DEPARTMENT OF CORRECTIONS

EMPLOYEE CONDUCT REPORT

THIS FORM TO BE USED IN COMPLIANCE WITH POLICY DIRECTIVE NO. 857.005

INSTRUCTIONS AND TIME LIMITS:

1. The person making the report shall provide a clear description of the incident under "Description of Incident" and, with any witness(es) or person(s) having knowledge, shall sign in the space provided and submit to the supervisor of the involved employee within fourteen (14) calendar days after the date of discovery of an employee's alleged misconduct.

2. The form shall be submitted to the employee involved who shall complete the "Employee's Statement" and return the report to his/her supervisor within seven (7) calendar days following the date of receipt.

3. The appropriate supervisor shall review the facts of the incident, complete the "Supervisor's Report" and submit the report to the Office Head within seven (7) calendar days following the date of receipt.

4. The Office Head or designated representative shall review and within thirty (30) calendar days following the date of receipt determine whether misconduct has occurred. This shall be reported under "Administrative Comments" and shared with the employee. When the supervisor and Office Head are the same person, the supervisor's supervisor shall complete the Administrative Comments.

EMPLOYEE INVOLVED	ORGANIZATIONAL UNIT	
Kalina, Michael	Health Services - SOC Infirmary	
POSITION TITLE	DATE OF INCIDENT	TIME OF INCIDENT
RN 2	10-14-97	☐ AM ☐ PM

DESCRIPTION OF INCIDENT:

On 10-14-97, during the 8:40 PM medli ne, you administered an overdosage of Klonopin 1mg (2 tablets) to I/[redacted] Approximately three hours after overdosing, I/[redacted] blood pressure was recorded at 60/40, below baseline. Subsequently, fifty minutes later, I/[redacted] physical condition required that he be transported to VGH for evaluation. When advising me of this issue you stated that you had noticed a difference in the content of I/[redacted] cup of medication and had hesitated before giving it to him. You then said that your thought was "Oh, there must have been a med change." You then gave I/[redacted] the medication cup without checking on the accuracy of the cups contents.

You were responsible for the on the job training of RN 2 Gray during your shift on 10/14/97 and for ensuring the accuracy of her work.

This inmate overdosage was not apparent to you until the 10:00 Pm narcotic count was conducted nd 2 Klonopin 1mg tablets were noted as missing. You called me at home to advise me of the missing meds. I instructed you that the infirmary staff involved in this incident should write a memo concerning this situation. I also instructed you to complete a "Medication and/or Treatment Error Report". I directed you to complete the memo's and error report prior to leaving the institution that same evening. You did not complete the "Medication And/Or Treatment Error Report" prior to leaving the institution as instructed.

You also failed to appropriately document on I/[redacted] medical chart the 8:40 PM additional dosage of Klonopin 1mg.

INITIATED BY:

NAME (PLEASE PRINT)	POSITION TITLE	SIGNATURE	DATE
RN 3 Teresa Bollinger	RN 3	Teresa Bollinger RN3	10/17/97

WITNESS(ES):

NAME	POSITION TITLE	SIGNATURE	DATE

DC 3-30 (REV. 3-85) -294-

0656 #1

DATE DELIVERED 10/7/97 2p EMPLOYEE ~~Bollinger RN3~~

EMPLOYEE'S STATEMENT:

The incident described on the EOR per RN3 Bollinger is factual according to the write-up I will further explain the situation in the evening of the incident in addition to the assigned investigation and the administration conference

Signature of Employee: [signature] Date: 10/21/97

SUPERVISOR'S REPORT: DATE RECEIVED BY SUPERVISOR Bollinger RN-3 BY: 10/21/97 4:29p

See attached

Signature & Title of Supervisor: [signature] Date: 11/5/97

ADMINISTRATIVE COMMENTS: DATE RECEIVED BY OFFICE HEAD ~~[signature]~~ 11-5-97 BY: [signature]

See attached report

Signature of Office Head: [signature] Date: 12-5-97

DISTRIBUTION:
ORIGINAL—EMPLOYEE'S PERSONNEL FILE
ONE COPY—EACH OVEE

3008ACK -294-

0657 #1
Attachment

DEPARTMENT OF CORRECTIONS

EMPLOYEE PROFILE

Name	Classification
Michael T. Kalina	Registered Nurse 2

Status	Current Range/Step	Amount	PID Date (Affects?)
Permanent	N45 / P	$3801.00	N/A

PROPOSED ACTION: Reduction in Salary - 5% for 3 months.

DATES					TOTAL LOSS
From 4/1/98	To 6/30/98	No. of Months 3			
RANGE/STEP From N45 P	To N45 N	($) 184.00			($) 552.00

A. PERSONNEL/PAY ACTIONS (Information obtained from P-2 Documents): Original date of hire, date(s) of agency/institution transfer(s), date(s) of promotion(s), date(s) of pay change(s) due to disciplinary action(s), etc. *List only information which is relevant to the action being proposed.*

	EFFECTIVE DATE	TYPE OF ACTION	DISCIPLINARY?
1	6/6/94	DATE OF HIRE - Probationary RN 2	
2			
3			
4			
5			
6			

☐ Above section continued on Page Two

B. EMPLOYEE PERFORMANCE EVALUATIONS

DATES (Mo/Yr) From To	Ratings * Far Exceeds	Ratings * Exceeds	Ratings * Normal	Ratings * Minimum	Ratings * Fails Min.	Type **	Comments (Note if EPE is part of Disciplinary Letter)
6/6/96 to 6/6/97		D, E	A, B, C			A	
6/6/95 to 6/6/96			A, B, C, D, E			A	
6/6/94 to 6/6/95		D	A, B, C, E			A	No prob EPE completed.
to							
to							
to							
to							
to							

☐ Above section continued on Page Two

* ***List Performance Dimensions:***

A = Accomplishment of Job Requirements
B = Job Knowledge and Competence
C = Job Reliability
D = Personal Relations
E = Communications Skills
F = Performance as Supervisor

* ***Indicate Type of Evaluation:***

P = Probationary
A = Annual
T = Trial
S = Special

CC: TRCC ✓
Cheryl ✓

BEFORE THE PERSONNEL APPEALS BOARD

STATE OF WASHINGTON

MICHAEL T. KALINA, Appellant, v. DEPARTMENT OF CORRECTIONS, Respondent.	Case No. RED-98-0033 NOTICE OF SCHEDULING

Notice is hereby given of scheduling the hearing on the appeal before the Personnel Appeals Board. The hearing will be held in the Main Conference Room, Special Offender Unit, Monroe Correctional Complex, Monroe, Washington, on **Wednesday, June 16, 1999, beginning at 9 a.m.**

The parties shall arrive at the hearing location thirty (30) minutes before the hearing time for the purpose of exchanging copies of, and when possible, stipulating to exhibits. The parties shall bring six (6) copies of the premarked exhibits which they intend to offer into evidence. Whenever possible, the parties should exchange witness lists prior to the day set for the hearing.

If the services of an interpreter are needed, notify Personnel Appeals Board staff at least two weeks prior to the hearing. The hearing site is barrier free and accessible to the disabled.

DATED this 9th day of November, 1998.

WASHINGTON STATE PERSONNEL APPEALS BOARD

Teresa Parsons

Teresa Parsons, Hearings Coordinator
(360) 664-0479

cc: Michael T. Kalina, Appellant
Mark A. Anderson, Teamsters
Roosevelt Currie, Jr., AAG
Jennie Adkins, DOC

Personnel Appeals Board
2828 Capitol Boulevard
Olympia, Washington 98504

2828 Capitol Blvd.
PO Box 40911
Olympia, WA 98504-0911

TRCC
Cheryl

VOICE (360) 586-1481
FAX (360) 753-0139
E-MAIL info-pab@pab.state.wa.us

STATE OF WASHINGTON

PERSONNEL APPEALS BOARD

August 12, 1998

HOME PAGE www.wa.gov/pab

Michael Kalina
[redacted]

Roosevelt Currie, Jr.
Assistant Attorney General
P.O. Box 40145
Olympia, WA 98504-0145

RE: Michael T. Kalina v. Department of Corrections, Reduction in Salary Appeal,
Case No.: RED-98-0033

Dear Mr. Kalina and Mr. Currie:

This letter is to advise you that this case has been assigned to Jennifer Woods. She is a mediator contracted by the Personnel Appeals Board. Ms. Woods will be contacting you for the purpose of scheduling a mutually agreeable date and time for a mediation. We appreciate your cooperation in scheduling mediation as soon as possible or the file may be returned to our office to set a date for hearing.

Mediation is an opportunity to bring the parties together to attempt a settlement of the issues on appeal without the need for a hearing. If settlement efforts are unsuccessful, the meeting will move into the prehearing phase and the parties will select a hearing date, attempt to narrow the scope of the issues to be presented to the board, discuss witness and exhibit lists, and possible stipulations between the parties.

If you have any questions, please contact me.

Sincerely,

Don Bennett
Executive Secretary

DB:py
cc: Jody Phillips
Jennie Adkins

0660

F:Paulette/Mediators/letter to parties

CHASE RIVELAND
Secretary

MAY 01 1998

Department of Corrections
Division of Human Resources

STATE OF WASHINGTON

DEPARTMENT OF CORRECTIONS

SPECIAL OFFENDER CENTER
P.O. Box 514 - Park Place • Monroe, Washington 98272-0514

April 28,1998

PERSONAL AND CONFIDENTIAL DELIVERY

Michael T. Kalina
[redacted]

Mr. Kalina:

This is official notification that you will be reduced in salary within your present class of Registered Nurse 2 at the Twin Rivers Corrections Center-Special Offender Center (TRCC-SOC), Range N45, Step P, $3801.00 per month to Step L, $3445.00 per month, effective May 15, 1998 through November 15, 1998, inclusive.

This disciplinary action is taken pursuant to the Civil Service Law of Washington State, Chapter 41.06, Revised Code of Washington, and the Merit System Rules, Title 356 Washington Administrative Code (WAC) Section 356-34-010 (1-a) Neglect of duty, (1-d) Insubordination, (1-h) Gross misconduct, (1-i) Willful violation of the published employing agency or department of personnel rules or regulations, and 356-34-020 **Reduction in salary - Demotion - Procedure.**

Specifically, you neglected your duty, were insubordinate, committed an act of gross misconduct and willfully violated published agency policy when on October 14, 1997, while performing your duties as a Registered Nurse 2, you were responsible for administering an inappropriate dosage (overdose)of the drug Klonopin to inmate [redacted] during the 8:40PM medline. Subsequently, after having ingested the overdose of Klonopin, inmate [redacted] blood pressure was recorded by LPN Leslie Young as below that of acceptable baseline. Consequently, later that same night, due to the onset of ongoing unstable vital signs, Linda Fluke, ARNP, directed that inmate [redacted] be transported to Valley General Hospital for a comprehensive evaluation of his condition and continued monitoring.

2828 Capitol Blvd.
PO Box 40911
Olympia, WA 98504-0911

CC: TRCC
Cheryl

VOICE (360) 586-1481
FAX (360) 753-0139
E-MAIL info-pab@pab.state.wa.us

STATE OF WASHINGTON
PERSONNEL APPEALS BOARD
HOME PAGE www.wa.gov/pab

June 7, 1999

Mark Anderson
Teamsters Local 313
220 S. 27th Street
Tacoma, WA 98402-2701

RE: Michael Kalina v. Department of Corrections, Reduction in Salary Appeal, Case No. RED-98-0033

Dear Mr. Anderson:

Enclosed is a copy of the order of the Personnel Appeals Board in the above-referenced matter. The order was entered by the Board on June 7, 1999.

Sincerely,

Don Bennett
Executive Secretary

DB:mt
Enclosure

cc: Michael Kalina, Appellant
Rob Kosin, AAG
Jennie Adkins, DOC

BEFORE THE PERSONNEL APPEALS BOARD
STATE OF WASHINGTON

MICHAEL KALINA, **Appellant,** **v.** **DEPARTMENT OF CORRECTIONS,** **Respondent.**	**CASE NO. RED-98-0033** **MOTION AND ORDER OF DISMISSAL**

The appellant hereby notifies the Personnel Appeals Board that he/she wishes to withdraw the above-entitled appeal.

Signed at Tacoma, Washington, this 2nd day of June, 1999.

Mark A. Anderson, WSBA # 26352
Attorney for Appellant

This matter came on regularly before the Personnel Appeals Board on the consideration of the request of the Appellant to withdraw his/her appeal. The Board having reviewed the files and records herein, being fully advised in the premises, and it appearing to the Board that the Appellant has requested to withdraw his/her appeal, now enters the following:

Teamsters Local No. 313
220 South 27th Street
Tacoma, WA 98402-2701
(253) 627-0103

ORDER

NOW, THEREFORE, IT IS HEREBY ORDERED that the Appellant's request to withdraw his/her appeal is granted and the appeal is dismissed.

DATED this 7th day of June 1999.

WASHINGTON STATE PERSONNEL APPEALS BOARD

Walter T. Hutchens

William L. Woods, Jr.

Harold L. McGee

Teamsters Local No. 313
220 South 27th Street
Tacoma, WA 98402-2701
(253) 627-0103

2828 Capitol Blvd,
PO Box 40911
Olympia, WA 98504-0911

Department of Corrections
Division of Human Resources

CC: TRCC
Cheryl L

VOICE (360) 586-1481
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STATE OF WASHINGTON

PERSONNEL APPEALS BOARD

HOME PAGE www.wa.gov/pab

November 19, 1998

PROPOSED LIST OF CUT-OFF DATES

Michael T. Kalina v. Department of Corrections
Case No.: RED-98-0033 (Reduction in Salary Appeal)

This statement is issued to record dates controlling the subsequent course of the proceedings in the above-referenced appeal. The following dates for completing discovery, exchange of lists of witnesses and exhibits and other prehearing matters are proposed.

1. Discovery is to be completed by May 17, 1999. Requests for discovery must be served with sufficient time for responses to be completed by May 17, 1999.

