I thought that it was a good meeting. I thought she understood and was cooperative." N.T. p. 21. According to Temple, such observations are "done with an RN [for whom there is a need to] determine[]

competency on medication administration, that they would need to pass three med passes." N.T. p. 22. Later that day appellant "passed meds with [Raup]." N.T. p. 23.

Julie Raup, the Hospital's Registered Nurse Instructor, testified her duties are "to educate, provide education training and/or retraining" to the Hospital's employees. N.T. p. 39. On August 21, 2017, she was asked to provide appellant's reeducation on medication administration; Raup testified she did not know why she was asked to do that. N.T. p. 39.

Raup testified she worked with appellant from Monday, August 21 to Friday. N.T. p. 40. When asked to describe that week, she stated:

> On Monday, I went to the manager's office and I met with [appellant] and Jill Temple. And so I had contact with both of them initially. And then I observed a med preparation and --- and passing with [appellant] later that day.
>
> On Tuesday I spoke with Jill Temple in regards to having [appellant] do an observation. Because we had done some things earlier on Monday. And I thought it might be good to have her see a med pass, many people learn much better by actually seeing then doing. And then see one do one.
>
> So I had a discussion on --- with her to --- to do that with [appellant] and she agreed.
>
> Wednesday, I think I had a conversation with [appellant]. Then later that evening --- or the afternoon, I had a conversation with Jill about how the med pass went.

> And then Friday I had watched a pour and pass with [appellant]. And then I was going to report with Jill. But Jill was unavailable that day. For some reason she wasn't in her office. And so then I spoke with Diane Dalberto.

N.T. pp. 40-42. Raup did a med pass with appellant on Wednesday. N.T. p. 42.

Raup indicated that she is familiar with the Hospital's policies and procedures regarding administration of medication, controlled substance, insulin administration and other matters. N.T. p. 43. She testified she reviewed the policy on administration of medication (AA Ex. 1) with appellant on Wednesday; she further testified:

> On the first day that I did a medication preparation and --- and passing with [appellant] in observing her, there were some critical care areas that didn't follow policy and procedure.
>
> And so Wednesday I wanted to go over [with] some specificity, just those areas where she had trouble and wasn't following policy and procedure.

N.T. pp. 46-47. She noted that the policies and procedures:

> were reviewed prior to my going with [appellant] to do the first medication, preparation and pass on Monday. I believe Jill Temple had done that. And that was confirmed when I went down to meet with [appellant], that that had been done.
>
> And then on Wednesday the, policy on medication administration . . . I reviewed those key points with her. And then the highlighted copy I then gave to her to keep.

N.T. p. 47.

When asked how she had documented appellant's competency, Raup testified:

> Danville State Hospital has Competency Forms, so that everyone who does medication administration or insulin injection or whatever they're doing, that everyone is looked at . . . and everyone is checked off on the key points based on the policy and procedure. So it was a Danville State Hospital Competency Form.

N.T. pp. 47-48. Raup prepared competency forms on Monday, August 21, Wednesday, August 23 and Friday, August 25, 2017. N.T. pp. 48-49; AA Ex. 4. Witness Statements based upon those forms were compiled for, and approved by, Raup. N.T. pp. 48-40; AA Ex. 5.

Raup then presented testimony detailing her observations of appellant over the noted period:

> On th[e 21st], I watched her pour her meds. And then I watched her administer them or pass them. At the end, there were some significant issues on that first day.
>
> She needed to be reminded multiple times, when she opened the medication, to recheck them with the medication administration record, which is also known as an MAR.
>
> She didn't do that third final check often enough for me, because it wasn't consistent to do that third check, which is a significant part of the process for passing medications.
>
> And on occasion --- like she didn't even --- she would have a medication that she knew she needed to get. She would just take the medication out of the drawer and put it in the wrapper, in the cup, which is how we pour. That's how we prepare our medication, how we pour them.
>
> And all three of these things, if you look at --- on the policy --- if you refer to section --- under procedure on page three of the policy and procedure for administration [of]

medications ---. One of the things there, it says that the --- you have to read the medication administration record and compare it with the label on the medication.

Multiple times she failed to do that. It says we open medication; you check it a second time, the label of the medication with the medication administration record. She failed to do that.

And thirdly, it says you do a third check to check, again, the medication administration before you actually give it to the patient. And that was being missed.

In addition, after you're finished with one of your patients and you give them medications. Before you move on to the next person to do this process of medication passing, you're supposed to go and sign for each medication that you administer.

Frequently, she would just see the next person getting ready to come up and she would just flip the medication to the next person, instead of going back and signing for each one of those meds. And I had to remind her several times about that.

Additionally, we --- when you prepare your medications, you're --- you're taking everything that's in the medication, looking at what --- like say we did a new medication pass.

This was at noon. We would take every medication that you have and you put it into a cup when you're preparing them. So then when the patient comes, you're ready to distribute them and pass them.

One of the things that helps people, especially when you're in this --- the --- the hospital system is, you want to make sure you take the opportunity to count your narcotics first, before you pass them. Because once you pass the medication, you can't go back and decide who got what and --- you know what I'm saying?

So I encouraged her before, when she was finished preparing ---. Prior to starting and passing the medication, I asked her if she would, you know, want to double-check --- the --- the narcotic count. And it seemed that she didn't quite know what I was talking about, referring to.

