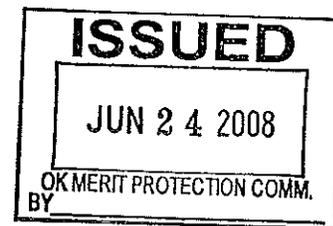


OKLAHOMA MERIT PROTECTION COMMISSION

STATE OF OKLAHOMA

KIM KWITOWSKI,)
Appellant)
vs.)
DEPARTMENT OF MENTAL HEALTH)
AND SUBSTANCE ABUSE SERVICES,)
Appellee.)

CASE NO. MPC 08-046



FINAL ORDER

Hearing on this matter was held before the undersigned duly appointed Administrative Law Judge on June 10, 2008 at the Merit Protection Commission offices in Oklahoma City, Oklahoma. Appellant, Kim Kwitowski, appeared in person and was represented by Philip L. Watson, Esq. Appellee, Department of Mental Health and Substance Abuse Services (hereinafter referred to as "DMHSAS" or "Appellee"), appeared by and through its counsel Katie Cox and Deneca Caine, Assistants General Counsel, and agency representative Dan Bowen, Executive Director of Griffin Memorial Hospital in Norman.

Appellant, a patient care assistant at Griffin Memorial Hospital in Norman, was discharged from her position following a therapeutic hold incident with a consumer in which Appellant allegedly (1) committed misconduct by physical or verbal abuse and acted in a manner that adversely affected consumer care, and (2) acted inefficiently by not complying with operational methods and violating Department, facility or other

internal policy, in accordance with Merit Rules 455:10-11-4, 455:10-11-11, 455:10-11-14, and 455:10-11-17 and DMHSAS Progressive Discipline Policy 5.8.

Whereupon, the sworn testimony of witnesses for both Appellee and Appellant was presented, along with the parties' exhibits. Exhibits 1 through 11 and Exhibit 17 were admitted and are incorporated herein and made a part hereof. Additionally, the undersigned granted a protective order with regards to Exhibit 17 to protect the privacy of persons named therein. Accordingly, after careful consideration of all evidence, testimony, and exhibits, the undersigned Administrative Law Judge issues the following findings of fact, conclusions of law, and order.

FINDINGS OF FACT

Appellant, was a patient care assistant (PCA) at Griffin Memorial Hospital, a psychiatric hospital in Norman, and had been employed there with DMHSAS for approximately seven years. Appellant was on duty on the evening of May 7, 2007 when, at approximately 9:19 p.m., one of the patients, hereinafter referred to as "Consumer"¹, having become agitated and wanting to leave the hospital, climbed over the desk at the nurse's station in an attempt to leave the facility. Appellant was one of several staff members who attempted to calm Consumer and redirect her back to the ward. Consumer would not comply with staff and a scuffle broke out in which a nurse was pushed to the floor. Consumer was restrained by staff and taken to the floor, facedown on her stomach. One staff member lay across her legs to prevent her from

¹ Consumer was a large, heavy-set 45-year-old female who was a voluntary patient at Griffin Memorial Hospital.

kicking; another staff member was restraining her right arm and shoulder; Appellant was restraining her left arm and shoulder.

During the course of the restraint, at least seven staff members were present and participated in or observed the restraint. Consumer was uncooperative, combative, and loud, and continued to struggle and shout until assistance arrived to carry Consumer to the seclusion room, where she was able to calm down.

Hospital Executive Director Don Bowen viewed the video tape of the incident, and concluded that the video showed Appellant had her knee on Consumer's back during most of the restraint, which is an improper and unauthorized patient hold. A request was made to the Office of Consumer Advocacy (OCA) to investigate the matter and determine whether any abuse or mistreatment occurred during the incident. Findings of the investigation concluded that during the restraint Appellant placed her knees on Consumer's back in an improper attempt to restrain Consumer; that such a hold caused or threatened harm to Consumer; and that Appellant was guilty of mistreatment and physical abuse. (Exhibit 17) A recommendation was made to discharge Appellant. (Exhibit 6) Appellant had previously received a reprimand on February 1, 2005 for misconduct by verbal consumer abuse – using offensive language in the presence of patients and staff. (Exhibit 4) Following a pre-termination hearing, Director Bowen made a final decision to discharge Appellant, effective September 21, 2007. (Exhibit 7) Appellant appealed the discharge.

Discussion

Appellant states that everything happened so quickly and with such confusion that she did not have time to think, only to act in what she thought was the best interest

of the Consumer and staff. She does not remember whether she had her knee on Consumer's back, but states that if she did, it was not done with intent to injure or harm Consumer, but merely to restrain her and restore order. Consumer never complained of pain or discomfort and was not injured in the incident. In fact, all of the other six staff members present stated to the OCA investigator that they never saw Appellant with her knee on Consumer's back. The only witness to indicate that she saw a knee placed on Consumer was another patient who stated that she saw a female staff member with a knee on Consumer's leg; that Consumer was "manhandled", was unable to speak, and could do little more than groan. This observation was diametrically different from statements given by all other witnesses interviewed by the OCA investigator, different from the two critical incident reports completed at the time of the incident (Exhibit 17), and this administrative law judge does not find the patient's statement accurate.