2. Witness lists and exhibit lists are to be exchanged on or before June 9, 1999. The parties reserve the right to supplement the lists.

3. Pre-hearing briefs, if prepared at the discretion of the parties, will be filed on or before June 11, 1999 in accordance with WAC 358-30-045.

4. The hearing in this matter will be held on June 16, 1999 beginning at 9:00 AM in Monroe, Washington.

The pre-hearing conference is scheduled for 9:00 AM on June 9, 1999. At that time, the Executive Secretary or designee will initiate a conference call with the parties' representatives to discuss possible stipulations on witnesses, exhibits, and the issue to be presented for determination by the Personnel Appeals Board.

The parties shall arrive at the hearing location thirty (30) minutes before the hearing time for the purpose of exchanging copies of exhibits and, if possible, stipulating to admission of exhibits. The parties shall bring six (6) copies of the pre-marked exhibits which they intend to offer into evidence.

Any objections or corrections must be filed with the Executive Secretary within 20 days of the date of this statement and shall, at the same time, be served upon each of the participants named above. This statement becomes part of the official record of the proceedings, and the stipulations will be binding on the parties, unless this statement is modified for good cause.

Dated: Nov. 19, 1998

PERSONNEL APPEALS BOARD

By: Don Bennett

Don Bennett
Executive Secretary

2828 Capitol Blvd.
PO Box 40911
Olympia, WA 98504-0911

VOICE (360) 586-1481
FAX (360) 753-0139
E-MAIL info-pab@pab.state.wa.us

PO APPM

STATE OF WASHINGTON

PERSONNEL APPEALS BOARD

HOME PAGE www.wa.gov/pab

cc: Tece Joy 7/1/98
Cheryl Landers

June 18, 1998

Michael T. Kalina
[redacted]

RE: Michael T. Kalina v. Department of Corrections, Reduction in Salary Appeal, Case No. RED-98-0033

Dear Mr. Kalina:

This letter is to acknowledge receipt of your appeal by the Personnel Appeals Board on June 12, 1998. The Board will conduct a hearing of your appeal on a date to be determined. The time it takes to schedule a hearing date is affected by the availability of the parties and the number of appeals pending before the Board.

You may attempt to resolve this appeal with the assistance of one of the Board's contracted mediators. If mediation is jointly requested by the parties before July 20, 1998, a mediator will be assigned to meet with the parties in a good faith effort to negotiate a resolution of the appeal.

If you are represented by a union representative or an attorney, please encourage them to coordinate a request for mediation with the appointing authority of the employing agency, or the assistant attorney general who represents the agency. You may initiate this contact directly if you are not represented. Appeals assigned to mediators will be returned after sixty (60) days if the parties are unable to agree upon a date for mediation, and then scheduled for hearing on the Personnel Appeals Board calendar.

Please note that pursuant to WAC 358-30-190, all future correspondence or filings to the Personnel Appeals Board need to also be served on the opposing side.

Sincerely,

Paulette Parke for
Don Bennett
Executive Secretary

DB:lh

cc: Linda A. Dalton, SAG
Jennie Adkins, DOC
Jody Phillips, Steward

z:\lh\newappl\kalina.doc

0667

D-98-0033

RECEIVED
JUN 17 1998
PERSONNEL APPEALS BOARD

APPEAL FORM

ASHINGTON STATE PERSONNEL APPEALS BOARD
23 Capitol Blvd.
O. Box 40911
ympia, WA 98504-0911

PH: SCAN 321-1481
(360) 586-1481
FAX: (360) 753-0139

[redacted]

PRINT OR TYPE - SIGN ON PAGE 2

ART I. APPELLANT IDENTIFICATION

NAME: KALINA, MICHAEL T.
(Last name, first name, middle initial)

HOME ADDRESS: [redacted]
(Number and street)
[redacted]
(City, state and ZIP code)

PHONE NUMBERS. (Include area code) WORK: 360-794-2236
HOME: [redacted]

EMPLOYING AGENCY OR INSTITUTION: DOC / SPECIAL OFFENDERS CENTER

AGENCY OR INSTITUTION THAT TOOK ACTION YOU ARE APPEALING: DOC / SOC

ART II. REPRESENTATIVE'S NAME, ADDRESS AND TELEPHONE NUMBER:

Jody Phillips - 360 794-2585

[redacted]

ART III. TYPE OF APPEAL

CHECK ONE OF THE FOLLOWING TO INDICATE THE TYPE OF APPEAL YOU ARE FILING:

__X__ a. Disciplinary (check applicable action(s)):
_____ Dismissal. _____ Suspension. _____ Demotion. __X__ Reduction in Salary.

_____ b. Disability Separation.

_____ c. Rule or Law Violation (complete Part IV of this form).

_____ d. Reduction in Force Layoff (complete Part IV of this form).

_____ e. Allocation (position classification) (complete Part V of this form).

_____ f. Declaratory Ruling (see WAC 358-20-050).

_____ g. Exemption of Position.

0668

June 9. 1998

Department of Personnel
Appeals Board
2828 Capitol Boulevard
Olympia. Washington 98504
Attention: Connie Gough

We would like to request an appeal on the decision for the reduction in salary on a Mr. Michael T. Kalina. RN2 at Twin Rivers Correction Center. Special Offender Center Division.

Nurse Kalina. has been employed at SOC since 6/94 and has proven himself to be dependable. personable and professional. His personnel file reflects this.

Neglect of Duty
We believe that Nurse Kalina protected the individual to the extent possible in this incident. He did not pour the dose of medication. a nurse [redacted] did: yet she did not receive an ECR for this same incident. She administered the 5 p.m. medication but did not sign the medication out of the narcotic log. Also. there was no signature from her on the medication record for the 5 p.m. medication having been given. Nurse Kalina believed this medication was missed at the 5 p.m. medication line. Nurse Kalina further checked the narcotic logbook and found no entry for the Klonopin having been given.

The quanity of medication given was accurate: the number of times given was not. However. this inmate had been on a higher dosing of Klonopin previously. 6mg the amount given in error.

The medication error was not discovered until 10 p.m. while doing narcotics count. It was at that time that Nurse Kalina took every step possible to notify the appropriate people of this occurrence. He contacted the unit to find out if the inmate had been given an additional dose. He also contacted his immediate supervisor and placed a call to the on-call practicioner.

There was no orientation sheet for Nurse Kalina to go by while orienting a new nurse to the floor. nor had there ever been one. It is common nursing practice to sign out narcotics prior to giving them. Nurse [redacted] did not do this. Nurse Kalina looked at the medications given at the 5 p.m. medication line. Due to the vast numbers and types of medications. how would a nurse quickly identify a medication that was out of place or incorrect? After discovering the Klonopin missing Nurse Kalina called Nurse [redacted] asking if she remembered giving the Klonopin dose. she could not.

Gross Misconduct
Nurse Kalina checked the narcotic log prior to issuing this inmate his Klonopin dose. However. due to the logbook not reflecting Nurse [redacted] having issued this earlier. he administered the medication. The inmate did not question getting his second dose of Klonopin that evening.

Willful Violation
We do not find a willful violation in this case. This was an honest error.

After a review of Nurse Kalina's personnel files Dennis That. Superintendent "moderated his decision relative to the severity of sanction". Will every nurse who does a medication error get a 10% reduction in pay for 6 months? This would involve several nurses every month just in the Monroe Command alone.

Further, the decision to send the inmate to the hospital was only done as a precaution. The inmate was not in grave medical danger. His vital signs were stable, although slowed. This was a combination of the Haldol Deconoate injection as well as the Klonopin that lowered his blood pressure, according to Dr. Judy Nelson, Staff Psychiatrist at SOC.

Nurse [redacted] submitted a memo on this incident. She states "I poured the meds and take full responsibility for this med error".

Nurse Kalina's job is not that of a supervisor. He was only orienting the above nurse to the new place of employment and should not be held liable for her error. Only a certified trainer can be held accountable for a trainee's error.

Insubordination
Nurse Kalina agrees that he did not finish the paper work that night prior to leaving his shift. The requested memo regarding the discrepancy was completed. However, he also car-pooled that evening and his ride leaves at 10:15 – 10:30. The paper work needing to be done would have taken an additional 20 minutes to complete beyond the normal departure time of 10:30 of his car-pool.

Thank you for your consideration in the above matter.

Sincerely,

Michael T. Kalina, RN2

Jody Phillips, Steward

EMPLOYEE CONDUCT REPORT—ADMINISTRATIVE COMMENTS
RE: Michael Kalina, Registered Nurse 2
December 4, 1997

Sandra Moore, Personnel Officer, and I met with you and Barry DeHaven, your Union Representative, on November 25, 1997, to discuss the Employee Conduct Report initiated on October 17, 1997, by Teresa Bollinger, RN 3.

The content of the Employee Conduct Report you received on October 17, 1997, for an incident that occurred on October 14, 1997, includes:

1. You administered an overdose of Klonopin to Inmate [redacted] who, as a result, had an adverse physical reaction requiring an emergency visit to Valley General Hospital;

2. This overdose was the result of inadequate supervision for on-the-job training of RN 2 [redacted]; and

3. You failed to follow an instruction from your supervisor to fill out a Medication and/or Treatment Error Report form prior to leaving the institution that same evening. In addition, you failed to appropriately document the medication error in Inmate [redacted] medical chart.

During our meeting, you clarified the difference between orienting a nurse and training a nurse. You stated that a nurse hiring into the position is trained to pour medications. Your stated belief was, your job was to orient her to our system. You noted to safely pour medications, a nurse should pour one inmate's medications at a time while reading the medication sheet on that inmate. You felt that RN [redacted] was responsible for the accuracy of the medications. You also noted there are no guidelines for orienting or training new nurses. You mentioned showing RN [redacted] the Narcotics Log, but you did not show her how to sign off on a medication sheet, once medications were administered. Although you noted it is standard practice to sign off on medication sheets after medications are administered.

You stated having a concern about being singled out when there have been several other medication errors since the time you received this ECR. You said you have heard this information by word of mouth, but could not give me specifics as to who has been making the medication errors. Furthermore, you said you have done some research on this inmate and noted that the overdose included a total of 4 mgs of Klonopin when in the past he has been prescribed

Attachment #1

6 mgs of Klonopin. You also mentioned that he received his Haldol Decanote injection the day of this incident which, you have been told in combination with the increased dosage of Klonopin can decrease blood pressure, which is why this inmate had an adverse reaction. In checking the inmate's medical record, I find your report to be accurate. However, apparently it was the additional dosage of Klonopin that caused Mr. [redacted] lowered blood pressure.

At the 8:40 medication line, the time the overdose occurred, you said you hesitated when you saw the dosage because you did not think he received an 8:40 dosage of Klonopin. Consequently, you looked at the Narcotics Log which indicated there was one dosage removed at 5:00 p.m. You assumed from this information that he had not received his 5:00 p.m. dosage. You did not further verify this by checking the medication card. You said the medication card may not have been signed off by 8:40 p.m. for the 5:00 p.m. medication line indicating checking the medication card may not have given you adequate information. Since you did not verify this, it remains unknown.

After the inmate was having medical problems as a result of this overdose, you contacted your supervisor, RN 3 Bollinger, to tell her of the problem. She instructed you to fill out appropriate documentation to include a Medication and/or Treatment Error Report, medical chart entry, and memo. You wrote memo about the incident; however, you failed to follow through with her directive to fill in a Medication and/or Treatment Error Report and document in the medical chart. During our meeting, you said your reason for not following through with this directive was that you were very angry at the time it happened and could not gather your thoughts in order to put them down reasonably.

Health Care Manager Norma Gray noted in her Investigative Report that there are several procedural problems with the administration of medications which are being corrected. However, in taking this into consideration and after reviewing all of the documentation and hearing your report of the incident, nevertheless, I find neglect of duty with regard to administering an overdose of medication to Inmate [redacted] because I feel you could have taken further steps to avoid the error by checking the medication sheet and checking the narcotics supply of Klonopin. Secondly, I find insubordination for failing to follow through with your supervisor's directive to fill out the Medication and/or Treatment Error Report and to complete the documentation in the medical chart. Feeling "too angry to gather your thoughts" is not an acceptable excuse for failing to carry out responsibilities as directed by your supervisor. Finding

Attachment #1

appropriate methods for managing your anger is an area for further discussion between you and your supervisor.

Ella Ray Sigmund 12-5-97

Ella Ray Sigmund DATE
Associate Superintendent

0673

Attachment #1

November 4, 1997

Supervisors Report

An extension of the Supervisors Report was approved to November 5, 1997.

During my investigation I came in and observed the medication setup/administration procedure for the 7 am medication delivery at SOC.

On October 30, 1997 I met with you and your Union Representative, ~~Sgt~~ c/o Barry DeHaven to discuss this ECR. During the discussion you wanted a statement in the ECR clarified. The sentence reads "you were responsible for the on-the-job training of RN [redacted] during your shift on 10/14/97 and for ensuring the accuracy of her work." You stated, "responsible for the on-the-job training" was inaccurate. You were orienting RN [redacted] to the PM shift. Both RN [redacted] and yourself agree that RN [redacted] set up the medications for both the 5 pm medline and 8:40 medline. RN [redacted] said after you checked the medication she set up you and her went to C-D units where she administered the 5 pm meds while you observed. The 8:40 medications were administered by you while RN [redacted] passed the medications in the lockdown area. In your response you state you observed what appeared to be Klonopin pills crushed in the inmates med cup at the 8:40 medline which should have been given at the 5 pm medline. You indicate you checked the Narcotic Log Book and there was only one entry for Klonopin which was at 5 pm. You did not check the medication card to verify that the 5 pm dose had been given. You also stated at that time you did not question the inmate about whether he had received his dose of Klonopin earlier in the day. The inmate is regularly given this medication at 5 pm and has been since September 16, 1997. The medication error was discovered at the 10 pm narcotic count by RN Gray, LPN Young, RN Wagner and yourself present. You then contacted C Unit and asked staff to ask the inmate if he had taken Klonopin at both 5 pm and 8:40 medline and the inmate indicated he did. Memos were written by RN Wagner, LPN Young, RN Gray and yourself indicating the narcotic count was incorrect by two 1 mg Klonopin tablets. After discovering the inmate had been given an extra dose of Klonopin you stated you did not initiate the Medication and/or Treatment Error Report even though RN 3 Bollinger reports she instructed you to nor did you chart anything in the inmates medical record. LPN Young assessed the patient at approximately 11 pm and found his blood pressure lowered. She contacted the on-call PA and received instructions to continue monitoring vital signs. At approximately 2 am the PA ordered the inmate transported to Valley General Hospital because of unstable vital signs. He returned at 2:50 am after vital signs were more stable. Inmate was then admitted to Room 1 for close observation.