* * *

When I asked her about doing this process, she said, I didn't know that. So it was --- it was my observation that she was unable to ---

So anyhow, we --- we went ahead, and we counted narcotics. And we made sure that everything that she had said that she took for a patient matched what was still left in the drawer. And that's a crucial point.

Because once you --- once you give a narcotic, and then you go back later before your next pass, to make sure that your meds are right --- if you haven't done that count, then you don't know who got the med in error or if they didn't get a medication.

So it's one of the things --- because we signed for these individually. In addition to signing for them on the medication administration record, it's --- it's a way to double-check yourself. Controlled substances are certainly much more --- placed of an emphasis, just because it was a controlled substance.

So --- so she did that and the medication count came out correctly. But you know, I needed to help her with that process.

The other thing that was a big issue is, you know --- well, we are --- from day one in --- in nursing school, we are trained about the five Rs with patients. Make sure you have the right patient, the right drug, the right dose, the right form and you're giving it at the right time.

And we have things in our policy here that help you make sure that all those five Rs are followed.

In the medication administration record when the patient comes up, there's a staff member who identifies them by name. We ask that we have two identifiers. So usually the staff will come up and --- and say, you know, Amanda S. is coming.

And then --- so that person comes up. And usually you can identify them, asking their name. [Appellant] would do that. She'd ask and --- so there was two identifiers.

The problem was, when she switches to the person, where they're --- because this is one big med book. And they go to their section where their medication administration record is. On the left-hand side there's a picture of that patient.

And for this first med pass, Megan S. came to the med room and she's identifies Megan S. [Appellant] said hello to Megan. Megan responded back.

But she failed to look at the picture. Because what she did is --- when she turned the med book open, she opened the med book to Amanda S. not Megan.

And so she reached in the drawer and she pulled Amanda's meds out and started matching them with the medication administration record. Which it would have matched. Problem was, that Amanda wasn't at the med room, it was Megan.

And Megan was watching. These folks were fairly competent to know what their meds were.

And when she started pulling some ---. She knew that she was pulling too many. And Megan said, are you sure they're mine? And that's when I looked at her and I said, you know, Megan is at the door for meds not Amanda.

Because I saw her pulling, but I was hoping she would catch it. I was hoping that she would look at the picture and recognize that that's not the person standing ---.

So --- and she, you know, put them back, put them in the drawer. Then she went to Megan's section and then continues. So that was a significant concern.

In the policy, it does say if a consumer says the wrong medication is being given to them, they should recheck. And she did do that. But she may not have caught it, because she was still thinking probably in her mind ---.

* * *

That visual confirmation using the photo --- consumer photo ID located on the MAR is to be done. And that could not have been done or she would have recognized that she had Amanda's meds and was attempting to prepare them for Megan.

* * *

But I would have highlighted --- everything that was on this first sheet on the competency that was an issue, I would have highlighted on --- on --- on the --- on the policy.

And so those were the two things that were there. And I had wrote --- written on the bottom, you know, overall she lacked consistency trying to use policy and procedure.

Now, she was on Unit 312. And 312, currently at that point, had, I don't know, 17 maybe 18 patients at the most. Most units have between 25 and 30 patients.

So she was afforded the opportunity to --- to have patients --- like a less number. So hopefully that --- this would have, you know been a --- I guess a little less stressful. Because there's not so many. You don't have to rush to try to get things done.

But there was just a lack of consistency, and I ---. So I did not approve her, I --- I failed her on the first med pass. And I wrote that she needed multiple reminders to check narcotic count prior to passing those meds. And she did not remember the importance of this process.

But she needed a lot of prompting to compare the actual meds with the medication administration record throughout the process of passing those 17 meds.

And then I also documented that --- that she admitted a little bit she was nervous. She was checking meds for one

> consumer, and it wasn't the consumer who was at the med line waiting to get meds. That she could --- she had been --- she had confused the two.
>
> And I did document --- and I wrote that. My recommendation at the bottom was to, you know, observe, you know, at least one or two other med passes.
>
> It's policy --- when we first come and we learn Danville State Hospital's policy and procedure in medication administration, we're all subject to three med passes that we need to be observed and passed three times.
>
> So my recommendation, because she didn't pass this one, was to have more until we could hit that three mark.
>
> * * *
>
> I went down and I spoke with Jill on how this --- how this med pass went. And then I did actually have a discussion with her, I believe.
>
> I had a discussion with [appellant] and asked how she felt it went. I think that was documented on my --- on my witness statement. And you know, she didn't think it went too awful bad.
>
> She also did a glucose check, an Accu-Chek, which checks someone's blood sugar with a finger stick. And she --- I --- I passed her on that competency. And she did really well with that process.
>
> The only thing was that when she was done, she put the gloves on, because you're dealing with blood and body fluids. And as part of our infection control policy, she did that. But unfortunately, she didn't remove her gloves and was starting to work with the next patient's stuff.

N.T. pp. 53-66. Appellant additionally failed to clean an insulin pen before administering a shot (N.T. p. 67) and demonstrated a lack of understanding of how to administer a proper dosage (N.T. pp. 69-73). Raup provided appellant additional education on the use of the insulin pen. N.T. p. 74.

Raup testified when she reported back to Temple after appellant's first pass, she recommended that appellant receive additional retraining. N.T. p. 74. Raup recommended that the additional retraining include giving appellant an opportunity to "watch a med pass, like a longer med pass." N.T. p. 75. On Wednesday, appellant was assigned to observe "the med pass at eight o'clock," before reporting to Raup. N.T. p. 76. Raup testified, in addition,

> I had taken medication administration policy and highlighted those areas that I just spoke about and reviewed those with her. It was very specific to just the things that was not done correctly on Monday.

