STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM

DECISION

APPELLANT

[redacted]

RESPONDENT

[redacted] MEDICAL CARE FACILITY

ADMINISTRATIVE LAW JUDGE: ERICK WILLIAMS

SSN: [redacted]

Docket No.: [redacted]
Case No.: [redacted]

JURISDICTION

On February 22, [redacted], the Unemployment Agency issued a determination that the claimant, Amy [redacted] (formerly Amy [redacted] referred to below as Amy [redacted]), was disqualified to receive unemployment compensation under MCL 421.29 (1) (b) because of misconduct. According to the determination, Ms. [redacted] was terminated from [redacted] Medical Care Facility on December 17, [redacted] for preparing medications for several different residents at the same time and dispensing them without verifying the patient, the drug, the dose, the route and the time, which was a violation of company policy; she was aware of the policy and had received verbal warnings prior to termination. Ms. [redacted] appealed the determination. On April 29, [redacted] the Unemployment Agency issued a re-determination that again found Ms. [redacted] disqualified for the same reason. On May 17 [redacted] Ms. [redacted] filed this appeal.

ISSUE

The issue here is whether Ms. [redacted] is disqualified under MCL 421.29 (1) (b) for misconduct. [redacted] Medical Care Facility has the burden of proof.

APPEARANCES

A hearing was held on June 18 and July 30, [redacted] J Latif Baig represented [redacted] Medical Care Facility. [redacted] epresented Ms. [redacted]

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FINDINGS OF FACT

The following exhibits were admitted in evidence:

Exhibit 1	[redacted] letter, 18 Dec [redacted]
Exhibit 2	"Performance counseling" 14 Dec [redacted]
Exhibit 7	Pharmacy rules
Exhibit 17	CMS Nursing Home Regulation Manual
Exhibit 43	Job description
Exhibit 48	Acknowledgment

Amy [redacted], LPN, (formerly [redacted], referred to below as Amy [redacted]) worked as a night shift nurse at the [redacted] County Medical Care Facility, a nursing home. Ms. [redacted] was hired in July [redacted]. The facility is governed by the [redacted] County Department of Human Services Board. In December [redacted] was the administrator of the facility. [redacted] was the director of nursing.

When nurses administer drugs to patients, they do so according to professional standards, sometimes expressed as the "five rights" – right patient, right drug, right dose, right route of administration, right time.

The [redacted] County Medical Care Facility has a policy on drug administration (Exhibit 5) that reads in part as follows:

> 4. Medications will be administered at the time that they are prepared. Doses will not be pre-poured.
>
> 14 (i). Identify the resident using the photo which is mounted in the ECS MAR system.
>
> 14 (k). Chart after administering the medication and before proceeding to the next resident.

The facility's policy was adopted in [redacted] and was updated in [redacted] and [redacted].

The facility contracts with a pharmacy, [redacted] that has a protocol for drug administration in long term care facilities, Exhibit 7, that reads in part:

> 3.3.2. Dose Preparation: Facility should take all measures required by facility policy and applicable law, including, but not limited to the following:

... Facility staff should only prepare medications for one resident at a time.

4.1.1 Prior to administration of medication, facility staff should take all measures required by facility policy and applicable law, including but not limited to the following: Facility staff should: Verify each time a medication is administered that it is the correct medication, at the correct dose, at the correct route, at the correct rate, at the correct time, for the correct resident as set forth in Appendix 17; Facility Medication Administration Schedule.

5.1 During medication administration, facility staff should take all measures required by facility policy and applicable law, including, but not limited to the following: Identify the resident per facility policy.

[redacted]s drug administration policy was adopted in 2007 and was updated in 2010.

Prior to December [redacted] Ms. [redacted] had not been disciplined for her method of administering drugs to patients.

Ms. [redacted]s last evaluation prior to December [redacted] was performed by the assistant director of nursing, who gave Ms. [redacted] a good rating, stating that she met expectations, and stating in particular that she followed the protocol for medication administration.

The director of nursing, [redacted], testified that all the records of the facility prior to December [redacted] indicated that Ms. [redacted] was administering medication appropriately, and there had been no evidence that [redacted] had committed a medication error.

Ms. [redacted] was fired on December 17, [redacted] based on her method of administering drugs to patients. The facility concluded that Ms. [redacted]s method violated the drug administration standards.

On December 7, [redacted], the In-service Director, reportedly made comments about Ms. [redacted]s method of administering drugs: Mr. [redacted] did not testify about his observations. All we have is a second hand report contained in a counseling memo, Exhibit 2, which reads in part:

> On December 7, 2012, In-service director [redacted] came in to the facility to observe you perform medication administration. You had already completed

your medication pass at the start of the medication administration time period (6:00 am med pass). It was noted from the medication audit report that you had passed 40 medications in a 15 to 20 minute period, as well as to several different residents at the same exact time. Per [redacted]s statement, you admitted that you signed off medications after you have completed passing all medications. Per statement, [redacted] made you aware that this is not standard nursing practice, does not follow policy that you must administer according to standard and policy. You confirmed you would do so.