M L Gray, Hcm WSR
11/5/97

0674

Attachment #1

STATE OF WASHINGTON
DEPARTMENT OF CORRECTIONS
MEMORANDUM

TO: T. Ballinger RN3 DATE: 10/14/97

FROM: M. Coleman RN2 SUBJECT: Narc Count

at 10pm count, the Klonopin 1 mg tabs were off by 2 tablets. When this was discovered - a search was done of narcotic cabinet and still none were found loose. I called RN Ballinger & about the situation and it was found that I/m [redacted] had rec'd 2 mgm of Klonopin @ 5pm - but rec'd an extra 2 mgs @ 840 medline. This was discovered when I called the unit and I/m described the meds he rec'd these crushed up pills @ 840. On call MD called of the incident @ 10:20 pm Count was 27 instead of 29. Michael Coleman 0675

DOC 02-110 (3/91)

Attachment #1

recycled paper

MEDICATION AND/OR TREATMENT ERROR REPORT

1. Statement of person discovering Error: Name D Laing RN/M Kalina Date 10-14-97
How was error discovered? @ 10pm on 10-14-97 the RN narcotic count was off. The Klonopin 1mg count was 27 when it should have been 29. There were 2 missing.

D Laing RN/M Kalina RN 10-14-97

2. Statement of person(s) who made the error: Name _____ Date _____
Detail of incident, Patient name(s), medication(s) or type of error - Medications or Treatment, date, location etc., what happened ?
M Kalina RN stated he thought he saw broken up blue pills in the 8pm med cup for I/M [redacted] M Kalina RN called unit C/O had staff ask I/M if he'd [illegible] taken the blue pills (Klonopin mg are blue in color). I/M stated yes. D Laing stated she had prepared medication

3. What could have been done to prevent the error ?
See attachment

(Page 2 on other side)

Attachment H

PMSD MED ERRO[redacted]E: I/M[redacted] Read Mode: Line:1

To: BOLLINGER TERESA [redacted] CC-DP-G1-THA 1

From: KALINA MICHAEL DOC-DP-G1-MKH 2

Date: Friday 17-Oct-97 at 1:03pm 3

Subject: MED ERROR RE: I/M[redacted] 4

5

ON THE EVENING OF 10/14/97, I WAS ORIENTING NEW NURSE [redacted] RN 6

WITH PASSING MEDS FOR THE C-D SIDE HERE AT SOC. AFTER POURING HER MEDS, 7

I LOOKED OVER THE 5PM DOSES, AND THEY LOOKED CORRECT. SHE ADMINISTERED 8

THE MEDS ON C-D UNITS WITHOUT INCIDENT. LATER THAT NIGHT, NURSE [redacted] 9

WAS TO ADMINISTER THE LOCK-DOWN MEDS TO THE UNITS, AND I WOULD 10

ADMINISTER THE MEDS AT THE BACK WINDOW AT THE 8:40 MED LINE. WHILE 11

ADMINISTERING THE MEDS AT THE BACK WINDOW, I NOTICED THAT I/M[redacted] 12

MEDS CONTAINED KLONOPIN PILLS CRUSHED AS PER OUR POLICY FOR NARCOTICS. 13

I CHECKED THE NARCOTICS LOG BOOK AND THERE WAS ONLY ONE ENTRY FOR 14

[redacted], WHICH WAS SIGNED OUT FOR 5PM. NO OTHER ENTRIES WERE NOTED ON 15

I/M[redacted]. I THEN GAVE THE I/M THE MEDS, THINKING THAT AN ERROR WAS 16

MADE ON THE TIME OF ADMINISTRATION OF THE MEDS. (THE 5PM DOSE OF 17

KLONOPIN WAS PUT IN THE 8:40 MED LINE CUP.) SO, I GAVE THE DOSE, GIVEN 18

THE DOCUMENTATION PRESENT IN THE NARCOTICS LOG. THEN, AT 10:00 NARCOTICS 19

COUNT, IT WAS DISCOVERED THAT THE KLONOPIN 1 MG TABLETS WERE OFF BY TWO 20

TABLETS. I RECALLED THE SITUATION WITH I/M[redacted] AND THE RN3 TERESA 21

Function:

Functions(1/6): PF2=NExt 3=ENd 4=MEnu 5=Find 6=AMend 7=BWd 8=FWD pf1=help

1579 Attachment #1

EMSD MED ERRO E: I/M Read Mode Line 22

BOLLINGER WAS CALLED. M S WERE WRITTEN REGARDING INCIDENT, AND 22
THE C UNIT BOOTH WAS CALLED. I REQUESTED THE BOOTH OFFICER ASK I/M 23
IF HE COULD RECALL WHAT MEDS HE RECIEVED AT 8:40 MED LINE. I 24
COULD HEAR THE I/M CLEARLY RECITE WHAT HE HAD RECIEVED. HE DESCRIBED A 25
BLUE POWDERED MED IN HIS CUP. THIS AND THE DESCREPANCY OF THE NARCOTICS 26
COUNT WOULD LEAD ME TO BELIEVE THAT THIS MED ERROR OCCURED AFTERWARDS. 27
I ASKED IF NURSE COULD RECALL IF THERE WAS A DOSE OF KLONOPIN IN 28
THE 5PM MED LINE FOR I/M AND SHE COULD NOT RECALL IF THERE WAS 29
GIVEN THE INFORMATION THAT WAS AT HAND, I BELIEVE AT THE TIME, THAT 30
THERE WAS AN ERROR IN THE TIME OF ADMINISTRATION OF THE MEDICATION, BUT 31
HAD I ANY HINT OF A MEDICATION ERROR, I WOULD NOT HAVE GIVEN THE MEDS. 32
ALSO IN ASKING NURSE IF SHE REMEMBERED IF THE MEDS WERE IN THE 5 PM 33
MED LINE, AT THE TIME OF ADMINISTRATION, AT 8:40, SHE WAS OVERWHELMED 34
WITH THE AMOUNT OF MEDS SHE POURED, AND WAS UNSURE IF THE DOSE WAS 35
INDEED PRESENT. THIS SITUATION, WAS TO ME, A LOSE/LOSE SITUATION. 36
IN THE FUTURE, IF I QUESTION THE DOSE OF MEDICATION, I WILL HOLD THE 37
MEDS, AND EXHAUST ALL AVENUES OF CONFIRMATION OF THE MEDICATION IN 38
QUESTION. 39
*** END OF MESSAGE ***

Function:
Functions(1/6): PF2=NExt 3=ENd 4=MEnu 5=Find 6=AMend 7=BWd 8=FWD pf1=help

Attachment

EMSD MED ERRO RE: I/M [redacted] Read Mode Line 39

QUESTION 39

*** END OF MESSAGE ***

[redacted]

Function:

Functions(1/6): PF2=NExt 3=ENd 4=MEnu 5=Find 6=AMend 7=BWd 8=FWD pf1=help

Attachment

4. Reviewing Supervisor. Name T Bollinger RN-3 Date 10/23/97
Brief statement of action and/or changes made to prevent future incidents.

Increase our support/supervision techniques when training new employees.
Change medication pouring/administration ~~protocol~~ procedures to a system that is efficient and accurate.

5. Statement of reviewing Practitioner. Name ~~Linda Hulse~~, ARNP Date 10-28-97
Result of error, future recommendations.

- IM [redacted] was "very sedated" and hypotensive when checked by nurses at ~ midnight 10-15-97, after the medication error was discovered. After consultation with the on-call provider and MD, IM [redacted] was sent to VGH ER for a more complete evaluation and monitoring. He was assessed and found to be stable, and ~~was~~ returned to SOC. It is thought his low blood pressure was caused by the Haldol decanoate IM injection he received late in the afternoon of 10-14-97, whose hypotensive side effects were potentiated by the Klonopin dose. It does not appear IM [redacted] has any further effects from the extra dose of Klonopin.
- Controlled medications such as Klonopin, should be signed out when they are poured, not at a later time. Standardized guidelines for new nurse train

6. Pharmacy & Therapeutics Committee Review. Date _____
Recommendations if any, changes in policies and/or procedures. Are there trends developing.

Signature P&T Chair _____.

n680

Attachment #1

INCIDENT REPORT TIME: 08:25.11

ID:4865 TYPE:MEDICAL EMERGEI STAFF REPORTING:I DON WOOD
TYPE: TYPE:
OCCURRED ON: 10/15/97 AT 01:45AM REPORTED ON: 10/15/97 AT 03:00AM
LOCATION: SPECIAL OFFNDR CONFIDENTIAL: NO
PLACE: HEALTH-HOSPITAL FACILITY

STAFF INVOLVED	INJ	HOS	OFFENDERS INVOLVED	INJ	HOS
LPN YOUNG	N	N	[redacted]	N	N
PA BARNES	N	N			
DR JONAS	N	N			

DESCRIPTION:
ON 10/15/97 AT APPROXIMATELY 0200 HOURS I/[redacted] WAS SENT TO MONROE VALLEY HOSPITAL. IT WAS REPORTED THAT THE INMATE WAS GIVEN A DOSE THAT EXCEEDED HIS PRESCRIBED AMOUNT. DUE TO HIS LOW BLOOD PRESSURE IT WAS DECIDED TO SHIP THE INMATE TO AN OUTSIDE HOSPITAL BY PA PAT BARNES. TRCC/SOC DUTY OFFICER RAY SIGMUND WAS NOTIFIED ALONG WITH ODO STAN GALVIN. MONROE FIRE DEPARTMENT ARRIVED AT SEEN TO TRANSPORT I/[redacted] I/[redacted] WAS RETURNED AT 0245 AM AND ADMITTED TO SOC INFIRMARY CELL #1. MEDICAL FILE PLACED INTO EVIDENCE LOCKER #2 PER DUTY OFFICER RAY SIGMUND.

PROPERTY DAMAGE: NO APPROXIMATE COST: $ 0
OTHER AGENCIES CONTACTED: DATE: 10/15/97 TIME: 02:04AM
911/SNO PAC
HOSP NAME: VALLEY GENERAL - MON FOLLOWUP RPT: NO AGAINST:

---------- OFFENDERS INVOLVED ----------

NAMES: [redacted] DOC NO: [redacted] CLASS: CLOSE
LAST KNOWN ADDR: [redacted] WA
DOB: 02/19/1973 SEX: M RACE: WHITE HISP.ORIG: N REL.DATE: 09/24/1999
MSC: BURGLARY I COUNTY: PIERCE
RECEIVED WCC-R: 08/12/97 TRANSFER TO PRESENT FACILITY: 08/18/97
VIC/WIT ELIGIBLE: YES FURLOUGH: NO
FBI NO: 917413WA9 SSA NO: - - SID NO: 17163505

0681

Attachment #1

DEPARTMENT OF CORRECTIONS

INPATIENT PROGRESS RECORD

☐ MEDICAL ☐ MHU

OFFENDER I.D. DATA

[redacted]

02719/73

NOTE: ALL NOTATIONS MUST BE SIGNED BY RESPONSIBLE HEALTH CARE PROVIDER

FACILITY : SPECIAL OFFENDER CENTER

DATE	TIME A.M.	TIME P.M.	
10-15-97		1P	S/O: per HO, pt tending R/T meds done, enc. pt
			to learn his own meds to ↑ sense of non-compliance
			V.S.S. at this time, pt rested quietly all AM
			Ø unusual behavior, Ø c/o, led c ADLs,
			requested to return to unit. A: Ø obvious
			probs at this time. P: disable to unit. R [illegible]
10-15-97		2:50 pm	S/O: Late entry: Back from Tay VGH,
			MD @ hosp. states BP stable @ 110/70.
Done on			More alert states he's fine. Still
			a little groggy. Admd to cell #1
10/16/97			for observation. BP 100/60-94.
night shift			Slept for nox. ↑ x1 to use BR. Δ
			position several times BP @ 0530
			110/60-92. D. Fluke notified in
			AM. A: Stable. P: Cont to observe –
			prob. back to unit tomorrow [illegible]

DOC 13-13 (REV. 4/91)

0682

Attachment #1

[redacted] 02/19/73

DATE	TIME	FACILITY	UNIT	ALLERGIES
10 Oct 97	1000	SOC	C	NKA

MR. stated

PLAN RX
1. Renew Elavil 75mg ghs x 60d
2. ↓ Haldol dec to 100mg (crossed out: po) IM [illegible] x 60d
3. Renew Klonopin 1mg qn/qpm x 30d
4. ↑ Depakote to 500mg po qn/qpm & 750mg po ghs x 60d

noted [illegible] 10/14/97 3P

2400 10-17-97 [illegible]

[illegible] MD

[redacted] 02/19/73

DATE	TIME	FACILITY	UNIT	ALLERGIES
10/16/97	7:15pm	SOC	C	NKA

Unit Boston officer notified me that the [redacted] fell while walking up stairs - fell forward and landed on (R) hand on knuckles. He came to infirmary and had some swelling noted to (R) side of (R) hand. Was able to move his fingers with apparent full range - given ice pack for his swelling - will refer to [illegible] tomorrow — [illegible signature]

PLAN RX

[redacted] 02/19/73

DATE	TIME	FACILITY	UNIT	ALLERGIES
10-15-97	250AM (crossed out)	SX	C	NKDA

(Late entry:)

Back from VGH. MD states BP more stable @ 110/70. More alert. States he feels fine. Admit to cell #10 for observation. BP 100/60-94. Slept for NOC. ↑ x1 to BR. Repositioned several times. BP @ 0530 110/60-92. J. Fluke notified in am.