N.T. p. 76. Appellant was given the opportunity to discuss the med pass she had just observed and to review the matters that had not been done properly on Monday; appellant declined to ask any questions. N.T. p. 76.

On Wednesday, August 23, 2017, Raup and appellant returned to the same unit as on Monday to try another med pass. N.T. p. 76. Raup testified:

> On the twenty-third, [appellant] prepared her meds and she passed them. And overall, she did excellent. She did really well. She was able to do everything correctly. She didn't need many reminders.
>
> A couple of times she had some issues with --- and I documented here on my medication administration, that she had a hard time remembering to go back and sign for something. But it was done in a timely manner. She seemed --- the consistency was much better.

N.T. pp. 76-77. Appellant similarly performed well on monitoring blood sugar and using an insulin pen. N.T. pp. 78-79.

To complete the required three successful administrations, Raup scheduled appellant to perform med passes at 8:00 a.m. and noon on Friday, August 25. N.T. pp. 79-80. Raup testified:

> [appellant] came in that day for an eight o'clock med pass, and she started preparing and --- and --- and getting her meds ready to give to the patients.
>
> And she had several different colored pieces of paper. And they were all cut up into like little squares. And she had them on the side.
>
> And when she was putting her meds, and doing all the checks and putting medications into the --- in the med cup to get ready to pass them, sometimes she was putting pieces of paper in there, different color papers.
>
> And I had asked her about that. And she said that it was her way of remembering that there was something missing. Well, policy doesn't say you can't do it, so I --- but the unfortunecity (sic) of that is, that it took a whole lot more time.
>
> Because each color must have represented something for --- for [appellant]. It must have something in particular. Like it might have represented a liquid or a powder medication.
>
> Because one of the things in our policy that says, when you're getting ready to administer medications ---. If you're --- you're preparing your meds and the medication calls for two tablespoons of Metamucil, you don't take the Metamucil out of the container, and put it in the medicine cup and put it in the drawer until you're actually ready to give it to them.
>
> That's why we don't open medication. We have to have three --- three checks. And once you take the powder out and put it in the cup there's no --- you can't do the rest of your checks.
>
> So you're supposed to take out the Metamucil bottle, or the Milk of Magnesia that might lead to whatever happens to be --- you set it on the cart.

And so there were times when she just left them wherever they were and put a reminder in the cup.

And so I found that --- well, it doesn't follow policy. I had --- having the colored strips in there didn't matter to me.

But the fact that she missed that first step of getting out that medication, making sure it was the correct meds, and that she had it --- putting it on there, that's kind of like your first check.

So she really wasn't preparing, she was kind of just putting a thing there to say, oh, I should go look for that later.

She wasn't consistent with checking the medications with the medication administration record. She wasn't consistent with double-checking and doing the third check before she administered to the patient.

Because she was preparing these meds and using these colored pieces of paper to help her remember things, it took much longer to prepare the medications. Which in and of itself isn't a big deal.

But our policy does state that we have from an hour --- prior to the medication is supposed to be given, we have an hour before and an hour after. So we have that two-hour leeway to make sure that everybody gets their meds.

So if the medication is reserved for nine o'clock, we had until 10:00. These medications were ordered for 8:00 a.m., so we could give them any time between 7:00 and 9:00.

According to my records, there were 17 patients that day. I think one patient refused their medications. So there were 16 to get.

And because it had taken longer to prepare her medications, by the cutoff time, which would have been 9:00 a.m., she had only been able to do six patients by 9:00 a.m.

There were nine patients still left who needed medications past what we'd call our compliant time. Is that a horrible thing? No.

But we have time frames for a reason. Because they would turn right around, and then we have noon meds we have to give them between 11:00 and 1:00.

So if you have a patient that got something at 8:00 and they [are supposed to] get something at 12:00, and you don't give it until 10:00 ---. And then they turn around --- you can't really give another at 11:00. So there's reasons why that hour to two-hour time frame is there.

She was very inconsistent, again, with going back and signing the back of the medication administration record, on the MAR, like to make sure she gave each med.

There was a time when someone asked for PRN. And she did everything she needed to do for that. And she ---.

* * *

A PRN is --- is a medication that --- a consumer has a headache, maybe, and they're asking for something that's not routinely ordered, that they have it if they need it or they ask for it. So it's an as-needed medication.

Milk of Mag, for constipation, that kind of stuff. Patient had come up and had a headache; asked for Tylenol.

She did what she needed to do. She assessed the pain. And she got the Tylenol out, and she poured it for the patient. And then she administered it and then she moved on. And she didn't sign for the --- for the medication.

And I said to her, don't you want to sign, you know, that you gave this PRN medication? And she said, no, I'll go back and do that later. But then you go back and do it later, you don't know what time you gave it.

Because in this particular case, a PRN medication you have to document the specific time you gave it. If you're giving a routine medication that says eight o'clock --- if you gave it at 8:05, you just signed for eight o'clock. So it's already on the medication administration form.

But a PRN is not. A PRN, you actually have to put the time in the block and your initial. So that somewhere --- if the next shift comes on and --- and they want to give something for --- for --- Tylenol for a headache, they can see when the last time it was given.

So it was important. And that's part of the policy that you sign for your medications right after you give it. That's why it's there.

She has trouble with the same thing that she had on Monday, she seemed to have the same trouble again on Friday.