It is important to note the Mr. [redacted] did not observe Ms. [redacted] passing drugs.

Ms. [redacted] testified that she talked to Mr. [redacted] on December 7th. As [redacted] recalls, [redacted] told her that the way she documented her medication passes was wrong. Her procedure did not meet nursing standards.

Ms. [redacted] testified that she waited until her medication pass was entirely finished before she made chart entries.

Ms. [redacted]s testimony on this point comports with Mr. [redacted]s observations. [redacted] reportedly stated that [redacted] "signed off medications after [redacted] had] completed passing all medications." Presumably, as a result, the medical charts showed that she had given drugs "to several different residents at the same exact time."

Ms. [redacted] testified that after her conversation with Mr. [redacted], she started documenting after every 5 or 6 residents.

[redacted] the director of nursing, testified that she came to the nursing home at 6:00 am to watch Ms. [redacted] do her medication pass. When [redacted] arrived, [redacted] had already completed her medication pass. Ms. [redacted], who suspected that Ms. [redacted] must be doing something wrong because she had finished her medication pass too early, printed out a report that showed that Ms. [redacted] was apparently giving multiple drugs to multiple patients at the same time. Ms. [redacted] concluded that Ms. [redacted] had not changed her method of administering drugs.

Ms. [redacted] testified that she called Ms. [redacted] and the nursing home administrator, [redacted] into her office. As [redacted] recalls, during that meeting, [redacted] said she did not follow the nursing home's policy and procedures. She set up medications and administered them and then documented them at a later time.

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Ms. [redacted] testified that, during the December 14 meeting, she did not admit she was violating policy and procedure. As [redacted] recalls, she stated that she was being cautious; she was following the "Five Rights." The only thing she did differently was charting at the end of the run.

At the December 14 meeting, Mr. [redacted] and Ms. [redacted] suspended Ms. [redacted] pending a final decision by the [redacted] County Department of Human Services Board.

The board met on December 17th and, on Mr. [redacted]s recommendation, fired Ms. [redacted]. The termination document (Exhibit 1), reads in part as follows:

> Please let this letter serve as your official written notice of employment termination from the [redacted] County Medical Care Facility.
>
> ... at the DHS Board meeting held on December 17, [redacted] you openly ... not following nursing standards of practice as well as facility policy ... medication administration on 3rd shift. You also acknowledged that you ... educated by our in-service director about the importance of following the standards of practice and facility policies, but still proceeded to do things your own ... to your actions of non-compliance coupled with your past disciplinary ... it was the decision of the [redacted] County Department of Human Services Board to support your prior suspension from work and terminate your employment with the [redacted] County Medical Care Facility on December 17, [redacted], effective December 14, [redacted]
>
> Accompanying this letter please find a copy of your most recent counseling statement that led up to your suspension and termination.

APPLICABLE LAW

MCL 421.29 (1) (b) reads:

> An individual is disqualified from receiving benefits if he or she ... was suspended or discharged for misconduct connected with the individual's work ...

REASONING AND CONCLUSIONS OF LAW

Ms. [redacted] was told by [redacted] on December 7, [redacted] that her method of documenting drug administration was contrary to nursing standards and the policies of the nursing home. In response to that instruction, Ms. [redacted] alleges that she changed her method and began to document after every 5 or 6 residents. On December 14, [redacted] the director of nursing ran a report that showed that Ms. [redacted] was still documenting after delivering drugs to multiple residents.

There is not enough evidence on this record to establish that Ms. [redacted] committed intentional misconduct. She made a change in her procedure. We don't have enough evidence to know exactly how Ms. [redacted] worked before the change or how she worked after the change. She was not warned on December 14th that the way she was working was inadequate or given a fair chance to conform her behavior to the facility's expectations.

Ms. [redacted] works the night shift. Mr. [redacted] did not observe her perform a medication pass. When [redacted] arrived at 6 am on December 7, [redacted] had already finished. Similarly Ms. [redacted] did not observe Ms. [redacted] pass medications. [redacted] arrived at 6 am on December 14 when [redacted] had already finished. Direct observation of Ms. [redacted]'s conduct would have been the best evidence of her conduct, and direct observation was possible. Mr. [redacted] or Ms. [redacted] could have arranged to arrive earlier to directly observe Ms. [redacted]'s work, but they did not. As a result, we do not have evidence adequately describing Ms. [redacted]'s conduct. When the underlying conduct is not proven, it is impossible to prove misconduct.