[illegible signature]

PLAN RX

Done on 10/14 night shift

[redacted]

ORDERED DATE	TIME A.M.	TIME P.M.	PLEASE SIGN ALL ORDERS	EXECUTED TIME A.M.	EXECUTED TIME P.M.	BY WHOM
10-5-97		2³⁵pm	Admit to cell #1 for			
			med watch / observation			
			T.O. P. Barnes PA [illegible signature]			
			Late Entry			
			Done on 10/16/97			
			night shift			

[redacted]

ORDERED DATE	TIME A.M.	TIME P.M.	PLEASE SIGN ALL ORDERS	EXECUTED TIME A.M.	EXECUTED TIME P.M.	BY WHOM
10-15-97		1P	Disch to unit when V.S.			
			stable V.O. L. Fluke ARNP			
			[illegible signature]			

[redacted]

ORDERED DATE	TIME A.M.	TIME P.M.	PLEASE SIGN ALL ORDERS	EXECUTED TIME A.M.	EXECUTED TIME P.M.	BY WHOM

C63

Attachment #1

[redacted] BP 60/40 - 100-14 then
A 0930 - 92 - 12 P. Barnes notified
wanted sent to VCH (just for
caution) Sent @ 1555A back
0550 AM BP 100/60 - 94, pt in cell
med. Watch BP @ 0530

G655

Attachment #1

☐ OUTPATIENT ☐ INPATIENT

DOC 13-160 (REV. 11/94) 11-1-5

PROVIDER	INITIALS	PROVIDER	INITIALS	PROVIDER	INITIALS
				D. Lawrence RN	DL

INJECTION SITES

RD-RIGHT DELTOID
LD-LEFT DELTOID
RGM-RIGHT GLUTEUS MEDIUS
LGM-LEFT GEUTEUS MEDIUS
RAT-RIGHT ANTERIOR THIGH
LAT-LEFT ANTERIOR THIGH
RLT-RIGHT LATERAL THIGH
LLT-LEFT LATERAL THIGH
RVG-RIGHT VENTROGLUTEAL
LVG-LEFT VENTROGLUTEAL

Rx	TIME	Days 1–31
Rx Depakote 500mg PO Q noon, Qpm, + QHS x60d DR. NH START 9-18-97 STOP (INC) 11-18-97	12N	Initials recorded days 1–14 (RD, RD, RD, M, …)
	5P	Initials recorded days 1–13
	8P	Initials recorded days 1–13
Calamine lotion to face, trunk, + extremities BID x 2wks DR. NH START 9-19-97 STOP (INC) 10-3-97	7A	Initials recorded (circled) days 1–3; remainder lined through
	5P	Initials recorded (circled) days 1–3; remainder lined through
Rx NAPROSYN 375 mg PO 11A + 8P (crossed out) DR. LF START 10/1 STOP (INC) 10/11	11A	X day 1; initials (circled) days 2–11; remainder lined through
	8P	Initials recorded days 1–10; X day 11; remainder lined through
Rx DR. START STOP (INC)		

ISSUABLES

ALLERGIES NKDA

MONTH/YEAR

FACILITY

NAME (LAST, FIRST, MIDDLE) [redacted]

DOC NUMBER [redacted]

OUTPATIENT ☐ INPATIENT ☐

MEDICATION RECORD

DOC 13-160 (REV. 11/94) H-1-5

PROVIDER	INITIALS	PROVIDER	INITIALS	PROVIDER	INITIALS
		R. Darnell, RN 11	RD		

INJECTION SITES

RD-RIGHT DELTOID
LD-LEFT DELTOID
RGM-RIGHT GLUTEUS MEDIUS
LGM-LEFT GEUTEUS MEDIUS
RVG-RIGHT VENTROGLUTEAL
LVG-LEFT VENTROGLUTEAL
RAT-RIGHT ANTERIOR THIGH
LAT-LEFT ANTERIOR THIGH
RLT-RIGHT LATERAL THIGH
LLT-LEFT LATERAL THIGH

Rx Clozaril 75mg po QHS x60d

DR. JN/Hs
START 9-2-97 STOP (INC) 11-2-97

Rx Haldol Decl 150mg IM Q2wks x60d

DR. JN/Hs
START 9-18-97 STOP (INC) 11-18-97

Rx Klonopin 2mg po Q noon + pm x30d

DR. JN/Hs
START 9-18-97 STOP (INC) 10-16-97

Rx Cogentin 0.5mg po Q noon + HS x60d

DR. JN/Hs
START 9-18-97 STOP (INC) 11-16-97

TIME	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

ISUABLES

ALLERGIES NKDA

MONTH/YEAR 10 97 FACILITY SOC

NAME (LAST, FIRST, MIDDLE) [redacted] DOC NUMBER [redacted]

C 2-4

STATE OF WASHINGTON
DEPARTMENT OF CORRECTIONS
MEMORANDUM

TO: T. Bollinger RN III DATE: 10/14/97

FROM: G Wagner RN SUBJECT: Narcotic count

After Leslie Young LPN and Mike Kalina RN II finished the narcotic count at 10p they discovered 11 Klonopin 1 mg tabs missing. I double checked the count and the Klonopin 1 mg was 27 instead of 29

G Wagner RN

DOC 02-110 (3/91)

T 688

Attachment #1

recycled paper

STATE OF WASHINGTON
DEPARTMENT OF CORRECTIONS
MEMORANDUM

TO: Teresa Bollinger RN3 DATE: 10-14-97

FROM: Leslie Young LPN SUBJECT: Narcotic Count

At 10pm on 10-14-97 the narcotic ~~county~~ count was off. Klonopin 1mg count was 27 + should have been 29.

L Young LPN

1639

DOC 02-110 (3/91)

Attachment #1

recycled paper

STATE OF WASHINGTON
DEPARTMENT OF CORRECTIONS
MEMORANDUM

TO: Theresa Belanger DATE: 10.14.97

FROM: [redacted] SUBJECT: Narcotic Count

At 2200 hrs the count was found to be off by 1 1/2 mgm Klonopin.

C'Unit was contacted & we were advised that [redacted] had received 2 mgms Klonopin @ hs that was in addition to his 5pm & should not have been given.

I poured the meds & take full responsibility for this med error.

Theresa was notified
Patrick Barnes was notified

[redacted] RN.

0690

DOC 02-110 (3/91)

Attachment #1

recycled paper

CHASE RIVELAND
Secretary

STATE OF WASHINGTON
DEPARTMENT OF CORRECTIONS
SPECIAL OFFENDER CENTER
P.O. Box 514 - Park Place • Monroe, Washington 98272-0514

November 6, 1997

TO: Michael Kalina, RN 2

FROM: Ella Ray Sigmund, (Acting) Associate Superintendent

SUBJECT: ECR Administrative Level Meeting

I have scheduled a meeting on Wednesday, November 19, 1997, at 2:00 p.m. in the TRCC-Special Offender Center Superintendent's Conference Room to discuss the allegations reflected in the Employee Conduct Report initiated on October 17, 1997, by Teresa Bollinger, Registered Nurse 3.

Attached for your review is the Employee Conduct Report packet.

If you are unable to attend this meeting as scheduled, please advise Judi Wheeler, 794-2204, as soon as possible.

ERS:jw

Attachment

cc: Dennis Thaut, Superintendent
Sandra Moore, Personnel Officer
Teresa Bollinger, RN 3

0691

Attachment #1

CHASE RIVELAND
Secretary

STATE OF WASHINGTON
DEPARTMENT OF CORRECTIONS
SPECIAL OFFENDER CENTER
P.O. Box 514 - Park Place • Monroe, Washington 98272-0514

November 19, 1997

TO: Michael Kalina, RN 2

FROM: Ella Ray Sigmund, Associate Superintendent E Ray Sigmund

SUBJECT: ECR Administrative Level Meeting

I have scheduled a meeting on Tuesday, November 25, 1997, at 2:00 p.m. in the TRCC-Special Offender Center Superintendent's Conference Room to discuss the allegations reflected in the Employee Conduct Report initiated on October 17, 1997, by Teresa Bollinger, Registered Nurse 3.

Attached for your review is the Employee Conduct Report packet.

If you are unable to attend this meeting as scheduled, please advise Judi Wheeler, 794-2204, as soon as possible.

ERS:jw

Attachment

cc: Dennis Thaut, Superintendent
Sandra Moore, Personnel Officer
Teresa Bollinger, RN 3

C692

Attachment A1

STATE OF WASHINGTON
DEPARTMENT OF CORRECTIONS
TWIN RIVERS CORRECTIONS CENTER
P.O. Box 888 • Monroe, Washington 98272-0888 • (360) 794-2400

TO: Whom it May Concern

FROM: Larry M. Conner

DATE: 11/17/97

SUBJECT: RN2 Kalina, Michael

At the request of C/O Barry DeHaven, I am writing this letter to express my opinions and observations of RN2 Michael Kalina. During my tenure as the Watch III Shift Lieutenant at the Special Offender Center (SOC), I worked very closely with RN2 Kalina.

I began working at the SOC in May 1990 as the Watch III Shift Commander. I worked in that position for approximately 3 ½ years prior to my current assignment as the Twin Rivers Corrections Center (TRCC) Training Coordinator.

Approximately one year after I began working at SOC, RN2 Kalina began working at SOC as an intermittent nurse, and subsequently hired and assigned to Watch III as an RN2. During this time, I worked very closely with RN2 Kalina and other nurses assigned to Watch III at SOC. As the Shift Lieutenant I have found RN2 Kalina to be very professional, and reliable regarding his duties during those times where our duties overlapped. His honesty, and forthrightness was something I valued as a Shift Lieutenant. Even in our disagreements he was always professional, and presented medical information in such a way that I could understand it and apply it to my duties as the Watch Commander.

In the time I worked with RN2 Kalina, I have never known him to misrepresent the facts, compromise his credibility, or do anything that would place his licensure at risk. In all the times I have worked with him, he has always attempted to follow procedures outlined in policy.

In conclusion, I have nothing more than the utmost respect for RN2 Michael Kalina and would welcome the opportunity to work with him again.

Larry M. Conner 11/17/97
Larry M. Conner Date

0693

Attachment #1

STATE OF WASHINGTON
DEPARTMENT OF CORRECTIONS
SPECIAL OFFENDER CENTER
P.O. BOX 514 Park Place Monroe, Washington 98272-0514

November 18, 1997

Since being employed at TRCC-SOC in 1995, I have witnessed RN2 Kalina, Mike on many occasions and have worked closely with him. He has been an asset to custody staff, inmates, and Supervisors. RN2 Kalina is able to work with a broad range of people under a variety of circumstances. RN2 Kalina has always been consistent in coverage for codes, team work, assisting other nurses when needed, and asking for assistance when needed. RN2 Kalina can be relied upon to complete written and oral directives from supervisors, as well as his excellent writing and communication skills with staff and inmates.

On many occasions when an inmate has refused to comply with taking medications for another nurse, RN2 Kalina has been asked to try and work with the individual to get the inmate to comply. On most of the situations RN2 Kalina is able to communicate and has developed a excellent rapport with inmates and staff and the inmates will comply for him.

RN2 Kalina has excellent interpersonal skills, demonstrates quality in all he has done that I have witnessed while working with him. RN2 Kalina manages resources effectively, establishes safe work unit environment, is very organized, and takes ownership appropriately when required to do so. I have also witnessed many occasions personally RN2 Kalina's ability to train others and do effectively and professionally. RN2 Kalina is a high promoter of positive moral and team work. RN2 Kalina is an asset and a excellent contribution to any agency and facility he is employed with. RN2 Kalina can be depended on by fellow staff, supervisors, inmates, and the general public in how effective he is as a nurse professional and a representative to the agency.

Sgt. Theresa L. Paulino / 11-18-97

0694

Attachment #1

November 28, 1997

To: Whom It Concerns

Re: Michael Kalina, R.N.

In my capacity as psychiatric consultant to the Special Offender Center of the Department of Corrections, I have known the above individual and worked closely with him for over two years. It is a privilege to be able to write a letter of recommendation in support of such a person.

Throughout the entire duration of my work at SOC, I have noted Mike to be cheerful, knowledgeable, hard working, efficient, compassionate, and caring. Although I try not to consider any one person to be indispensable to the team, it is significant that it is more difficult for me to do my job when Mike is absent. I consider this a marker of the extent to which I rely on his skill and helpful attitude.

For the past year and more, Mike has been responsible for coordinating and publishing the schedule for all 24 hours per week of the psychiatric consultants. This involves not only a thorough background knowledge of the work routine of myself and the other psychiatrist, but up-to-date information, both clinical and demographic, about all 80-100 inmates in the facility. I have often admired his ability to juggle the myriad schedules involved (nursing, psychiatry, psychology, counseling and administration) and deal with all the ruffled feathers—to me an indication of managerial expertise.

Above all I value in Mike or any coworker his integrity. I trust Mike implicitly and he has never betrayed my or anyone's trust that I have observed while working at SOC. Our job situation requires us to work with some very difficult people, and I consider it the highest praise that I have never observed Mike to behave inappropriately towards anyone. I have also on more than one occasion seen him go out of his way in support of someone he felt was being unfairly treated.

I am available to answer any questions regarding the above or to provide additional information if required. Any staff answering the infirmary line at (360) 794-2236 should be able to contact me.

Sincerely,

Judith K. Morishima-Nelson, M.D.