Additionally, on Friday those same two patients --- Megan came up to the desk, asked --- and Megan was identified. Came up and got her meds.

Again, [appellant] pulled out Amanda's meds, switched to Amanda's MARs, medication administration record, and was starting to go through them.

And I said, [appellant], Megan's at the desk, not Amanda. And she said, oh yeah, I --- I would have caught that.

And I guess my thought is, she wouldn't have caught it, because the picture of Amanda was there. She had Amanda's meds and she had Amanda's administration record.

If she would have switched to Megan's administration record, she would have found that none of the meds in the cup that she had already poured would have been right. So she wouldn't have --- like she would not have caught it.

So it was the exact same two patients and the exact same process that was missed.

One of the other things that was on there is when you --- a person comes up and take their meds, all the things that you've already prepared for that person, and you go down the list and you make sure, again, that you got everyone, you're looking at it, you're opening it, you're making sure you have everything.

One particular time she was putting the discarded packages in a wax cup on the med cart instead of throwing the empty things in the garbage.

There's nothing wrong with that, but it gets full quick. And so the thing was full, so she in the middle of getting ready to double-check and triple-check the meds to give to a patient, she gathered them up, she put old wrappers and then wrappers that still had meds in them, that she hadn't administered yet, in that same cup and threw it in the garbage.

And then she said, oh, I'm missing some meds. And so I went back and like --- that --- that didn't make sense for me --- for her to be actually missing medication.

And so I had --- we were going to open up the Thymer cart, which comes, that has extra meds in it. And I happened to go over to the cart and I saw she had a --- a new cup was there, but there was nothing in it.

And I just happened to pick up the old cup that was in the trash can and there were the meds. There was still medications and they were the ones that she was missing.

And so I said, here they are. They were still in the wrapper, still unopened. And so she continued on her way and she got everything.

There was one patient who came to the --- to the med room, and they kind of looked at what they had. And they said, I think I'm missing something.

And so we looked, and we could identify which ones were there. And then she was able to identify which one was missing.

And [appellant] would go down, and she looked. And sure enough, she did miss something.

But that's still not a med error. I mean, that's --- the patient caught it. She didn't get all her checks in. Patient caught it. But many times there are patients who don't know what their meds are.

So had we had a patient who didn't know what their medications were, it would not have gotten caught.

It was not a med error, but it was a policy and procedural error that could have caused a medication error.

Again, she was like very inconsistent with --- with everything on Monday again.

The little colored pieces of paper she had, I figured if it was going to help her remember stuff, that was okay.

What ended up happening is, nine patients didn't get their meds by nine o'clock. It took until 9:45 for everyone to get their medications. And by ten o'clock, 10:30 at the most, we have to take out the entire cart on that day and exchange it with the new cart.

And then we have to prepare the new meds to pass to the patients by 11 o'clock. It was already 9:45. She still had some documentation to do from the PRNs and some of those things.

And so I had asked that another --- I got another nurse to come. They signed out; she continued to finish her documentation.

Because somebody needed to come very, very quickly, and exchange the cart and get the medications ready in five minutes for the --- for the next group.

And so we didn't --- we never did do that new med pass on Friday. Because I had to take some time to call the physicians, the medical and the psych to explain to them that their medications were given late.

And I had to look at each person and see if they got the medication they got at 9:45 or 9:30, were they getting it again at 11:00.

You know, we had to look at a lot of things. So I --- I couldn't be with her to do the med pass for noon.

She did the insulin pen. I was comfortable with that. She did a second one, two in a row. But the med passing in and of itself was extremely inconsistent. Which was very surprising. I thought she had it. Wednesday was so great.

> And then Friday was really significant. She mixed up the two patients.
>
> She threw away --- she just didn't have --- she didn't seem to have a pattern. She didn't seem to have any kind of routine. And so it really --- it didn't serve her well.
>
> So on that day I went down to speak with Jill about the noon --- about the eight o'clock med pass. Jill was not in her office, but Diane Dalberto was. And so I went down and spoke with her about the concerns from that med pass.
>
> I did talk to [appellant] when that happened, and asked her how she felt. She said, well, she knew she was a little slow.
>
> I mean, in the scheme of things, if you're 15 minutes late, if you're accurate, it doesn't matter. But when you're 45 minutes late on a unit that is only half the number of patients of most units, that's kind of significant.
>
> And there so many other things, the mixing up of two patients, throwing away of medications.
>
> So I --- I know she made some comments to me. I know she was really frustrated with herself. She may have been frustrated with me, because I told her I couldn't pass her on that med pass.
>
> And I know that she was upset, saying, you know, that I wanted her to be perfect. And I said to her all through this process, I don't want you to be perfect. There is no such thing as perfection. I want you to develop[] safe medication administration habits.
>
> That's --- that's what we all want. That's what we go to school for. That's part of what we do.
>
> That's why policies and procedures are in place. And I just wanted her to develop good safe habits. But she couldn't consistently do that for me.

N.T. pp. 80-95. Raup testified she concluded that appellant "was unable to be consistent in performing accurate and safe medication administration." N.T. p. 97.

Dawn Buckles, a Registered Nurse at the Hospital, was the Charge Nurse on Unit 312 on Monday, August 21, 2017, and observed appellant while she worked with Raup passing medications. N.T. pp. 155-156. Buckles testified after Raup finished with appellant, she continued to observe appellant passing medications. N.T. pp. 156-157. Buckles testified she saw appellant leave the medication room with the top half of the door unsecured. N.T. pp. 157-158. According to Buckles, appellant's action created a problem

> [b]ecause any of the residents could have jumped over the window. They could have reached in, grabbed medication, they could have jumped over the door.
>
> The [medication] room has to be secured at all times when someone is not in the room.