We don't know the instructions that Mr. [redacted] gave to Ms. [redacted]. [redacted] did not testify. We therefore don't know whether [redacted] violated [redacted]'s instructions. [redacted] testified that, in response to [redacted]'s criticism, she made some changes in the way she performed her medication passes; no evidence contradicts her testimony on that point. But without detailed evidence about how Ms. [redacted] performed her medication passes and without detailed evidence about Mr. [redacted]'s instructions, we don't know whether the changes that Ms. [redacted] made in her practice conformed to Mr. [redacted]'s instructions or in what way they failed to conform.

The nursing home accuses Ms. [redacted] of violating nursing standards and facility and pharmacy policies in the way she administered drugs, but the policies of the nursing home and the pharmacy and the standards of practice in nursing did not suddenly change in December [redacted] Ms. [redacted] had been passing drugs at the facility for five years under those policies, and she had never been criticized for violating them, which implies that the facility tolerated [redacted]'s method of administering drugs. Perhaps in

December [redacted] the facility was seeking to improve its quality of its care; perhaps it was seeking to change the way Ms. [redacted] had administered drugs in the past; but if so, the facility should have given Ms. [redacted] more guidance and better notice of exactly what they now expected her to do. In this case, Ms. [redacted] did not have a fair chance to improve.

Michigan uses the definition of "misconduct" announced by the Wisconsin Supreme Court in *Boynton Cab Company v Neubeck*, 237 Wis 249; 296 NW 636, 640 (WI Sup Ct, 1941), *cited with approval in Carter v Michigan Employment Security Commission*, 364 Mich 538, 541; 111 NW2d 817, 819 (1961):

> The term 'misconduct'... is limited to conduct evincing such willful or wanton disregard of an employer's interests as is found in deliberate violations or disregard of standards of behavior which the employer has the right to expect of his employee, or in carelessness or negligence of such degree or recurrence as to manifest equal culpability, wrongful intent or evil design, or to show an intentional and substantial disregard of the employer's interests or of the employee's duties and obligations to his employer. On the other hand mere inefficiency, unsatisfactory conduct, failure in good performance as the result of inability or incapacity, inadvertencies or ordinary negligence in isolated instances, or good-faith errors in judgment or discretion are not to be deemed 'misconduct' within the meaning of the statute.

The *Boynton Cab* definition contains two parts, separated by the phrase, "on the other hand." One should as far as possible give effect to both parts and hesitate to treat either part as ineffectual. See generally, *Herman v Berrien County*, 481 Mich 352, 366; 750 NW2d 570, 579 (2008). *Apsey v Memorial Hospital*, 477 Mich 120, 130; 730 NW2d 695, 700-701 (2007). *Sun Valley Foods v Ward*, 460 Mich 230, 236-237; 596 NW2d 119, 123 (1999). *Bailey v US*, 516 US 137, 145 (1995).

Ms. [redacted] made an effort to comply with instructions. Her effort seems to have been made in good faith; there is no evidence to the contrary. A good faith error in judgment is not misconduct and accordingly Ms. [redacted] did not commit misconduct under the *Boynton Cab* definition.

It has been held that an employee who disobeys an ambiguous order or who disobeys a policy that has not been communicated to him does not commit misconduct. *Vocational, Technical & Adult Education District 13 v Department of Industrial, Labor & Human Relations*, 76 Wis 2d 230, 241-42; 251 NW2d 41, 47 (1977).

Since we don't know the instructions that Mr. [redacted] gave to Ms. [redacted], the instructions are ambiguous, and it is impossible to conclude that Ms. [redacted] disobeyed them. Ms. [redacted] passed medications for five years using a method evidently tolerated by the facility. Mr. [redacted]'s instructions in December [redacted] may have signaled a change in policy, interpretation, or enforcement, but because the change was not clearly communicated, and because [redacted] was not given a fair chance to comply, one cannot conclude that [redacted] intentionally disobeyed a work rule.

Not every work-rule violation is misconduct. The worker's actions must suggest an intentional and substantial disregard of the employer's interests or of the worker's duties and obligations to the employer. *Razmus v Kirkhof Transformer*, 137 Mich App 311; 357 NW2d 683 (1984). Since there is not enough evidence of wrongful intent, Ms. [redacted] did not commit misconduct by disobeying a work rule, and she is not disqualified under MCL 421.29 (1) (b).

ORDER

The determination issued by the Unemployment Agency on April 29, 2013 is reversed. The claimant is not disqualified under MCL 421.29 (1) (b).

Erick Williams

ERICK WILLIAMS
ADMINISTRATIVE LAW JUDGE

Mailed at Lansing, MI on **August 5,** [redacted]

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