Attachment #1

TO: MOORE SANDRA DOC-DP-G1-SMB 29-OCT-97 09:48:19
SPECIAL OFFE :R CENTER
16730 177TH AVE
MONROE WA 98272-0000

FROM: MOORE SANDRA DOC-DP-G1-SMB 29-OCT-97 09:34:48
SPECIAL OFFENDER CENTER
16730 177TH AVE
MONROE WA 98272-0000

SUBJECT: RE: MIKE KALINA ECR DOC-DP-G1-SMB/MA#9495453

TO: GRAYBEAL RICHARD DOC-DP-G1-DG7
FROM: MOORE SANDRA DOC-DP-G1-SMB
DATE: THURSDAY 23-OCT-97 AT 3:00PM
SUBJECT: MIKE KALINA ECR
CC: THAUT DENNIS DOC-DP-G1-DT2

HI DICK,
KALINA TURNED HIS RESPONSE INTO TERESA ON 10-21 AND BECAUSE WE WEREN'T SURE WHO WAS TO BE INVESTIGATING THE INCIDENT, TERESA BROUGHT THE ECR TO ME. IT WOULD BE NICE IF NORMA GRAY'S WORKLOAD COULD ACCOMMODATE THE INVESTIGATION AS SHE WOULD BE VIEWED AS A NEUTRAL ENTITY, ALTHOUGH I UNDERSTAND THAT THE RN 3 AT TRCC-MI, ANN, HAS BEEN MENTIONED AS THE POSSIBLE PERSON TO CONDUCT THE SUPERVISORY INVESTIGATION. SO, WHO DO YOU AND DENNIS WANT TO ASSIGN IT TO?
DENNIS,
AS THE RESPONSE TO THIS WOULD BE DUE ON 10-28-97 NORMALLY, AN EXTENSION APPROVAL FROM YOU FOR COMPLETION OF THE SUPERVISORY INVESTIGATION IS NECESSARY. I KNOW THAT IN ORDER FOR NORMA TO HANDLE THE INVESTIGATION, YOU WOULD NEED TO TALK TO KEN, BUT I SUGGESTED HER AS SHE IS FAMILIAR WITH THE SETTING/PLAYERS, AND ANN IS NOT.

..... MESSAGE AMENDED BY: DOC-DP-G1-DG7 GRAYBEAL RICHARD
ON: FRI 24-OCT-97 AT: 8:44AM
I MUCH PREFER HAVING NORMA GRAY DO THE INVESTIGATION ALTHOUGH ANE IS CERTAINLY COMPETENT TO HANDLE IT. A TIME EXTENSION ALSO SEEMS APPROPRIATE.

CC: THAUT DENNIS DOC-DP-G1-DT2

..... MESSAGE AMENDED BY: DOC-DP-G1-DT2 THAUT DENNIS
ON: TUE 28-OCT-97 AT: 1:42PM
EXTENSION APPROVED.

..... ROUTED ON: TUE 28-OCT-97 AT: 1:43PM
FROM: DOC-DP-G1-DT2 THAUT DENNIS
TO: DOC-DP-G1-SMB MOORE SANDRA
DOC-DP-D1-NGA GRAY NORMA

..... MESSAGE AMENDED BY: DOC-DP-G1-SMB MOORE SANDRA
ON: WED 29-OCT-97 AT: 9:34AM
DENNIS THAUT HAS APPROVED AN EXTENSION TO THE COMPLETION OF THE SUPERVISOR'S REPORT TO NOVEMBER 5, 1997.

Attachment #1

DEPARTMENT OF CORRECTIONS

EMPLOYEE RIGHTS PURSUANT TO ARTICLE 8.2 OF INSTITUTIONS CBA

It is alleged that you have committed misconduct. As part of the investigation you may be interviewed about the alleged incident. In accordance with Article 8.2 of the Collective Bargaining Agreement between the Department of Corrections and the Washington Public Employees Association, you have the following rights:

1. To have representation by the Union during an interview;
2. To receive written notice of the allegation(s) and an opportunity to respond;
3. To decline to respond to questions during an interview; however, Management may proceed without benefit of your comments;
4. To refuse under state law to submit to polygraph examinations except as provided by applicable statute; and
5. To have the investigation concluded without unreasonable delay.

I have read the rights to which I am entitled.

Michael Wilson PA-2 — Employee Signature — 10/17/97 — Date

D Bollinger CO-3 — Witness Signature — 10/17/97 — Date

Original: Personnel Office
Yellow: Supervisor
Pink: Employee

DOC 3-116 (REV 6/93)

0697

Attachment #1

EMPLOYEE HANDBOOK

FOR THE

STATE OF WASHINGTON
DEPARTMENT OF CORRECTIONS

JUNE 1993

0699

Attachment #2 and #3

- Provide for restitution;
- Be accountable to the citizens of the state;
- Meet the national standards appropriate to the State of Washington.

CODE OF ETHICS

High moral and ethical standards among correctional employees are essential for the success of the department's programs. The Department of Corrections subscribes to a code of unfailing honesty, respect for dignity and individuality of human beings, and a commitment to professional and compassionate service.

DEPARTMENT EXPECTATIONS

As a new employee of the department, you will have many things to learn, not the least of which will be the expectations of your supervisor, your co-workers, and the agency as a whole. To assist you with this responsibility, following is a list of some departmental expectations for your study. Familiarize yourself with the list so that you may understand and fulfill the duties of your position.

As a representative of the Department of Corrections, you will be expected to:

- Positively represent Washington State government to everyone you meet. You are our best public relations agent;
- Dress appropriately for your job classification and duties. Clothing may not have mottos, logos, or advertisements that may be offensive or in conflict with the goals of the Department;
- Wear issued uniforms only as authorized;
- Be a good citizen, obey laws while on and off-duty. Your conduct off duty may reflect on your fitness for duty;
- Treat fellow staff with dignity and respect;
- Be impartial, understanding and respectful to offenders;
- Serve each offender with appropriate concern for their welfare and with no purpose of personal gain;

Attachment #2 and #3

- Report all personal contact from offenders, their families, or known associates, outside your job in accordance with department procedures;
- Report through the proper chain of command any corrupt or unethical behavior which could affect an offender or the department's integrity;
- Remain constantly alert in all situations;
- Custody staff: remain at your job/post until properly relieved;
- Let your supervisor know about any personal, emergency use of equipment or phones;
- Obtain appropriate permission before removing any state property from state premises;
- Conduct yourself and perform your duties safely;
- Smoke only in designated smoking areas.

It is also important as a new employee, that you understand some of the specific prohibitions that the department must enforce. <u>You are not allowed to</u>:

- Discriminate against any offender, employee, prospective employee, or volunteer on the basis of race, color, religion, gender, sexual orientation, age, creed, national origin, marital status, veteran status or disability;
- Use profanity or inflammatory remarks with offenders or individuals with whom you work;
- Report to work under the influence of alcohol or drugs;
- Traffic or bring any article of contraband into an institution, facility or office;
- Barter or make personal deals with offenders, offender families or visitors;
- Engage in personal relationships with offenders, their family members, or close personal associates;

Attachment #3

DEPARTMENT OF CORRECTIONS
DIVISION OF PRISONS

Twin Rivers Corrections Center

FIELD INSTRUCTION

NUMBER	
TR 610.900	
ISSUE DATE 92 10/27/92	EFFECTIVE DATE 11/27/92
PAGE 1 of 8	

TITLE

MEDICATION MANAGEMENT

AUTHORITY: Division of Prisons audit checklist "Drugs, syringes, needles and hazardous surgical instruments."

PURPOSE: To establish guidelines for procurement, storage, distribution and disposal of medications at the Twin Rivers Corrections Center.

APPLICABILITY: All Twin Rivers Corrections Center Staff involved in the management of medications.

DEFINITIONS:

Controlled Substances Log: Log of TRCC controlled substances activities, maintained by RN staff and kept in the medication room controlled substances cabinet.

Crash Cart: Mobile cart containing emergency medications and supplies, maintained by the Nursing staff and is used only in the event of medical emergencies.

Dispensed Medication: Those medications legally packaged and labeled by a pharmacy by order of a licensed health care provider with prescriptive authority, for an individual patient.

Drug Profile: Individual patient record of all medications dispensed to that patient by the facility maintaining the profile.

Floor Stock: No more than a three day supply of medications pre-packaged by pharmacy staff with partial labeling. To be used (after pharmacy hours) by RN staff to begin treatment until the full prescription can be dispensed.

Medication Cart: Lockable cart containing (pharmacy) dispensed medications. Kept in the TRCC medication room.

Command C Controlled Substances Log: Log of all Command C Pharmacy controlled substances activities, maintained by Pharmacy staff and kept in the Command C controlled substances vault.

Multiple Dose Medications: These medications will be dispensed by pharmacy staff in clear ziplock baggies and issued to inmate patients. All labels will be fixed to the baggy and contain the following information:

1. Inmate name and number
2. Medication strength
3. Number of pills dispensed (contained in the baggie)
4. Direction for use

0701

P2

Attachment #4

5. Dates for which prescription is valid; to include expiration date
6. Prescribing practitioner
7. Prescription number, when applicable.

These medications include:

1. Antibiotics - full course (exception: Minocin) - 10 day supply
2. Anti-inflammatory agents - as ordered, up to 10 day supply
3. Antihistamines/Decongestants (except those mentioned below), as ordered, up to 10 day supply
4. Asthma medication - 30 day supply
5. Ulcer medication - 30 day supply
6. Cardiac/Antihypertensive - 30 day supply
7. Topical medication - 30 day supply
8. Optic/Opthalmic preparations - full course
9. Over-the-counter medications (i.e., vitamins, antacids), as ordered
10. Seizure medications - 7 day supply (except controlled substances)
11. Miscellaneous medications requiring monitoring - 7 day supply
    a. Acyclovir
    b. Accutane
    c. Midrin
    d. Ergotomines

Single Dose Medications: Medications considered to be abusable which must be dispensed by single dose only and are ingested at the time issued. These medications are:

1. Controlled substances (Codeine, Demerol)
2. Psychotropics
3. Restricted antihistamines (Benadryl, Hydroxizine, Phenergan)
4. Anticoagulants
5. Muscle relaxants (Flexeril, Parafon Forte, Phenergan)
6. Restricted anti-inflammatory agents (Dolobid)
7. Antituberculin

FIELD INSTRUCTION:

Responsibility:

The Health Care Manager 1 is responsible for the management of all medications stored and distributed by Health Services. The Monroe Command Pharmacy Supervisor is responsible for all medications procured, stored, dispensed and disposed of by the Command C Pharmacy. (B.1)

Pharmacy Manual:

The Command C Pharmacy Manual (See Attachment "A" -Manual Index) establishes a system for purchase, records maintenance, inventory, storage, security, audits and disposal of all medications stored in and managed by the Command C Pharmacy located in Washington State Reformatory Health Services. (B.3; C.1, .2, .4; D.1; E.1a, b; F.1a, b, c, d, e; F.2; H.1, 2, 3; I)

Locations of Medication Storage:

1. Medication room; where all dispensed medications, floor stock medications and over the counter medications are stored. This area also serves as the distribution site for medication lines.

2. Crash cart; stored in the treatment room, containing no more than one to two doses per medication.

3. Lab: Medications stored here are refrigerated injectable insulin (for daily patient use), over the counter issuables per standing order, nebulizer solutions and tetanus serums. (C.3)

Security Access:

1. Med Room. Keys to this area are restricted per Twin Rivers Corrections Center Policy 410.011 to one RN per shift. It is a two door system requiring that one door be locked prior to unlocking the second. Additionally, all controlled substances are kept in a cabinet in this medication room with keys restricted to one RN per shift.

2. Crash Cart: Padlocked with a tamper proof seal that is checked and logged daily by RN staff (See Attachment "B", Daily Equipment Checks). Treatment room is locked whenever unoccupied. Keys to the treatment room and the crash cart are restricted to designated health care staff per Twin Rivers Corrections Center Policy 410.011.

3. Nurses Station: Keys are restricted to designated health care staff per TRCC policy 410.011. (C.2, D.1)

Records:

1. Drug profile: Stored on the hard disc of the Command C Pharmacy computer.

2. Medication Record: All medications distributed or issued by TRCC health services staff are recorded on the individual's medication record, noting medication dosages, date and time, and staff initials (see Attachment C). Medication records are a permanent document in the inmate's Health Record. (F.1.f.)

3. Custody staff shall maintain records of over the counter medications issued per TRCC policy 610.990. (J.2)

Annual Review:

1. The Health Care Manager 1 shall prepare an annual report for the Superintendent noting status of the medication management system and correction of any deficiencies identified in the quarterly audit described above. (L.1)

2. The Superintendent and the Health Care Manager 1 shall annually review the "Medication Management" policy and procedure. All modifications shall be reviewed for approval by the Assistant Director, Division of Prisons, Command C. (L.2, 3)

PROCEDURE: CONTROLLED SUBSTANCES MEDICATIONS

ACTION:		ACTION BY:
Pharmacist	1.	Will order controlled substances utilizing standard DEA form which is mailed directly to vendor.
Command C Medical Supply Technician	2.	Receives and delivers medication directly to pharmacy staff.
Pharmacist	3.	Will verify, store in pharmacy vault, and log in (Command C Pharmacy Log) all controlled substances. (See Attachment D). (B.3., C.2., F.1.a.b.e.)
	4.	Maintains copies of all invoices in the Controlled Substance Vault. Duplicates kept by Medical Supply Technician and Command Accountant (F.1.a.b.e.)
Physician/Dentist/ Physician Assistant/ Accredited Registered Nurse Practitioner	5.	Will prescribe controlled substances as authorized by licensure. Controlled substances will be ordered for no more than 72 hours.
RN/LPN	6.	Will process controlled substance orders by:
		A. Noting on Medication Record (DOC Form #13-16) (Attachment "C"), the patient's name, number, prescribing authority and inclusive dates of prescriptions.
		B. Completing the numbered "Controlled Substance Order Form" (see example - Attachment "E") and forwarding to the Pharmacist.
Pharmacist	7.	Will log in the numbered form on the Controlled Substance Order Form Log (See Attachment "F").
	8.	Prepares requested supply of controlled substances.