N.T. p. 158. Buckles indicated that leaving the door unsecured is contrary to policy. N.T. p. 158.

Buckles further testified, "I had attempted to speak with her peer to peer. And I said, you know, slow down." N.T. pp. 158-159. According to Buckles, appellant "appeared to be flustered." N.T. p. 160. When Buckles offered to let appellant take her break, appellant "said to [Buckles], yes, she needed to have a break, because she was stressed at that point." N.T. p. 161.

Diane Dalberto, the Hospital's Chief Nurse Executive, oversees its Nursing Department. N.T. p. 171. Dalberto testified she was involved in the PDC following appellant's unsuccessful remediation. N.T. p. 172. According to Dalberto the PDC addressed "the Human Resources policy on failure to follow. I think it's 7174. And it was based on medication administration, insulin administration and

nursing documentation of medications." N.T. p. 173. Dalberto testified the policy's suggested level of discipline for failing to follow instructions or procedures was "discharge." N.T. p. 174.

Dalberto testified that, during the PDC, appellant disagreed with the allegations being made:

> [appellant] indicated that she felt that she did everything properly. She stated she felt that she didn't do anything wrong. But then, during the conversation, did admit to doing different procedures incorrectly.

N.T. p. 176. Dalberto explained:

> [Appellant] indicated that she admitted that she didn't know how to pinch the skin properly when giving an insulin injection. And thus, the consumer may not have received the full dose insulin on 8/21.
>
> She admitted that she didn't wipe the end of the insulin pen with an alcohol swab prior to applying the needle on May 21.
>
> . . . she indicated that she did not give all ordered medications to one of the consumers and had to call a consumer back to give her the remainder of her medications.
>
> And she admitted that she didn't sign off on the medications right away, right after giving the medications.

N.T. pp. 176-177. Dalberto, when asked whether she accepted appellant's statements in opposition to other claimed infractions, responded "no." N.T. p. 177. Dalberto testified that, after the PDC, appellant "was suspended pending [her submission of a] written statement and the follow-up." N.T. p. 178.

When asked how the appointing authority concluded that appellant's removal was warranted, Dalberto stated:

> [appellant] had just been suspended. So we looked at that information. Along with the fact that an RN is required to pass medications and determine that it was appropriate for. And also looking at the discipline that is on the 7174 with the consider to discharge. And the significance of an RN needing to pass medication. So she was terminated.

N.T. p. 179. Dalberto indicated that when an RN fails training in passing medication, it is standard procedure to terminate that employee. N.T. p. 182. She noted that other RNs have been removed for failure to demonstrate competency in administering medications and testified she reported appellant's failure to the Nurse Licensing Board. N.T. pp. 182-183.

Thomas Burk, the Hospital's Chief Operations Officer, indicated that he was one of the decision-makers relative to the removal of appellant. N.T. p. 224. When asked how he determined that removal was appropriate, Burk stated:

> Based on the fact that [appellant] was not able to pass the med pass examination or training. There's a process for that. That is what the determination was.
>
> * * *
>
> By itself, it's standing alone because a nurse needs to be able to pass medication.

N.T. p. 224. He further indicated that appellant would have been removed solely for failure to pass the med pass review. N.T. p. 225. On cross-examination, Burk restated the decision to remove appellant "was based solely on the fact that she did not pass the competency test of medication distribution." N.T. p. 234.

Appellant corroborated earlier testimony indicating that when she returned to duty on August 21, 2017, she reported to the Hospital's Nursing Office where she met with Jill Temple. N.T. p. 254. Appellant stated Temple had appellant review "some policies and procedures," then escorted her to Unit 312, where she met with Julie Raup, the Hospital's RN Instructor. N.T. pp. 254-256. Appellant testified Raup, "said for me to start getting the meds ready for the 11:00 med pass on Unit 312." N.T. p. 257. According to appellant, no one explained, to her, the purpose of the med pass. N.T. p. 257. Appellant noted that the med passes at 8:00 a.m. and 2000 or 2100 were considered the major med passes; during those times, the majority of patients receive medications. N.T. p. 258.

Appellant indicated that a major medication pass was not a component of her employment as a third-shift nurse; appellant testified during that shift "very few" patients received medication. N.T. pp. 258-259. She further noted "[u]sually it's not very many patients that get the blood finger sticks and glucometer, . . . with a follow-up insulin." N.T. p. 259. Appellant testified she started working third shift in 2011 and had not completed a major med pass in six to seven years. N.T. p. 259.

Appellant testified as follows regarding the three checks of a medication pass:

> Q:[7] Can you explain to me what these three checks are?
>
> A: The first check is when you have the MAR. You have to have the MAR. You open it up to the very first person in the alphabet, because you go alphabetically. So you open it up and you see the name of the patient.

[7] Unless otherwise noted, all quoted questions were posed by appellant's counsel.

And you begin at the left-hand top. Well, it tells you what medication the patient gets. So you sit or stand - - - it's comfortable for me to sit - - - at the med cart, and you proceed. You start opening up the drawers.

And the first check is - - - I use my left hand and finger to point at the first med. I'll see what the name of it is. Say eight o'clock, a person gets it at eight o'clock. So I pull out the drawers. I locate that eight o'clock med dose. And then I put it in a med cup.

