3-31-2011

DEPARTMENT OF MENTAL HEALTH, vs. CHIBUZOR OKOLOCHA, Grievant.

BEFORE THE CIVIL SERVICE COMMISSION OF THE STATE OF TENNESSEE

IN THE MATTER OF: **DEPARTMENT OF MENTAL HEALTH,** ***v.*** **CHIBUZOR OKOLOCHA,** ***Grievant.***	**DOCKET NO: 26.15-108576J**

INITIAL ORDER

This matter was heard on March 31, 2011, in Nashville, Tennessee, before Administrative Judge Mary M. Collier, assigned by the Secretary of State, Administrative Procedures Division, to sit for the Civil Service Commission of the State of Tennessee. Richard A. Prybilla, Assistant General Counsel for the Middle Tennessee Mental Health Institute, represented the Tennessee Department of Mental Health, which was formerly named the Tennessee Department of Mental Health and Developmental Disabilities.[1] The Grievant, Chibuzor Okolocha, represented himself, waiving the right to employ legal counsel.

The issue of this hearing was whether the Department properly terminated Mr. Okolocha's employment. After consideration of all of the evidence, arguments of counsel and parties, and the entire record in this matter, it is determined that Mr. Okolocha's termination of employment was proven to be appropriate by a preponderance of the evidence and should therefore be **UPHELD**. This decision is based upon the following.

[1] At the time this appeal was filed, the name of the Department was the Department of Mental Health and Developmental Disabilities. Since that time, the Department's name has been changed to the Department of Mental Health. Herein, the Grievant's former employer will be referred to as the "Department."

PROCEDURAL HISTORY

On December 7, 2009, the Grievant was recommended for dismissal from state service for violation of Middle Tennessee Mental Health Institute ("MTMHI") policy # 0214.01, which pertains to the Management of Patients at Risk. The Grievant was offered the opportunity to have a due process hearing, which took place on December 29, 2009. Candace L. Gilligan, Chief Executive Officer of MTMHI, upheld the recommendation for the Grievant's dismissal in a letter dated January 12, 2010. The Grievant appealed Ms. Gilligan's decision, requesting a Level III Hearing, which was held on March 2, 2010. On March 10, 2010, Bruce Gilmore, Assistant Superintendent for Administration of MTMHI, upheld the recommendation for the Grievant's dismissal. The Grievant appealed Mr. Gilmore's decision, requesting a Level IV Grievance Hearing, which took place on June 7, 2010. On June 21, 2010, Virginia Trotter Betts, then Commissioner of the Department, upheld the termination of the Grievant's employment with the Department.

By letter dated July 3, 2010, which was not mailed until July 14, 2010, the Grievant requested a Level V hearing before an administrative judge sitting for the Civil Service Commission. By letter dated August 10, 2010, Deborah E. Story, then Secretary of the Civil Service Commission, acknowledged the Grievant's request, and forwarded it to the Administrative Procedures Division.

A pre-hearing telephone conference was held on October 13, 2010, during which the Grievant moved for a continuance in order to allow the Tennessee State Employees' Association (TSEA) time to review his file to determine whether TSEA would provide him with legal counsel. A second pre-hearing telephone conference was held on November 9, 2010, during which TSEA employee Susan O'Bryan explained that TSEA was still reviewing the Grievant's

file. A third pre-hearing telephone conference was held on December 9, 2010, during which the Grievant explained that he was still seeking legal counsel. However, it was determined that the Grievant had been given ample time to obtain the services of legal representation via either TSEA or private counsel and the hearing was set for March 31, 2011. A final pre-hearing telephone conference was held on March 1, 2011, during which it was determined that the parties were ready of the hearing to be heard on its scheduled date of March 31, 2011.

The hearing was held on March 31, 2011. The Transcript was filed on May 10, 2011. The RECORD was held open to allow the parties to file proposed findings of fact and conclusions of law. The Department's proposed findings of fact and conclusions of law were due to be filed on June 9, 2011. On May 27, 2011, the Department filed proposed findings of fact and conclusions of law. The Grievant's optional proposed findings of fact and conclusions of law were due to be filed on June 16, 2011. To date, the Grievant has not filed any proposed findings of fact or conclusions of law.