Pharmacist	9.	Signs order form verifying order filled.
	10.	Issues to Nursing staff.
	11.	Obtains 2 RN/LPN signatures verifying their receipt of requested controlled substances.
	12.	Forwards copy of completed order form to the Health Care Manager I.
	13.	Maintains file of original (completed) order forms in the Command C Pharmacy.
RN/LPN	14.	Places controlled substances in the medication room cabinet and logs in controlled substances in the Controlled Substances Log (See Attachment "G").
	15.	Logs out and dispenses medications as ordered and record same on patient's profile. Medications will be issued in crushed form or in water at the waiting room medications slot.
	16.	Observe inmate compliance of oral medications. (J.1.)
	17.	Record date and time of medications dispensed on appropriate inmate's medication record and initial same. (F.1.f.)
	18.	Will inventory all controlled substances at the end of shift with oncoming RN/LPN and note same on the Controlled Substances Log. (I.1.)
	19.	Will return to the pharmacist any unused or outdated controlled substances and cosigns with pharmacist log entry in the Controlled Substances Log. (C.4.)

PROCEDURE: **NON-CONTROLLED SUBSTANCES**

Physician/Dentist/ Physician Assistant/ Accredited Registered Nurse Practitioner

1. Will prescribe medications as authorized by licensure.

RN/LPN

2. Will process medication orders by:

   A. Noting on Medication Record the patient's name, number, prescribing authority, and inclusive dates of the prescription.

   B. Forwarding the prescription to the pharmacy.

Pharmacy

3. Will prepare medications as prescribed, either in "single dose" or "multiple dose" packages.

4. Note prescription on patient's drug profile (computer entry).

5. Deliver medications to RN/LPN staff.

RN/LPN

6. Store medications in locked medication cart in the medication room. (C.2.)

7. Will dispense medications as ordered:

   A. Medications will be given at the medication window four times daily.

   B. Will witness the patient ingesting all single dose medications. (J.1.)

   C. Will record on the medication card the date, time, medication dispensed or issued, and initial the same. (F.1.f.)

8. Will return all unused, outdated medications to the Pharmacist when prescription expires. (C.4., H.1.)

0707

REFERENCES: TRCC Policy 410.011
TRCC Policy 610.990
Board of Pharmacy Rules and Regulations
Division of Prisons Audit Checklist "Drugs, Syringes, Needles and Hazardous Surgical Instruments."
CSB 13.27
ACA 2-4317
WAC-36

SUPERCEDES: TRCC Policy 610.900 dated 4-15-91

Janet Barbour
Janet Barbour, Superintendent
Twin Rivers Corrections Center

Tom Rolfs 10/01/92
Tom Rolfs, Assistant Director
Division of Prisons, Command C

DAILY EQUIPMENT MONITOR

For The Month Of _____ 19__

EQUIPMENT	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
II PAK																															
CI																															
CYCEN																															
: EQUIPMENT																															
IP INHICATION EQUIPMENT																															
ACKLIGHT																															
URGICAL PACKS (q 30 d)																															
RASH CART SEAL																															
RASH CART CONTENTS (q 2 wks)																															
EKG																															
Glucometers																															
Refrigerator Temps (2) LAB / NURSING / CAB.																															
Otoscopes full																															
Hydrocollator full																															

Attachment 4 (7/96)

☐ OUTPATIENT
☐ INPATIENT

DEPARTMENT OF CORRECTIONS

MEDICATION RECORD

PROVIDER	INITIALS	PROVIDER	INITIALS	PROVIDER	INITIALS	INJECTION SITES
						RD—RIGHT DELTOID LD—LEFT DELTOID RAT—RIGHT ANTERIOR THIGH LAT—LEFT ANTERIOR THIGH
						RGM—RIGHT GLUTEUS MEDIUS LGM—LEFT GLUTEUS MEDIUS RLT—RIGHT LATERAL THIGH LLT—LEFT LATERAL THIGH RVG—RIGHT VENTROGLUTEAL LVG—LEFT VENTROGLUTEAL

	Time	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
R DR. START STOP (INC.)																																
R DR. START STOP (INC.)																																
R DR. START STOP (INC.)																																
R DR. START STOP (INC.)																																

ISSUABLES

ALLERGIES

MONTH/YEAR

FACILITY

(LAST FIRST MIDDLE) DOC NUMBER

Attachment #4

0710

Log #3

Date	Issued From	Issued To	Qty	Bal	Signature
1/1/88	Balance Forward			420	J Jankord
1/8/88	Pharm Vault	TRCC #777	50	330	J Jankord
1/12/88	✓ ✓	WSR # 791	50	320	J Jankord
1/15/88	✓ ✓	TRCC #792	50	250	J Jankord
5/24/88	✓ ✓	TRCC #794	25	225	C Johnson
8/29/88	✓ ✓	TRCC #795	25	200	J Jankord
9/02/88	✓ ✓	TRCC #001	75	125	C Johnson
7-6-88	PO # 191455 Velo Inv 207344	Pharm Vault	500	625	J Jankord
11/1/88	Pharm Vault	WSR #789 IPU	50	575	J Jankord
9/13/88	TRCC	Pharm Vault	44	619	C Johnson
9/16/88	Pharm Vault	WSR #012	50	569	C Johnson
9/21/88	✓ ✓	~~WSR~~ SOC #027	50	519	C Johnson
"	✓ ✓	TRCC #005	25	494	C Johnson
9/27/88	✓ ✓	TRCC #008	25	469	C Johnson
10/4/88	Inventory	26.40/500		469	C Johnson
10/4/88	Pharm Vault	TRCC # 9	25	444	J Jankord
10/24/88	✓ ✓	TRCC #32	25	419	J Jankord
11/4/88	✓ ✓	TRCC #038	50	369	C Johnson
11/10/88	✓ ✓	WSR IPU #058	50	319	C Johnson
11/13/88	✓ ✓	WSR IPU #53	50	269	J Jankord
11/22/88	✓ ✓	TRCC #067	25	244	C Johnson
11/29/88	✓ ✓	SOC #069	25	219	C Johnson
11/30/88	Inventory			219	C Johnson
12/4/88	Pharm Vault	TRCC #71	25	194	J Jankord
12/8/88	✓ ✓	WSR #61	25	169	J Jankord
12/13/88	✓ ✓	WSR #062	25	144	C Johnson
12/14/88	✓ ✓	SOC TRCC #85	85	119	J Jankord
12/14/88	PO 192027 Velo Inv # 296882	Pharm Vault	500	619	J Jankord
12/21/88	Pharm Vault	TRCC #86	50	569	J Jankord
[illegible]	[illegible]	TRCC #093	25	544	C Johnson

CONTROLLED SUBSTANCE ORDER : CSM NO. UUU750

7/6/88 TIME: 1300

Requesting Unit - Circle appropriate:

FACILITY: WSR (TRCC) SOC
DEPARTMENT: Inpatient (Outpatient)

We request the Pharmacy supply the following controlled substances. This quantity is not to exceed an estimated four day supply, or one unit, whichever is the greater amount: ALL CHANGES OR ERRORS MUST BE INITIALED.

SUPPLY on hand	NEED (Check)	DESCRIPTION	QUANTITY Unit/ea/ # per unit	PHARMACY Qty Sent, Lot #, Exp da
		ORAL		
		Acetaminophen with Codeine 30 mg Tab, 25/Unit		
		Clonazepam 2mg (Klonopin) each		
0	14	Diazepam 5mg Tab (Valium) 10/unit	14	14 Lot 1218 Exp
8	1	Diazepam 10mg Tab (Valium) 10/unit		
		Methadone tabs 10 mg each		
		Oxycodone with Acetaminophen (Tylox) 25/unit		
		Phenobarbital 30mg Tab 10/unit		
		Pentazocine 50mg (Talwin NX), 25/unit		
		Other		
		INJECTABLE		
		Diazepam 10/mg/2ml inj. (Valium) 1/each		
		Meperidine 50mg Inj. (Demerol) 10/unit		
		Meperidine 75mg Inj. (Demerol) 10/unit		
		Meperidine 100mg Inj. (Demerol) 10/unit		
		Morphine SO4 10 mg Inj. 10/unit		
		Other		
		CONTROLLED SUB. ORDER FORMS, 1 ea.		

SIGNATURE OF TWO AUTHORIZED HEALTH CARE PROVIDERS:

Requesting

Co-Signature

SIGNATURE OF PHARMACIST FILLING ORDER

Signature of Pharmacist

7/6/88
Date Filled

1:38 PM
Time Filled

#4
Attachment

SIGNATURE OF TWO RECEIVING HEALTH CARE PROVIDERS

Card # [illegible]

Date	Time	Administered or stock issued to patient	Amount out	Bal (54)	Signature
[illegible]	5P	Janis	-2	52	J Brown RN
[illegible]	8P	Janis	-2	50	[illegible]
[illegible]	11P	Count Correct		50	[illegible]
6/29/88	2am	Count Correct		52	[illegible]
"	6am				[illegible]
"		Janis	-2	48	[illegible]
	12pm	Janis	-2	46	[illegible]
6-29-88	4P	Count Correct		46	[illegible]
6-29-88	5P	Janis	-2	44	[illegible]
6-29-88	8P	Janis	-2	42	[illegible]
6/30/88	2am	Count Correct		42	[illegible]
6/30/88	7:30A	count correct J Barberger		42	[illegible]
6/30-88	8A	stock transferred to dept!	-42	0	[illegible]
7/3/88	1:30P	Transfered from inpt unit to pharm. 46		46	[illegible]
	2P	count correct		46	[illegible]
7/3/88	10P	Count correct		46	[illegible]
7/4/88	6A	Count Correct		46	[illegible]
7/4/88	2p	Count Correct		46	[illegible]
7/4/88	9p	Count Correct		46	[illegible]
7/5/88	12a	Count Correct		46	[illegible]
7-5-88	6A	Count Correct		46	J Barberger
7-5-88	2P	Count Correct		46	J Brown RN
7/5/88	10p	Count Correct		46	J Brown RN
7-6-88	6A	Count Correct		46	J Barberger
7-6-88	2P	Count Correct		46	[illegible]
7/6/88	10	Count Correct		46	J Brown RN
7-7-88	6a	Count Correct		46	J Barberger
7/88	10P	Count Correct		46	[illegible]
7/8/88	6A	Count correct		46	[illegible]
7/8/88	2P	Count Correct		46	[illegible]
7-8-88	9P	Count Correct		46	[illegible]

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Attachment #4

WASHINGTON STATE SPECIAL OFFENDER CENTER

HEALTH CARE OPERATIONAL MANUAL

INFIRMARY PROCEDURE

SUBJECT: MEDICATION AND/OR TREATMENT ERROR

INCIDENT REPORTING:

OBJECTIVE:

1. To ensure that dispensing and distribution of medication and treatment conform to state and federal regulations as well as good pharmacy and clinical practices.

2. To ensure that health care providers are performing at a level of good professional quality.

3. To ensure that if medication or treatment errors are made, there is a method for following up and provide for minimum risk to the patient, the facility, and the professional staff.

DEFINITION: Medication and/or treatment errors will be deemed to exist when one or more of the following conditions are met:

1. When medication is not received by the right person, at the right dose and/or at the right time.

2. When a treatment or medication was not processed currently from the health record and therefore not done as ordered.

3. When medication was given to a person for whom it was not ordered.

PROCEDURE:

1. Medication errors will be reported to supervisors immediately. After hours, either the Nurse Practitioner or the Physician's Assistant, whoever is on call, will be notified.

2. The PA or NP will make a decision regarding health risks as a result of the medication error and be responsible for follow-up for any health care needs resulting from that medication error.

3. The staff person making the error will fill out Medication Error Incident Report (see form attached) before leaving shift.

4. Medication will be charted in the Health Record as given.

Attachment #5

5. The Supervisor will complete the form on the next scheduled day. Immediate action will be taken if necessary to rectify any potential dangerous procedural admission of personnel problem, if that was deemed to have caused this error.

6. A copy of the medication and/or Treatment Error Incident Report will be distributed to the Chair Person, the Health Care Manager, and the Prescribing Provider for review.

7. The original medication and/or Treatment Error Incident Report will be kept in the supervisor's personal personnel file.

8. Repeat or serious medication or treatment errors will result in letters of reprimand or Employee Conduct Reports.

Gary Wellman HC
Gary Wellman
Health Care Manager, SOC

Fran Bartley CW 3
Fran Bartley
Nursing Supervisor, SOC

FB:se
#JB Infirmary

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Attachment #5

MEDICATION AND/OR TREATMENT ERROR REPORT

1. Statement of person discovering Error. Name _____ Date _____
How was error discovered ?

2. Statement of person(s) who made the error. Name _____ Date _____
Detail of incident, Patient name(s), medication(s) or type of error - Medications or Treatment, date, location etc., what happened ?

3. What could have been done to prevent the error ?

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(page 2 on other side)

Attachment #5

4. Reviewing Supervisor. Name_____ Date _____
Brief statement of action and/or changes made to prevent future incidents.

5. Statement of reviewing Practitioner. Name_____ Date_____
Result of error, future recommendations.

6. Pharmacy & Therapeutics Committee Review. Date _____
Recommendations if any, changes in policies and/or procedures. Are there trends developing.

Signature P&T Chair _____.

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Attachment #5

MONROE COMMAND CENTRAL PHARMACY
POLICY AND PROCEDURE
MANUAL

Table of Contents

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Attachment #6

P. Adverse Reaction

Health care staff must be alert to the potential for, or presence of, adverse drug reactions. All significant a.d.r. will be recorded in the patient's health record with a copy forwarded to the pharmacist, the prescribing practitioner, and the nursing supervisor.

If indicated, the pharmacy supervisor will make written report to the Food and Drug Administration, the Monroe Command Pharmacy and Therapeutics Committee, and the drug manufacturer.
The report will include:

* Patient's age, sex and race
* Description of the drug reaction and suspected cause
* Name of drug(s) suspected of causing the reaction
* Administration route and dose
* Name(s) of other drugs received by patient
* Treatment of the reaction, if any

Q. Medication Errors

All drug errors shall upon discovery, be recorded in an incident report and reported to the prescribing practitioner and to the Pharmacy, WAC 246-873-080.