And that is - - - they call it your pouring meds. And that's check number one.

Q: What about the remaining checks?

A: Well, you go down from top to the bottom of every card. And most patients have more than one card. You flip through the first card and you go to the second one. So you're putting the meds for check number one inside med cups.

And sometimes some of them have so many medications, you have to use more than one med cup. But then you're done with the first patient in the alphabet and proceed down the line until you get to the last patient in the alphabet. And then that way you're done with check number one.

After you're done with every individual patient's meds from check number one, you put that med cup back into that patient's drawer, until you're done with all of them.

Q: Okay. So just sticking with one patient. And just what would the second or third checks consist of?

A: Well, when you're ready to open up the med drawer to start the mad pass --- and I, you know, I didn't explain about the narcotics involved. But you see who's standing in line, because they do not stand in line in alphabetical order. So you see who the patient is.

You have to identify the patient using the identifying checks, which is the ID picture that's on the left-hand side of the first page of the MAR for that particular patient. So you identify the patient using that ID picture. And you ask the patient to please state the first and last name.

And you repeat the first and last name after them, so that you're sure that you're on the right patient. And that is the first of the six patient lines. So there's six patient lines. And that's the first one.

Q: I guess just what I'm --- if there's a way for you to concisely explain it. I'm just trying to get an understanding of what the second and third checks in the system.

A: Oh, I'm sorry. Okay. The second check is you have to --- once the patient is up and you identify the patient, you're going to have to check the MAR again against the label of each dose of medication. So you're checking to make sure that you have the right medicine again.

Then you go to open up that unit dose container. And you have to then count the medicine. Or it could be a powdered medicine that you mix. But the second check is you're checking again, the medication again, against the MAR, to make sure that you do have the right medicine.

And then the check number three is when you tier the most of them up in pills and unit dose containers and you tier that unit dose. And you can either look against the MAR for the third time before you drop that pill into the med cup or you can actually drop that pill into the med cup, keep that empty med container in your hand and do the third check by seeing that this is the label of the medication. This is the name of the med and it matches the medication on the MAR.

N.T. pp. 260-264. Appellant testified she performed the noted checks for each patient on August 21. N.T. p. 264.

Appellant however, further testified as follows regarding Raup's instructions regarding the checks:

> A: I couldn't just have my left finger on the name of the med and the time at eight o'clock in the morning. Even though I make sure that that finger don't slide off.
>
> When I went to pick up the medication out of the drawer, you have to --- you have to take every medicine one by one. And when you're talking about medicine, you're talking about one dose.
>
> The patient might have more than one unit dose container. If they have to take 600 milligrams of the pill and there's only 300 milligrams in one pill, you've got to make sure you pick up two pills.
>
> Well, then anyhow, she wanted me to lay it --- do a physical placement and lay it on the left-hand side of the MAR instead of just looking at it and comparing it with this, when ---. I had to bring it over.
>
> I was instructed to bring it over and touch it alongside of the printed or written block where the medication was listed. And I had to do that for each medicine. And I not only had to do that for check number one, I had to do it for check number two and check number three.
>
> Q: So when you say you had to do if for check number two and check number three, you're referring to the empty wrappers at that point?
>
> A: Yeah, because when the patient come up to the med door, when you see who it is, you take the med cup out of that patient's drawer. They're arranged in the cup.

> You can't - - -the way the plastic cup is, you can't keep them in the order that you took them from the MAR. You're just going to be basically reacclimate. So you have to dump - - - dump the medication cup down, to make the pills fall out, to do check number two.
>
> So again, when you dump them down on the med cart - - - . And actually a lot of times, I'll use the far left right corner of the opened Kardex or MAR. And I will pick it up. And then I will compare to do the second check with the MAR against the label of the medicine.
>
> And then I have to open it for the third check. And then when I open it for the third check, I have to physically bring it - - -. So I had to physically bring it over to do check number two.
>
> And then physically bring it over again to check number three. Instead of just looking at it in the normal fashion, the way I've been doing all the years and the way I've seen other nurses do it.

N.T. pp. 264-267. Appellant noted "the severity of the patients that are in psychiatric state facilities, they usually do get a good many medications." N.T. p. 268. Appellant further noted that hospital policy does not require that medications be physically placed "alongside of the name of the medicine." N.T. p. 268. Appellant testified her unfamiliarity with the patients additionally hindered her performance. N.T. pp. 274-275.

Appellant also testified Raup provided additional distraction; appellant testified:

> [t]he entire time, she constantly talked and she constantly moved about the med room. She walked up like alongside me but walked away, and come back up and again walked away, constantly talking. And I was trying to focus . . . on the task at hand.
>
> * * *
>
> She spoke about different things. She spoke to me about another nurse.
>
> * * *
>
> She spoke about different people. She spoke about her own experiences. And this was at the time I'm doing the check number one.
>
> There were a few times that she mentioned the procedure that I was doing at the present time, which doesn't seem anything wrong with that. She was making comments to me that --- I felt rather intimidated.

N.T. pp. 276, 278.

Noting that none of the involved patients had developed complications, appellant similarly testified she had experience administering insulin to patients and detailed the manner in which she performed checks and injections. N.T. pp. 279-285. Appellant specifically noted her ability to "pinch-up" a patient's skin, when needed. N.T. pp. 282-283. Appellant denied ever telling Dalberto that she did not know how to pinch the skin. N.T. pp. 283-284.