SUMMARY OF EVIDENCE

Four (4) witnesses testified at the hearing:

(1) Dorothy King, Registered Nurse 3 at MTMHI;

(2) Shirley Edmonson, Nursing Educator Manager for Nursing at MTMHI;

(3) Margie Dunn, Human Resources Director at MTMHI; and

(4) Grievant, Chibuzor Okolocha.

Seven (7) exhibits were entered into evidence:

EXHIBIT 1 — MTMHI Nursing Staff (Tech) 3rd Shift Assignment Sheet for 11-8-09;

EXHIBIT 2 — Management of Patients at Risk;

EXHIBIT 3 — March 15, 2007, Notice of Disciplinary Action;

EXHIBIT 4 — December 7, 2009, Letter Recommending Dismissal from State service;

EXHIBIT 5 — January 12, 2010, Dismissal Decision;

EXHIBIT 6 — March 10, 2010, Level III Grievance Decision;

and

EXHIBIT 7 — June 21, 2010, Step IV Grievance Hearing Decision.

FINDINGS OF FACT

1. The Grievant, Chibuzor Okolocha, was employed by Middle Tennessee Mental Health Institute ("MTMHI") as a Psychiatric Technician.

2. On December 19, 2006, the Grievant was recommended for a two day suspension for violation of Tennessee Department of Personnel Rule #1120-10-06 (20), Sleeping or Failure to Remain Alert During Duty Hours, and MTMHI Nursing Policy #0214.01, Management of Patients at Risk. The Grievant did not request a due process hearing nor did he petition for an appeal of his two day suspension in 2006.

3. The Grievant was recommended for dismissal from state service on December 7, 2009, for violation of MTMHI's policy pertaining to the Management of Patients at Risk, policy # 0214.01, following MTMHI's disciplinary track for a second offense of this MTMHI policy.

4. MTMHI's Management of Patients at Risk policy # 0214.01 requires that one-to-one observation include: "constant visual 24-hour observation by assigning one (1) individual staff member who must also be within arm's length of the patient (unless otherwise ordered) with no physical barriers (such as walls or furniture) between the staff member and the patient. The staff member must be able to visualize the hands of the patient at all times. This level of observation shall be prescribed for the patient at highest risk. The well-being of the patient must be continually checked by the staff member while on this level of observation. . . ."

5. MTMHI patients who are placed on one-to-one observation are considered to be patients at the highest level of risk for hurting themselves or others.

6. The Disciplinary Track section of MTMHI's Management of Patients at Risk policy # 0214.01 provides:

> Since maintaining patient observation is an important part of insuring patient safety, the Executive Council and the Governing Body of Middle Tennessee Mental Health Institute has determined that any failure of an individual staff person [sic] carry out or fully comply with the observation assignments and all requirements associated with that assignment, as specified in sections III. C. and IV. B. of this policy, shall be considered to be **Patient Neglect**. The following disciplinary track shall be applied:
>
> - **First Offense** – Three Day Suspension
> - **Second Offense** – Termination
>
> **The above disciplinary track shall apply only IF THE PATIENT DOES NOT ELOPE AND NO HARM OR INJURY occurs to a patient as a result of a staff person's failure to maintain proper observation. If a patient elopes, is injured or harmed, becomes ill, or dies as a result of a staff person's failure to maintain proper patient observation, the staff person responsible for the observation shall be subject to termination on the FIRST OFFENSE.**

7. The Grievant attended a training session pertaining to the Management of Patients at Risk and he is familiar with MTMHI's Management of Patients at Risk policy # 0214.01.

8. During the third shift on November 8, 2009, the Grievant was assigned to the one-to-one observation of a patient. During this shift, the Grievant left his assigned patient's room to go and make a pot of coffee. When the Grievant left his assigned patient's room, there was no MTMHI staff member in the patient's room observing the patient one-to-one. When the Grievant left his assigned patient's room, there was no MTMHI staff member within arm's length of the patient the Grievant was assigned to observe one-to-one.

9. While making her rounds during the third shift on November 8, 2009, Deborah King, a registered nurse and clinical supervisor at MTMHI, walked into a patient's room and observed the clipboard with the observation sheet indicating that the patient was assigned to one-

to-one observation. At the time Ms. King first entered the patient's room, neither the Grievant nor any other MTMHI staff member was in the room with the one-to-one patient. At that time, no one was within arm's length of the patient the Grievant was assigned to observe one-to-one. After finding the one-to-one patient without observation staff, Ms. King left the room to get the nurse's assistant in order to determine why no one was observing the one-to-one patient.