A Medication Error is defined as a dose of medication that deviates from the providers order as written in the patient's chart. Except for errors of omission, the medication must actually reach the patient; i.e., a wrong dose that is detected and corrected before administration to the patient is not a medication error.
The following are categories/examples of medications error:

1. Omission Error: the failure to administer an ordered dose. If the dose is not administered because of patient refusal or recognized contraindications, no error has occurred.

2. Unauthorized Drug: Administration to a patient of a medication dosage not authorized for that patient. I.e., dose given to the wrong patient, duplicate dose, administration of an unordered drug or dose given outside of clinical parameters (med. order to be administered only if the patients's blood pressure falls below a predetermined level).

3. Wrong Dose: Any dose that is a.) wrong number of units (i.e., tabs) or b.) above or below the ordered dose.

4. Wrong Rate: Administration of a drug at the wrong rate.

5. Wrong Route: Administration of a drug by a route other than that ordered.

6. Wrong Dosage Form: Administration of a drug by the correct route, but incorrect form. Example: use of an ophthalmic solution when an ointment was ordered.

7. Wrong Time: Administration of a drug outside of the scheduled administration time.

Whenever a medication error is detected, the patient's primary provider (ARNP,PA, or MD) must be informed immediately. A written report will be initiated by the staff member who made or discovered the error, depending on the circumstances, using the Medication and/or Treatment Error Report Form and submitted to his/her supervisor who will investigate the incident and complete the supervisor portion of the form. The MTER form shall then be routed to the provider involved in the treatment of the patient, for comment. A copy will then be forwarded to the Pharmacy. Each institution will establish a procedure for analyzing each incident. These reports will be forwarded by the Pharmacy to the MC P&T Committee for final review.

See Following page for:

Medication and/or Treatment Error Report Form

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Attachment #6

DEPARTMENT OF CORRECTIONS

NEW EMPLOYEE CHECKLIST

NAME Michael Kalera DATE 6/6/94 POSITION RN 2

OFFICE/INSTITUTION SOC SUPERVISOR Fran Bartley

1. STATEWIDE ACKNOWLEDGMENTS

A. RECEIPT OF HANDBOOK: I acknowledge receipt of the Employee Handbook, Washington State Department of Corrections, and agree to become familiar with and have a thorough knowledge and understanding of the contents.

EmployeeSignature Michael Kalera DATE 6/17/94

B. PERSONNEL POLICY DIRECTIVE ACKNOWLEDGEMENT: I have reviewed and understand that I am responsible for knowing and following the Department of Corrections' Personnel Policy Directives. I was told where the Department Policy Directive Manual is kept and realize that I am expected to be familiar with the manual and to keep current on policy directives. If I have any questions, I understand that I am to contact my supervisor or my personnel officer.

EmployeeSignature _____ DATE _____

C. CONFLICT OF INTEREST DECLARATION: I am not currently related to or residing with any employee of the State who is in my supervisory chain of command or in an adult relationship over or below me. I understand that I must report to my supervisor in writing any current or potential conflict of interest in accordance with the laws of the State of Washington, and local institution/office policies/procedures.

EmployeeSignature Michael Kalera DATE 6/17/94

2. FIELD LOCATION ACKNOWLEDGEMENTS

A. CORRECTIONS ACADEMY: All Correctional Officers will be required to attend the Washington State Criminal Justice Training Commission (CJTC) Corrections Officers Academy, and all Correctional Counselors and Community Corrections Officers will be required to attend the CJTC Correctional Services Academy. I understand that a passing score from the CJTC Academy is required for continued employment. The academies are normally scheduled for a two-week period for counselors and a four-week academy for Correctional Officers. Classes are conducted Monday through Friday, 8:00 a.m. to 5:00 p.m. I understand that, subsequent to the training and/or institution/office training, I will be assigned to my permanent schedule of either day, swing, graveyard, or turnaround shifts with any 2-day period scheduled off.

EmployeeSignature _____ DATE _____

Original: Personnel File
cc: Employee

0721

Attachment #7

DEPARTMENT OF CORRECTIONS – NEW EMPLOYEE CHECKLIST

Name _____

Section A. Personnel/Payroll Forms Completed

Statewide (or N/A)

- X Application
- X Felony Record Disclosure
- X W-4
- X Personnel Questionnaire
- X Employee I.D./Emergency Card
- — Union Enrollment Card
- X Medical/Dental Enrollment
- X LTD Enrollment
- X Life Insurance Enrollment
- X Employee Permanent Record (Retirement Enrollment) Copy of Soc. Sec. card attached.
- X IRCA Form (Identification noted)
- X Acknowledgement of Search
- X Verification of Military Service
- — Intermittent Staff - Informational Letter
- X Orientation Schedule
- X Automatic Deposit Forms
- — _____
- — _____
- — _____
- — _____
- — _____

Section B. Personnel/Payroll Materials Received

Statewide (or N/A)

- X Relationships with offenders policy
- X "A Guide to the Washington State Department of Corrections"
- X Employee Handbook
- X Collective Bargaining Agreement
- X Whistleblower Procedure (10-82 Reed memo)
- X Secretary's Statement on Affirmative Action/Committee
- X Internal Discrimination
- X Non-Discrimination Policy 100.500
- X Equal Employment/Affirmative Action Policy 810.005
- X Sexual Harassment Policy 853.025
- X List of Stewards, officers, Union/Management Committee members (union may provide)
- X Medical/Dental Benefit Newspaper
- X LTD Certificate of Coverage
- X Life Insurance Certificate of Coverage
- X Retirement Newspaper
- X Employee Accessibility Policy
- X Continuation of Medical/Dental Coverage

Statewide (continued)

- ✓ Appointment letter, including status, classification, starting salary/wage, starting date, length of probation, PID, benefits
- ✓ Payroll dates list
- ✓ "Join Us" (Wash. St. Emp. Credit Union)
- ✓ Deferred Compensation pamphlet and memo
- ✓ Nationwide Automobile Insurance pamphlet
- ✓ Nationwide Homeowners Insurance pamphlet
- ✓ Employee Advisory Service pamphlet
- ✓ Drug-Free Work Place Policy
- ✓ Reasonable Accommodation Policy
- ✓ Personal Dry Cleaning Service memo
- ✓ Lawsuit Processing memo
- ✓ Disability Insurance information
- ✓ Cancer Insurance Information
- ✓ Brainstorm form
- — _____
- — _____

The above checked topics have been reviewed with me.

Employee Signature Michael Nelson Date 6/17/94

Dept. Reviewer Signature(s) Linda Gilstrap Date 6/17/94

Date _____

Attachment #7 0723

Name Michael D Kalina
Page 4

I understand it is my responsibility to familiarize myself with the local institution/office policies and procedures, DOC policies and procedures, pertinent post orders, the duties described in my classification questionnaire and the expectations of my work unit.

I understand that the above is not intended to be inclusive but to ensure that basic information is provided.

Employee Signature Michael Kalina Date 6/17/94

Section C. Topics Covered by Personnel/Payroll Office

_____ Paycheck (when, where, overtime, automatic deposit, paydates) (leave and types explained on pay check and according to policy)

_____ Mandatory deductions: OASI, FICA, Retirement, Union, Medical Aid

_____ Copy of Classification Questionnaire Position Number _____

_____ Performance Evaluation Process

_____ Accident Reporting, L & I Claims, Workers' Compensation, Assault Legislation

_____ Intra-Institutional Transfer Requests (Article 9, Transfers, Institution Collective Bargaining Agreement)

_____ Role of Personnel Office

_____ Recruitment Announcements/Applications (promotional opportunities, local list versus Department of Personnel registers)

_____ State employment registers

_____ Affirmative Action/Non-Discrimination/Sexual Harassment

_____ Local of Merit System Rules, Revised Code of Washington, Washington Admisistr Code, Departmental Policies

The above checked topics have been reviewed with me.

Employee Signature _____ Date _____
Dept. Reviewer Signature (s) _____ Date _____
_____ Date _____

0724

Attachment #7

During a telephone conversation initiated by you that night to advise Teresa Bollinger, RN 3, of the situation, she directed you to immediately complete a memo addressed to her describing the incident and events of the evening of 10-14-97 concerning inmate [redacted] Ms. Bollinger also directed you to complete the "Medication and/or Treatment Error Report" form, stating to you that both these documents should be completed prior to your departure from the institution that night.

You failed to complete the "Medication and/or Treatment Error Report" form prior to your departure from the institution the evening of 10-14-97. You also failed to appropriately adhere to policy by not documenting the 8:40 PM dosage of Klonopin on inmate [redacted] medical chart.. An Employee Conduct Report completed 12-5-97 (Attachment #1) describing this incident in greater detail is attached hereto and incorporated herein.

The Department of Corrections Employee Handbook of June, 1993, **CODE OF ETHICS**, page 2, (Attachment #2) states in part:

"High moral and ethical standards among correctional employees are essential for the success of the department's programs. The Department of Corrections subscribes to . . . a commitment to professional and compassionate service."

The DOC Employee Handbook also states, in part, on pages 2 and 3 (Attachment #3) under **DEPARTMENT EXPECTATIONS**:

". . . you will have many things to learn, not the least of which will be the expectations of your supervisor, your co-workers, and the agency as a whole.

As a representative of the Department of Corrections, **you will be expected to:**

Conduct yourself and perform your duties safely."

Twin Rivers Corrections Center (TRCC) Institution Field Instruction TR 610.900 **MEDICATION MANAGEMENT** (Attachment #4) page 4, states, in part:

"Records:

2. Medication Record: All medications distributed or issued by TRCC health services staff are recorded on the individual's medication record, noting medication, dosages, date and time, and staff

initials (see Attachment C). Medication records are a permanent document in the inmate's Health Record."

On page 5 of this same Institution Field Instruction TR 610.900 under CONTROLLED SUBSTANCES MEDICATIONS , it states, in part:

> "6. (RN/LPN) will process controlled substance orders by:
> A. Noting on Medication Record (DOC Form #13-16) (Attachment "C"), the patient's name, number, prescribing authority and inclusive dates of prescriptions."

The Washington State Special Offender Center Health Care Operational Manual Infirmary Procedure (Attachment #5) regarding **MEDICATION AND/OR TREATMENT ERROR** under PROCEDURE states, in part,

"3. The staff person making the error will fill out Medication Error Incident Report (see form attached) before leaving shift.

4. Medication will be charted in the Health Record as given."

The Monroe Command Central Pharmacy Policy and Procedure Manual (Attachment #6) under Q. Medication Errors. states, in part:

"A Medication Error is defined as a dose of medication that deviates from the providers order as written in the patient's chart. . . .The following are categories/examples of medications error:

> 2. Unauthorized Drug: Administration to a patient of a medication dosage not authorized for that patient, i.e. dose given to the wrong patient, duplicate dose, ..."

A written report will be initiated by the staff member who made or discovered the error, depending on the circumstances, using the Medication and/or Treatment Error Report Form and submitted to his/her supervisor who will investigate the incident and complete the supervisor portion of the form."

On June 17, 1994, you signed the New Employee Checklist (Attachment #7) in which you acknowledged receipt for the Washington State Department of Corrections Employee Handbook, agreeing to become familiar with and have a thorough knowledge and understanding of its contents. In this same document, your signature further indicates acknowledgment that you understood you were to be responsible for familiarizing yourself with local institution/office policies and

procedures, including DOC policies and procedures. Copies of the previously identified numbered attachments 2 through 7 are attached hereto and incorporated herein.

As a Registered Nurse 2 at Twin Rivers Corrections Center - Special Offender Center and an employee of the Department of Corrections, you have a duty, responsibility, and obligation to act with a high degree of professionalism in all aspects of performance, especially those aspects related to the accuracy of medical service, safety and well-being of the clientele you serve. You must be aware of and unfailingly adhere to the policies and procedures prescribed to by the Department for the continued success of the programs it manages.

During this incident, you admittedly were responsible for appropriately orienting newly hired RN 2 [redacted] Though she prepared the medications for delivery to specific inmates, you actually administered the 8:40 PM medications. In so doing, you said that you noted what appeared to be a discrepancy in the medication prepared for inmate [redacted] 8:40 PM dosage. However, prior to giving the medication to inmate [redacted], you failed to adequately ensure the accuracy of the prescribed dosage. Consequently, your negligence in not pursuing appropriate follow-through procedures to circumvent a dosage error resulted in the eventual transport of inmate [redacted] to Valley General Hospital for assessment and monitoring of unstable vital signs due to an overdose ingestion of the drug Klonopin 1 mg.

Upon advising RN3 Teresa Bollinger by telephone conversation of the incident involving inmate [redacted], she directed you to complete two actions before leaving the institution that evening. Ms. Bollinger told you to complete a memo addressed to her relative to the incident involving inmate [redacted], as well as complete a Medication and/or Treatment Error Report form. Also, per written policy, you should also have documented the overdose of Klonopin 1 mg. on the individual's medical chart, which you failed to do.

You purposely did not complete either the medical chart entry or the Medication and/or Treatment Error Report prior to leaving the institution on 10-14-97. You stated to Ms. Sigmund during the Administrative Comments review meeting that you were too angry that evening about the situation to be able to collect your thoughts and comply with Ms. Bollinger's directions to you.

By your behavior in this incident you have clearly demonstrated:

1) a neglect of your duty to act professionally and responsibly, thereby placing at risk an individual whose health care you are

charged with providing and protecting from harm to the extent possible within your realm of professional expertise;

2) a neglect of your duty to be responsible for the procedural orientation of a new RN 2 employee and the expectation of that responsibility includes overseeing the accuracy of the new hire's performance of duty;

3) an act of flagrant insubordination in that you consciously chose to ignore your supervisor's directive to complete appropriate documentation of the incident prior to leaving the institution the night of 10-14-97;

4) an act of gross misconduct in that you endangered the health and well-being of an individual in your care by failing to thoroughly research your suspicion relative to the possibility that the 8:40 PM dosage of medication provided by you to inmate [redacted] was inaccurate; and

5) a willful violation of published Institution Field Instruction, the Washington State Special Offender Center Health Care Operational Manual Infirmary Procedure, the Monroe Command Central Pharmacy Policy and Procedure manual, and the Department's Employee Handbook in that you have failed to perform your duties appropriately per the Department's written expectations and rules.