The video of the incident appears to show Appellant kneeling beside Consumer with one knee on Consumer's back and then re-positioning herself and placing the other knee on Consumer's back. (Exhibit 5) The video shows that Appellant held Consumer in this restraining manner for about four minutes before she was relieved by another PCA. Upon review of the video, all of the witnesses, who earlier stated to the OCA investigator that they did not see Appellant's knee on Consumer, admitted to the investigator that the video appeared to show Appellant with her knee on Consumer's back.²

The DMHSAS utilizes the Creating a Positive Environment (CAPE) curriculum throughout the department and its facilities, including Griffin Memorial Hospital. The

² None of the six staff witnesses present during the incident testified at the hearing, and their observations stated in this Order were taken from the OCA investigative report. At the time of the investigation, the Consumer had been discharged from the hospital and the investigator could not interview her.

CAPE philosophy and training promotes effective verbal and non-verbal communication skills in dealings with patients to ensure safety and promote their dignity and self-esteem. All DMHSAS employees are required to successfully complete twelve hours of training on verbal intervention skills. Additionally, staff who provide patient care, including PCA's, are required to successfully complete four more hours of physical intervention training. This training must be completed before an employee can provide direct care services and must be maintained with annual update training for a minimum of three hours each of verbal intervention skills and techniques and physical intervention techniques. (Exhibit 1)

Robert Goldsberry, a 21-year CAPE trainer, testified that the physical intervention training includes videos, demonstrations, and hands-on role play on the correct and incorrect procedures for physical intervention with patients. Employees are taught that when restraining a patient in a horizontal position, the patient should be rolled to his or her side, with a staff member on the feet and another staff member holding the patient's forearm behind him/her. Director Bowen testified that when a patient is taken to the floor, he or she should be rolled onto their back and their extremities held. Lying across the legs is acceptable procedure. Restraining the arms is also proper. Both Director Bowen and Mr. Goldsberry testified that a patient should never be held on their stomach and never have weight on their body. Mr. Goldsberry testified that restraining a patient on his/her stomach is not a safe hold, as it can effect breathing and cause an obstructed airway. Further, any pressure on the back is unsafe. A patient cannot be held down with another person's body weight on his or her body.

The purpose of the CAPE training and required annual continuing training is to ensure that patient care providers act safely and properly in unforeseen emergency situations such as the one presented here. Appellant was the most senior PCA on the scene and, after receiving the required CAPE training and after seven years on the job, should have been aware of proper holding procedures.

Based on a preponderance of the evidence presented at the hearing, the undersigned Administrative Law Judge finds that just cause exists to support Appellee's allegations concerning Appellant Kim Kwitowski's (1) misconduct for physical or verbal abuse and acting in a manner that adversely affected consumer care, and (2) inefficiency for not complying with operational methods and for violating Department, facility or other internal policy, in accordance with Merit Rules 455:10-11-4, 455:10-11-11, 455:10-11-14, and 455:10-11-17 and DMHSAS Progressive Discipline Policy 5.8. The undersigned further finds that just cause exists to discipline Appellant and that the discipline imposed – discharge – was not an abuse of discretion under the circumstances presented here.

CONCLUSIONS OF LAW

1. The Oklahoma Merit Protection Commission has jurisdiction over the parties and subject matter in the above-entitled matter.

2. Any findings of fact that are properly conclusions of law are so incorporated herein as conclusions of law.

3. The burden of proof in this case was placed on Appellee pursuant to Merit Rule 455:10-9-2(f)(1) to show by a preponderance of the evidence that just cause exists for the adverse action and that the discipline imposed was just.

4. Merit Rule 455:10-11-14 states that a permanent classified employee may be discharged for misconduct, inefficiency, inability to perform the duties of his job, willful violation of Merit Rules, conduct unbecoming a public employee, and any other just cause.

5. Merit Rule 455:10-11-4 provides for progressive discipline to ensure impartiality, consistency, and predictability of discipline, and flexibility to vary penalties, and states that a single incident may justify a higher step without proceeding through lower steps of discipline.

6. Merit Rule 455:10-11-11 provides that the second phase of progressive discipline includes discharge.

7. DMHSAS Progressive Discipline Policy 5.8 - 3.i defines the category of "misconduct" to include physical or verbal consumer abuse.

8. DMHSAS Progressive Discipline Policy 5.8 - 3.iii defines the category of "inefficiency" to include not complying with operational methods and violating department, facility or other internal policy.

9. DMHSAS Progressive Discipline Policy 5.8 – 7.a. describes "aggravating circumstances" to include conduct placing consumers at risk of injury or danger, and two or more categories of infractions resulting from the same occurrence.

10. Appellee Department of Mental Health and Substance Abuse Services has met its burden to prove, by a preponderance of the evidence, that Appellant, Kim

Kwitowski, violated agency policy and Merit Rules by engaging in an improper restraint of a patient/consumer, and that just cause exists for Appellant's discharge.

ORDER

IT IS THEREFORE ORDERED, ADJUDGED, AND DECREED by the undersigned Administrative Law Judge that the petition of Appellant is hereby **DENIED** and her discharge is sustained.

DATED this 23rd day of June, 2008

A handwritten signature in cursive script, appearing to read "Annita M. Bridges", is written over a horizontal line. To the right of the signature, there are some faint, illegible markings.

Annita M. Bridges, OBA # 1119
Administrative Law Judge

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