When asked to recount her experiences on August 23, 2017, appellant indicated that she did not go to the Hospital's Education Department; appellant testified she has never been to the Hospital's Education Department or to Raup's

office. N.T. p. 286. She indicated that she did not review policies with Raup and that the only education she received from Raup involved her "verbaliz[ing] things to me during the med passing . . ." N.T. p. 287. Appellant corroborated earlier testimony noting that, on that date, she successfully performed an 11:00 a.m. med pass under Raup's observation. N.T. p. 287.

Appellant similarly corroborated that on Friday, August 25, 2017, she was assigned to perform the 8:00 a.m. med pass; she indicated that she did not know why, after successfully completing the Wednesday med pass, she was again being tested. N.T. pp. 288-289. Appellant acknowledged that she brought index cards in five different colors and explained:

> I would put them, during check number one, inside the med cup, along with the other pills. Then when I do check number two and I have to dump over the contents of the med cup, those colored index cards will red flag that tells me, look, make sure this patient gets their [correct medication].

N.T. pp. 290-291. Appellant testified the action did not take much time and that she had been using it since her time at Harrisburg State Hospital. N.T. p. 291. According to appellant it was a memory aid she used because she was not familiar with the Unit. N.T. pp. 292-293. Appellant noted that when Raup objected to her use of the cards, she stopped using them. N.T. p. 293.

Appellant testified at some point on the 25th, she requested that someone be provided to help her identify the patients; no help was provided. N.T. p. 293. Appellant acknowledged misplacing three pills, inadvertently putting them with wrappers to be discarded; appellant testified she found the pills herself. N.T. pp. 296-299. Appellant also acknowledged that to speed the line, she failed to

immediately initial the MAR after administering medications to the first two patients; she however testified she caught her error and did not make that mistake again. N.T. pp. 299-300.

Section 807 of the Civil Service Act states "No regular employee in the classified service shall be removed except for just cause." 71 P.S. § 741.807. In *Perry v. State Civil Service Commission (Department of Labor and Industry)*, 38 A.3d 942 (Pa. Commw. Ct. 2011), the Commonwealth Court of Pennsylvania stated:

> [t]he term "just cause" is not defined in the Act. Just cause must be merit-related, and the criteria for determining whether an appointing authority had just cause for removal must touch upon the employee's competency and ability in some rational and logical manner.
>
> What constitutes just cause for removal is largely a matter of discretion on the part of the head of the department. However, to be sufficient, the cause should be personal to the employee and such as to render the employee unfit for his or her position, thus making dismissal justifiable and for the good of the service.

38 A.3d at 951, citing *Woods v. State Civil Service Commission (New Castle Youth Development Center, Department of Public Welfare)*, 590 Pa. 337, 912 A.2d 803 (2006), *Ming Wei v. State Civil Service Commission (Department of Health)*, 961 A.2d 254 (Pa. Commw. Ct. 2008)*; Pennsylvania Board of Probation and Parole v. State Civil Service Commission (Manson),* 4 A.3d 1106 (Pa. Commw. Ct. 2010). Following our review of the record as a whole, we find that the appointing authority has met its burden.

In support of our conclusion, we note the testimony of Temple stating a requirement that on her return appellant demonstrate her competency by successfully completing three medication passes; we also note the testimony of Raup regarding her August 21, 23 and 25, 2017 observations of appellant's performance of medication administration duties. The record establishes that the administration of medications is an essential function of RN employment at the facility; it is a duty left solely to the nursing staff. N.T. pp. 182, 214, 228; AA Ex. 1, p. 1. Burk's discussion of the consequences of any failure of the appointing authority to ensure that its employees adhere to its standards on the administration of medications makes it apparent that the appointing authority has acted reasonably by attributing substantial importance to this responsibility. N.T. pp. 228-229. Raup's conclusion that appellant failed to demonstrate that she could effectively perform the duties as directed by the appointing authority establishes a *prima facie* justification for removal.

In opposition, appellant does not dispute the appointing authority's requirement that she be subject to assessment;[8] appellant has instead: 1) challenged the assessment as subjective; 2) challenged the fairness of the assessment; 3) challenged the manner in which the assessment was conducted; and 4) challenged the appointing authority's conclusions based upon the assessment. Ap. Bf. pp. 6-19. Appellant has additionally alleged that her removal was "the product of unlawful discrimination and retaliation." Ap. Bf. p. 20. Appellant has presented no evidence other than her own testimony; neither her testimony nor her arguments have been sufficient to overcome the appointing authority's case.

[8] Although appellant testified she was unaware why, after successfully completing a Wednesday August 23 med pass, she was again being observed on Friday August 25 (N.T. p. 289), appellant has not challenged the appointing authority's assertion that its policy required that she successfully complete three. N.T. pp. 20-22, 32-33, 195.

Appellant's assertion that the assessment was subjective (Ap. Bf. pp. 9-11) is, we believe, correct; that subjective nature, however, is not, standing alone, evidence that the evaluation is either inaccurate, unreliable or discriminatory. The conclusion, that appellant's med pass performances on August 21 and 25 were inadequate, has been supported by Raup's credible testimony addressing specific actions undertaken by appellant in a manner contrary to the appointing authority's policies. Appellant, having presented no credible testimony sufficient to persuade this Commission that she did not commit the observed policy violations, cannot prevail on this argument.

