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NEW YORK STATE DEPARTMENT OF LABOR

UNEMPLOYMENT INSURANCE DIVISION

ADJUDICATION SERVICES OFFICE

September, 2013

INTERPRETATION SERVICE-BENEFIT CLAIMS

MISCONDUCT
Neglect of Duty
Healthcare workers

Falsification of Records

A claimant, who falsifies medical records indicating she had administered medicine to three patients when she had not done so, has committed an act of disqualifying misconduct.

A.B. 571,264 A

The employer and the Commissioner of Labor applied to the Appeal Board pursuant to Labor Law 534 for a reopening and reconsideration of Appeal Board No. 566041, filed January 11,2013, which reversed the decision of the Administrative Law Judge and overruled the initial determination disqualifying the claimant from receiving benefits effective December21, 2011, on the basis that the claimant lost employment through misconduct in connection with that employment and holding that the wages paid to the claimant by prior to January 11, 2013, cannot be used toward the establishment of a claim for benefits .Upon consideration of the application to reopen, after due notice to the parties, and the written statements submitted on behalf of the employer and the Commissioner of Labor, the Board has decided to reopen and reconsider its decision. The Board makes the following:

FINDINGS OF FACT: The claimant worked for six years as a direct care worker/counselor in a licensed residence for persons with profound developmental disabilities. The policy of the employer requires that medication logs are to be signed AFTER medication is given. The procedure, which was known to the claimant, required the worker to pour the medication, give it to the resident, observe the resident take the medication, and then note that the medication had been given and that the patient was observed. The log is not signed before the medication is given because the residents may suffer from psychiatric or emotional problems and refuse to take their medication. Medications are poured for each individual patient, one at a time. If the medication cannot be given, then it is flushed. The claimant was trained in this medication procedure during a four hour certification course. She recertifies on a yearly basis. The claimant also undergoes annual in service training where medication policy is reviewed. The claimant has 18 years experience administering medication. The employer has a zero tolerance policy for falsification of medication documentation. On December 20, 2011, the claimant was working the 3 p.m. to 11 p.m. shift. She was scheduled to give 3 residents their medications at 9 p.m. One of the resident's suffers from severe seizure disorder and is prescribed anti-seizure medication. The three residents were sleeping at 9 p.m. The claimant signed the medication log that she had given the drugs and observed the residents take their medication. She then poured the medication for the three residents. She did not administer the medication. The claimant had been feeling ill that day, and when a coworker offered to take her home, she accepted. She asked another coworker to wake the residents and give them their medication. The coworker did not do so. The next morning, another direct care worker noticed that drugs had been poured for three residents. She checked the log and noticed that the claimant had indicated that she had administered the medication. The claimant was called and she admitted that she had poured the medication but that she hadn't administered it. The claimant was discharged pursuant to the no tolerance policy.

OPINION: We have reopened this case and reviewed our prior decision in light of the statements submitted by the employer and the Commissioner of Labor. The credible evidence establishes that the claimant was discharged because she falsified medical logs indicating that she had administered medication to three residents, when in fact she had not. The claimant's falsification of the medical log led to the residents not

receiving their required medication on the night of December 20, 2011. Her action put these three individuals at risk of severe health consequences. We are not persuaded by the claimant's argument that she felt ill and left the residence due to illness before she could administer the medication herself. The claimant's illness and leaving of the home came after she had already violated the employer's reasonable medication rule by pre- signing the medication log. The only excuse that the claimant has for pre-signing the log was that she did so to keep track of what she was doing. However, as evidenced by the consequences in this case, pre signing of the log that drugs had been given, when they were not, did not properly track the administration of the medication. We are also not persuaded by the claimant's argument that she pre-signed that she had administered the drugs because the residents were asleep and she didn't want to waken them. She would have had to wake the residents under any circumstances to give them their medication so pre-signing the log had no affect on the residents' sleep. Additionally, by pre-signing the log that three residents had received their medication, rather than administering the drugs one by one as per policy, put three residents at risk. Finally, the failure of her coworker to administer medication after claimant left the facility does not exonerate the claimant from fault. It was her obligation to administer the medication and then sign the log, not to sign the log in violation of policy. The Board has held that the degree of care expected of a claimant must be commensurate with the potential for harm. (Appeal Board Case No. 561,236) In this case three severally disabled individuals, including one with seizure disorder, did not receive their necessary medication because of claimant's falsification of the medication log. The Court has also held that a claimant's failure to comply with the employer's policies and procedure may constitute misconduct especially where the claimant is employed as a medical professional whose failure to adhere to prescribed safety procedures could jeopardize the safety of a patient (Matter of Jill, 23 AD3d 979 {2005}; see also Matter of Wright, 249 AD2d 668 {1998} and Matter of Martin, 299 AD2d 624 {2002}). The lack of a prior warning is not controlling in this case. Because of the potential for medical harm to the residents under its care the employer had a no tolerance policy for falsification of medical records. The claimant knew of the no tolerance policy. We must therefore conclude that under the circumstances of this case the claimant is disqualified from receipt of benefits.

DECISION: The decision of the Appeal Board is rescinded. The decision of the Administrative Law Judge is affirmed. The Department of Labor issued the initial determination disqualifying the claimant from receiving benefits effective December 21, 2011, on the basis that the claimant lost employment through misconduct in connection with that employment and holding that the wages paid to the claimant by OHEL CHILDRENS HOME FUND prior to December 21, 2011, cannot be used toward the establishment of a claim for benefits. The claimant is denied benefits with respect to the issues decided herein.

COMMENTS

1. This decision is in accord with several Court and Appeal Board decisions (see above) that have held that a patient *does not* have to be actually harmed by the claimant s failure to follow policy and procedures. The key element is the potential for harm.

2. The Court and Appeal Board decisions further demonstrate that a healthcare professional is appropriately held to a high standard of care in the performance of job duties, because of the potential for harm that could result from mistakes.

3. In this decision the Appeal Board held the lack of a prior warning in this case is not controlling as the claimant was aware of the employer s zero tolerance policy.