In considering the ramifications suffered by this individual as a direct result of your neglect of duty coupled with the potential magnitude of adverse consequences this type of situation could have additionally presented to an individual in your professional care as well as to the Department as a whole, I have given careful consideration to the severity of sanction I would deem appropriate to address this level of misconduct. A review of your personnel file has moderated my decision relative to severity of sanction and therefore, I have determined to reduce your salary as a Registered Nurse 2 as indicated in paragraph one of this letter.

I must forewarn you that future acts of misconduct could result in further corrective and/or disciplinary action up to and including dismissal.

Under the provisions of Washington Administrative Codes 358-20-010 and 040, you have the right to appeal this action to the Personnel Appeals Board, 2828 Capitol Boulevard, Olympia, Washington, 98504,

within thirty (30) days from the effective date stated in paragraph one of this letter. As an alternative, you may file a grievance under the provisions of Article 10 of the Collective Bargaining Agreement between the Department of Corrections and the Washington Public Employees Association.

The Merit System Rules (WACs), Department of Corrections' policies, Twin Rivers Corrections Center-Special Offender Center Field Instructions and the Collective Bargaining Agreement are available for your review upon request.

Dennis Thaut
Superintendent

DT:sm
Attachments

cc: Jennie Adkins, Human Resources Administrator, Office of Administrative Services
Phil Stanley, NW Regional Administrator, Office of Correctional Operations
Linda Dalton, Senior Assistant Attorney General
Cheryl Landers, NW Area Personnel Manager
Robert Riordan, Personnel Officer
Sandra Moore, Personnel Officer
Personnel File

CC: Sandy Crabs
Reg. Admin

***** CONFIDENTIAL *****

DEPARTMENT OF CORRECTIONS
DISCIPLINARY ACTION AUTHORIZATION

RECEIVED
MAR 11 1998
OFFICE OF THE ATTORNEY GENERAL
LABOR & PERSONNEL DIVISION

Michael T Kalina
Employee's Name

3/9/98
Date Received at Headquarters

Registered Nurse 2
Employee's Job Classification

TRCC-MHC
Employee's Job Location

Sandy Moore/794-2206
Assigned Personnel Officer/Phone #

RECOMMENDED ACTION:

Reduction in Pay: RIP/5% for 3 months/ $ 552.
(Percentage/Length) (Total $ Amount)

Demotion to: _____
(Job Classification)

Suspension: _____ / $
(Length) (Total $ Loss)

Dismissal: _____
(Effective)

4-15-98
Date completed form faxed to PO

The attached disciplinary action has been reviewed as noted below. "This information is provided under the attorney/client relationship and invokes that privilege. It should be considered CONFIDENTIAL in nature."

Initials/Title	Date	Approve	Disapprove	Comments
DHR Director	3/10/98	✓		
AAG Elizabeth Hirsch	3/12/98	✓		any Q's please call — (360) 664-4174. EdL
Appropriate Division Director	4/8/98	✓	10% / 6 month	- Good employee otherwise but this is a very sensitive situation would not be able to sustain discipline when compared to similar actions in past
DOC Secretary	4-13-98	✓	10% 6 mo.	

Please hand deliver to all reviewers and return to Leslie Carrigg, DHR, 8th Floor, upon completion.

0731

Phil –

This involves a potentially life threatening reaction [illegible]

RECEIVED
DEPARTMENT OF CORRECTIONS

APR 07 1998

EVERETT OFFICE

– Nothing prior
– Has occurred w/ other Nurses in Monroe institutions
– Reported to Pharmacy Board
Nursing Board
– Never denied – fully admitted.

CHASE RIVELAND
Secretary

DRAFT

STATE OF WASHINGTON
DEPARTMENT OF CORRECTIONS
SPECIAL OFFENDER CENTER
P.O. Box 514 · Park Place · Monroe, Washington 98272-0514

February , 1998

PERSONAL AND CONFIDENTIAL DELIVERY

Michael T. Kalina
[redacted]

Mr. Kalina:

This is official notification that you will be reduced in salary within your present class of Registered Nurse 2 at the Twin Rivers Corrections Center-Special Offender Center (TRCC-SOC), Range N45, Step P, $3801.00 per month to Step N, $3617.00 per month, effective _____ through _____, inclusive.

This disciplinary action is taken pursuant to the Civil Service Law of Washington State, Chapter 41.06, Revised Code of Washington, and the Merit System Rules, Title 356 Washington Administrative Code (WAC) Section 356-34-010 (1-a) Neglect of duty, (1-d) Insubordination, (1-h) Gross misconduct, (1-i) Willful violation of the published employing agency or department of personnel rules or regulations, and 356-34-020 Reduction in salary - Demotion - Procedure.

Specifically, you neglected your duty, were insubordinate, committed an act of gross misconduct and willfully violated published agency policy when on October 14, 1997, while performing your duties as a Registered Nurse 2, you were responsible for administering an inappropriate dosage (overdose) of the drug Klonopin 1mg to inmate [redacted] Subsequently, after having ingested the overdose of Klonopin 1mg, inmate [redacted] blood pressure was recorded as below that of acceptable baseline. Consequently, later that same night, due to the onset of ongoing unstable vital signs, Linda Fluke, ARNP, directed that inmate [redacted] be transported to Valley General Hospital for a comprehensive evaluation of his condition and continued monitoring.

During a telephone conversation that night to advise Teresa Bollinger, RN 3, of the situation, she directed you to immediately complete a memo addressed to her describing the incident and events of the evening of 10/14/97

0733

DRAFT

concerning inmate [redacted] Ms. Bollinger also directed you to complete the "Medication and/or Treatment Error Report" form, stating to you that both these documents should be completed prior to your departure from the institution that night.

You failed to complete the "Medication and/or Treatment Error Report" form prior to your departure from the institution the evening of 10-14-97. You also failed to appropriately adhere to policy by not documenting the 8:40 pm dosage of Klonopin 1 mg on inmate [redacted] medical chart.. An Employee Conduct Report completed 12-5-97 (Attachment #1) describing this incident in greater detail is attached hereto and incorporated herein.

The Department of Corrections Employee Handbook of June, 1993, **CODE OF ETHICS**, page 2, (Attachment #2) states in part:

"High moral and ethical standards among correctional employees are essential for the success of the department's programs. The Department of Corrections subscribes to . . . a commitment to professional and compassionate service."

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As a representative of the Department of Corrections, **you will be expected to:**

Conduct yourself and perform your duties safely."

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> "6. (RN/LPN) will process controlled substance orders by:
> A. Noting on Medication Record (DOC Form #13-16) (Attachment "C"), the patient's name, number, prescribing authority and inclusive dates of prescriptions."

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"3. · The staff person making the error will fill out Medication Error Incident Report (see form attached) before leaving shift.

4. Medication will be charted in the Health Record as given."

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A written report will be initiated by the staff member who made or discovered the error, depending on the circumstances, using the Medication and/or Treatment Error Report Form and submitted to his/her supervisor who will investigate the incident and complete the supervisor portion of the form."

On June 17, 1994, you signed the New Employee Checklist (Attachment #7) in which you acknowledged receipt for the Washington State Department of Corrections Employee Handbook, agreeing to become familiar with and have a thorough knowledge and understanding of its contents. In this same document, your signature further indicates acknowledgment that you understood you were to be responsible for familiarizing yourself with local institution/office policies and procedures, including DOC policies and procedures. Copies of the previously identified numbered attachments 2 through 7 are attached hereto and incorporated herein.

DRAFT

As a Registered Nurse 2 at Twin Rivers Corrections Center - Special Offender Center and employee of the Department of Corrections, you have a duty, responsibility, and obligation to act with a high degree of professionalism in all aspects of performance, especially those aspects related to the accuracy of medical service, safety and well-being of the clientele you serve. You must be aware of and unfailingly adhere to the policies and procedures prescribed to by the Department for the continued success of the programs it manages.

During this incident, you admittedly were responsible for appropriately orienting newly hired RN 2 [redacted] Though she prepared the medications for delivery to specific inmates, you actually administered the 8:40 pm medications. In so doing, you said that you noted what appeared to be a discrepancy in the medication prepared for inmate [redacted] 8:40 pm dosage. However, prior to giving the medication to inmate [redacted] you failed to adequately ensure the accuracy of the prescribed dosage. Consequently, your negligence in pursuing appropriate follow-through procedures to circumvent a dosage error resulted in the eventual transport of inmate [redacted] to Valley General Hospital for assessment and monitoring of unstable vital signs due to an overdose ingestion of the drug Klonopin 1 mg.

Upon advising RN3 Teresa Bollinger by telephone conversation of the incident involving inmate [redacted], she directed you to complete ~~three~~ actions before leaving the institution that evening. Ms. Bollinger told you to complete a memo addressed to her relative to the incident involving inmate [redacted] as well as complete a Medication and/or Treatment Error Report form. Per written policy, you should ~~also~~ have documented the overdose of Klonopin 1 mg. on the individual's medical chart.

You purposely did not complete either the medical chart entry or the Medication and/or Treatment Error Report prior to leaving the institution on 10-14-97. You stated to Ms. Sigmund during the Administrative Comments review meeting that you were too angry that evening about the situation to be able to collect your thoughts and comply with Ms. Bollinger's directions to you.

By your behavior in this incident you have clearly demonstrated:

1) a neglect of your duty ~~in that you have failed~~ to act professionally and responsibly, thereby placing at risk an individual whose health care you are charged with providing and protecting from harm to the extent possible within your realm of professional expertise;

DRAFT

2) a neglect of your duty ~~in that you were~~ to be responsible for the procedural orientation of a new RN 2 employee ~~and~~ the expectation of that responsibility includes overseeing the accuracy of the new hire's performance of duty;
3) an act of flagrant insubordination in that you consciously chose to ignore your supervisor's directive to complete appropriate documentation of the incident prior to leaving the institution the night of 10-14-97;
4) an act of gross misconduct in that you endangered the health and well-being of an individual in your care by failing to thoroughly research your suspicion relative to the possibility that the 8:40 pm dosage of medication provided by you to inmate [redacted] was inaccurate; and
5) a willful violation of published Institution Field Instruction, the Washington State Special Offender Center Health Care Operational Manual Infirmary Procedure, the Monroe Command Central Pharmacy Policy and Procedure manual, and the Department's Employee Handbook in that you have failed to perform your duties appropriately per the Department's written expectations and rules.

In considering the ramifications suffered by this individual as a direct result of your neglect ~~to~~ duty coupled with the potential magnitude of adverse consequences this type of situation could have additionally presented to an individual in your professional care as well as to the Department as a whole, I have given careful consideration to the severity of sanction I would deem appropriate to address this level of misconduct. A review of your personnel file has moderated my decision relative to severity of sanction and therefore, I have determined to reduce your salary as a Registered Nurse 2 as indicated in paragraph one of this letter.

I must forewarn you that future acts of misconduct could result in further corrective and/or disciplinary action up to and including dismissal.

Under the provisions of Washington Administrative Codes 358-20-010 and 040, you have the right to appeal this action to the Personnel Appeals Board, 2828 Capitol Boulevard, Olympia, Washington, 98504, within thirty (30) days from the effective date stated in paragraph one of this letter. As an alternative, you may file a grievance under the provisions of Article 10 of the Collective Bargaining Agreement between the Department of Corrections and the Washington Public Employees Association.

DRAFT

The Merit System Rules (WACs), Department of Corrections' policies, Twin Rivers Corrections Center-Special Offender Center Field Instructions and the Collective Bargaining Agreement are available for your review upon request.

Dennis Thaut
Superintendent

DT:sm
Attachments

cc: Jennie Adkins, Human Resources Administrator, Office of Administrative Services
Phil Stanley, NW Regional Administrator, Office of Correctional Operations
Michael Sellars, Assistant Attorney General
Cheryl Landers, NW Area Personnel Manager
Robert Riordan, Personnel Officer
Sandra Moore, Personnel Officer
Personnel File

CHASE RIVELAND
Secretary

RECEIVED
MAY 01 1998
Department of Corrections
Division of Human Resources

STATE OF WASHINGTON
DEPARTMENT OF CORRECTIONS
SPECIAL OFFENDER CENTER
P.O. Box 514 · Park Place · Monroe, Washington 98272-0514

April 28, 1998

PERSONAL AND CONFIDENTIAL DELIVERY

Michael T. Kalina
[redacted]

Mr. Kalina:

This is official notification that you will be reduced in salary within your present class of Registered Nurse 2 at the Twin Rivers Corrections Center-Special Offender Center (TRCC-SOC), Range N45, Step P, $3801.00 per month to Step L, $3445.00 per month, effective May 15, 1998 through November 15, 1998, inclusive.

This disciplinary action is taken pursuant to the Civil Service Law of Washington State, Chapter 41.06, Revised Code of Washington, and the Merit System Rules, Title 356 Washington Administrative Code (WAC) Section 356-34-010 (1-a) Neglect of duty, (1-d) Insubordination, (1-h) Gross misconduct, (1-i) Willful violation of the published employing agency or department of personnel rules or regulations, and 356-34-020 **Reduction in salary - Demotion - Procedure.**

Specifically, you neglected your duty, were insubordinate, committed an act of gross misconduct and willfully violated published agency policy when on October 14, 1997, while performing your duties as a Registered Nurse 2, you were responsible for administering an inappropriate dosage (overdose) of the drug Klonopin to inmate [redacted] during the 8:40PM medline. Subsequently, after having ingested the overdose of Klonopin, inmate [redacted] blood pressure was recorded by LPN Leslie Young as below that of acceptable baseline. Consequently, later that same night, due to the onset of ongoing unstable vital signs, Linda Fluke, ARNP, directed that inmate [redacted] be transported to Valley General Hospital for a comprehensive evaluation of his condition and continued monitoring.