Appellant's claim that the competency review was unfair centers on the differences between the patients, shift and Unit where she was tested and her normal assignment; appellant's argument is, again, unpersuasive. Appellant has presented no evidence establishing that the noted differences are, in any way, inconsistent with the routine performance required of any individual employed as a Registered Nurse with the appointing authority. The mere fact that appellant previously worked with specific patients, during a specific shift does not lead us to conclude that she would have been returned to the same assignment; so long as the review addressed the performance of duties relevant to Registered Nurse employment, the Commission is unwilling to deem it unfair.

Appellant challenges the manner in which the review was conducted by arguing: 1) that Raup "jumped the gun" by pointing out that appellant had misidentified a patient rather than waiting for appellant to correct herself (Ap. Bf. pp. 13-14); 2) that Raup similarly unnecessarily reminded her to perform a narcotic count on August 21 (Ap. Bf. pp. 15-16); and 3) that Raup erred by concluding that appellant failed to properly inject insulin on August 21, 2017 (Ap. Bf. pp. 16-17).

Credible testimony however establishes that appellant during her PDC acknowledged the August 21 insulin failure and a failure to properly clean a needle (N.T. p. 176); even were we to accept appellant's statement that the August 21 count reminder was unnecessary, appellant has not persuaded the Commission that her August 21 performance should have been deemed successful. Similarly, even were we to accept appellant's claim that she would have caught her patient misidentification during the August 25, 2017 medication pass, her performance still would have been properly deemed inadequate even if solely due to her late completion of the pass.

Appellant's challenge to the appointing authority's reliance on Raup's observations and conclusions argues: 1) that the appointing authority "failed to meaningfully review" the retraining and competency evaluations (Ap. Bf. pp. 6-9); and 2) that Raup's observations and conclusions do not "establish that [appellant] was incapable of performing her job duties" (Ap. Bf. pp. 17-19). The record contains no indication that the appointing authority has alleged that appellant is unable to perform job duties. The appointing authority has, however, persuasively demonstrated that appellant, during two med pass observations, failed to perform those job duties in the manner it required. The record contains no evidence establishing what, if any, "meaningful review" other than an evaluation of appellant's performance, the appointing authority was obligated to perform; we find nothing that would lead us to conclude that the appointing authority was required to re-examine the apparently accurate and job-related observations and conclusions presented by Raup and Dalberto.

Having rejected appellant's arguments in opposition to the appointing authority's charges, we will again note that appellant has also presented allegations of discrimination due to her disability and/or in retaliation for her complaints of harassment and discriminatory treatment. Ap. Bf. pp. 20-26. Appellant's claims having been brought under Section 951(b) of the Civil Service Act, the initial burden was placed upon appellant to present evidence that, if believed and otherwise left unexplained, indicates that more likely than not discrimination has occurred. *Moore v. State Civil Service Commission (Department of Corrections)*, 922 A.2d 80, 85 (Pa. Commw. Ct. 2007), citing *Henderson v. Commonwealth, Office of the Budget*, 126 Pa. Commw. Ct. 607, 614, 560 A.2d 859, 863 (1989). A presumption of discrimination would thereby be established. The appointing authority would then need to introduce evidence of a "non-discriminatory explanation" for the challenged personnel action. Once that is done, it would be left to this Commission, in its role as the trier of fact, to determine which party's explanation of the appointing authority's motivation it believes. *Henderson*, 126 Pa. Commw. at 615, 560 A.2d at 863. Appellant's assertions of discrimination have been reviewed; those claims will be dismissed.

The only evidence on the subject establishes that the decision to suspend appellant was made by a panel consisting of the Hospital's Chief Operating Officer, its CEO and its Nursing Director (N.T. pp. 223-224); two of the three—Dalberto and Burk—testified at hearing. Appellant has presented nothing which, in any way, disputes their assertion of her failure to successfully complete two of three medication administration competency evaluations undertaken on her return from suspension on prior charges related to her administration of medications. Appellant's claim of discrimination has instead been built upon a chain of events—*i.e.*, 1) her removal was due to her performance on observed medication

administration passes; and 2) she was assigned to observed med passes due to her return from suspension—which she alleges began with a suspension motivated by discrimination. The noted suspension however has been upheld by this Commission and appellant's claim of discriminatory suspension was dismissed. *See Zajac v. Department of Human Services*, SCSC Appeal No. 29734, issued September 3, 2019. Appellant having presented no additional evidence in this appeal in support of either her allegation of discrimination or her claim of retaliation, both are also dismissed herein. Accordingly, we enter the following:

## CONCLUSIONS OF LAW

1. The appointing authority has presented credible evidence to establish that the removal of appellant was for just cause sufficient under Section 807 of the Civil Service Act, as amended.
2. Appellant has failed to introduce credible evidence sufficient to establish that the challenged removal was imposed due to discrimination violative of Section 905.1 of the Civil Service Act, as amended.

## ORDER

AND NOW, the State Civil Service Commission, by agreement of two of its members,[9] dismisses the appeal of Theresa R. Zajac challenging her removal from regular Registered Nurse employment with the Danville State Hospital,

[9] Chairman Teresa Osborne, who took office March 22, 2019, did not participate in the discussion or decision on this appeal.

Department of Human Services and sustains the action of the Danville State Hospital, Department of Human Services in the removal of Theresa R. Zajac from regular Registered Nurse employment effective August 26, 2017.

State Civil Service Commission

Gregory M. Lane
Commissioner

Bryan R. Lentz
Commissioner

Mailed: September 3, 2019