10. After exiting the patient's room, Ms. King observed the Grievant walk down the hall at a fast pace, go into the unattended one-to-one patient's room, sit down, and put the clipboard in his lap. At that point, Ms. King returned to the room and asked the Grievant if the previously unattended one-to-one patient was the Grievant's assigned patient, and if he was assigned to observe him one-to-one. The Grievant responded in the affirmative to both questions and explained that he had left the patient and gone to make a pot of coffee. The Grievant was not carrying a cup of coffee when he returned to his assigned patient's room.

11. Although the Grievant acknowledged to Ms. King that he was assigned to observe the one-to-one patient and that he understood the requirements of a one-to-one assignment, he did not explain to her why the patient had been left unattended other than his statement that he had gone to make a pot of coffee.

12. The Grievant's testimony that Donna Wagner was in the patient's room observing the one-to-one patient is contradicted by the Grievant's own testimony that to his knowledge no one was within arm's length of the patient while he went to get the coffee as well as Ms. King's testimony that no MTMHI staff member was in the room when she first arrived. Ms. King's testimony is found to be more credible and the Grievant's testimony that Ms. Wagner was in the room is found not to be credible. It is found that the Grievant left his assigned one-to-one patient unattended when he left the room to go and make a pot of coffee.

ANALYSIS *and* CONCLUSIONS OF LAW

It is determined that the Department has proven by the preponderance of the evidence, that the Grievant violated the MTMHI Management of Patients at Risk Policy # 0214.01. This Policy requires that one-to-one observation include:

> constant visual 24-hour observation by assigning one (1) individual staff member who must also be within arm's length of the patient (unless otherwise ordered) with no physical barriers (such as walls or furniture) between the staff member and the patient. The staff member must be able to visualize the hands of the patient at all times. This level of observation shall be prescribed for the patient at highest risk. The well-being of the patient must be continually checked by the staff member while on this level of observation. . . .

HRG. EX. 2 (emphasis in original). This policy clearly requires a psychiatric technician assigned to observe a patient one-to-one to remain within arm's length of the patient.

On November 8, 2009, when the Grievant left his assigned patient's room to make a pot of coffee, no one was within arm's length of the patient the Grievant was assigned to observe one-to-one. Going to make a pot of coffee is not an emergency situation. A one-to-one patient should not be left alone to allow an MTMHI employee to make a pot of coffee. Instead, another employee must first relieve the thirsty employee before the employee leaves the patient to go to make a pot of coffee.

Leaving his assigned one-to-one patient unattended on November 8, 2009, is conduct in direct violation of the MTMHI Management of Patients at Risk Policy # 0214.01. This was the second violation by the Grievant of the MTMHI Management of Patients at Risk Policy # 0214.01. Pursuant to the MTMHI Management of Patients at Risk Policy # 0214.01, termination of employment is the proper level of discipline for an employee's second violation of this Policy.

It is determined that the Department proved that the Grievant violated the MTMHI Management of Patients at Risk Policy # 0214.01 by a preponderance of the evidence. It is also

determined that the Department proved by a preponderance of the evidence that this was the Grievant's second violation of the MTMHI Management of Patients at Risk Policy # 0214.01. Accordingly, Chibuzor Okolocha's termination of employment from his position as a psychiatric technician was proven appropriate by a preponderance of the evidence and **it is ORDERED that the termination of Chibuzor Okolocha's employment with Middle Tennessee Mental Health Institute is UPHELD**.

It is so **ORDERED**.

This INITIAL ORDER entered and effective this the _____ day of _____ 2011.

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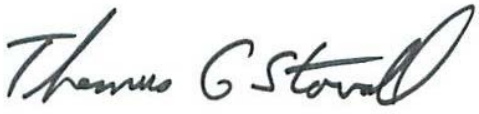
MARY M. COLLIER
ADMINISTRATIVE JUDGE
ADMINISTRATIVE PROCEDURES DIVISION
OFFICE OF THE SECRETARY OF STATE

Filed in the Administrative Procedures Division, Office of the Secretary of State, this the _____ day of _____ 2012.



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