Jenny Adkins

RECEIVED
OCT 27 1994
Department of Corrections
Division of Human Resources

STATE OF WASHINGTON
DEPARTMENT OF CORRECTIONS
WASHINGTON CORRECTIONS CENTER FOR WOMEN
P.O. Box 17 MS: WP-04 • 9601 Bujacich Rd. N.W. • Gig Harbor, Washington 98335-0017

October 20, 1994

PERSONAL DELIVERY/CONFIDENTIAL

Beverly D. Traweek
[redacted]

Ms. Traweek:

This is official notification that you will be reduced in pay within your present class of Registered Nurse 2, range N45, Step P, $3,548 per month to step L, $3,216 effective December 1, 1994 through February 28, 1995.

This disciplinary action is taken pursuant to the Civil Service Law of Washington State, Chapter 41.06 RCW, and the Washington Administrative Code, Title 356 WAC (MSR), and Sections 356-34-010 (1) (a) Neglect of duty; (b) inefficiency; and (h) gross misconduct, and 356-34-020 Reduction in salary-Demotion-Procedures.

Specifically, On May 14, 1994 Offender [redacted], DOC# [redacted] who has a heart disease, presented herself to you with complaints of dizziness, lightheadedness and fatigue. In response, you admittedly took her blood pressure and found abnormally low blood pressures (less than 60 in the second figure). Subsequently, you failed to record the offender's complaints or blood pressures in the medical record or chart (Primary Encounter Report, DOC 13-435). Furthermore, you did not inform Dr. Christopher Badger, Medical Duty Officer, of the complaint or low blood pressures. Instead, you dismissed the offender from the clinic, and she returned to her living unit without specific instructions. These incidents are described in more detail in the Employee Conduct Report (ECR) completed on September 8, 1994 which is attached hereto and incorporated herein as Attachment #1.

Minimum Health Record Documentation Requirements effective September 3, 1993 states in pertinent part:

"DEFINITION:

ENCOUNTER: Any face-to-face contact made by a health provider/practitioner (other than those occurring in connection with a group session) with an offender, whether

for diagnostic, therapeutic or instructional purposes, which is sufficiently substantive in nature to require an entry in the clinical record, log or treatment record...

HEALTH RECORD: The record which contains all health-related information about an offender to include, but not limited to, medical, mental and dental health items of an identifying nature, data bases, assessment, treatment plans, diagnosis, treatment, progress, clinical events, and discharge or other summaries...

PROCEDURE:
GENERAL DOCUMENTATION PRINCIPLES: ...

10. At the conclusion of each encounter, the health care provider/practitioner shall document diagnosis, impression, and/or assessment."

You understood it was your responsibility to thoroughly review each section of the health care manual as evidenced by your signature on the signature sheet dated October 30, 1993. Your signature on this sheet certified that you reviewed, understood and could perform each procedure outlined in the Health Care Manual. A copy is attached hereto and incorporated herein as Attachment #2.

As a Registered Nurse(RN) you have a duty to work efficiently, exercise sound medical judgement and comply with standard nursing practices which are a part of any basic nurses training. A trained RN should know that a physician should be made aware of any or all abnormal physical condition(s) found during a patient examination and that it is required to record patient contact (i.e. vital signs) in medical charts and records whenever a patient is examined or treated. Recording requirements and standards were reinforced by clinic practices regarding medical record documentation as published under "Minimum Health Record Documentation Requirements" in the nurses procedures manual at this institution as stated above.

You neglected your duty and were inefficient when you admittedly "forgot" to write the offender's complaints and blood pressure readings in her medical records on May 14, 1994 in order to be in compliance with standard nursing practices and the "Nurses Procedure Manual" located in the clinic. Forgetting to record critical medical information related to the progression of a heart patients condition and treatment places the patient at risk for severe medical complications and thereby cannot be tolerated.

You further neglected your duty, were inefficient and committed an act of gross misconduct when you failed to notify Dr. Badger, the Medical Duty Officer, of the offender's complaints and blood pressure levels. You state that you didn't contact Dr. Badger because the offender had shown abnormally low blood pressure in

the past. But, according to Dr. Badger, your actions could have had serious implications as stated in his memorandum to Donna Morgan dated May 18, 1994 (Attachment #1, page 5 of 9) in pertinent part:

> "...The occurrence of this episode is extremely disturbing because Inmate [redacted] has significant ischemic heart disease for which she receives a variety of medications. The level of her blood pressure was such that she would be at risk for life threatening complication such as a heart attack or a ... (stroke) as injury from a syncopal episode if the low blood pressure continued. Fortunately, Inmate [redacted] is quite insightful regarding her illness and its treatment. She appropriately attributed this low pressure to her medication changes and discontinued the Prozac on her own. Fortunately, this was sufficient to correct the hypotension and there were no adverse consequences. Her blood pressure on May 16, 1994, was 110/80..."

A review of your personnel file was conducted to assist me in determining an appropriate sanction. Overall your work performance was rated "normal" with a few areas assessed as "exceeds". Other information from your personnel record which is pertinent to this review include:

> 1.) Letter of appreciation - reporting for work under extreme weather condition.
> 2.) Letter of commendation - actions resulting in saving a staff's life.

Your work performance has been good in some respects, however there is a previous incident in which you failed to follow established written procedures and demonstrated indifference in complying with those reporting procedures. This incident coupled with your present actions begins to establish a pattern in your behavior which is of concern.

In determining the appropriate disciplinary action in this case, I have weighted both your overall work history and your willingness in assuming responsibility for your conduct as expressed during our meeting on August 18, 1994. Therefore I am persuaded that a reduction in your salary is appropriate for these circumstances.

The delivery of poor Health Care performance which jeopardizes patient care or safety cannot and will not be tolerated at this institution. You are warned that future acts of this nature may result in further disciplinary action including dismissal.

Under the provisions of WAC 358-20-010 and 358-20-040, you have the right to appeal this action to the Personnel Appeals Board. Your appeal must be filed in writing at the Office of the Executive Secretary, Personnel Appeals Board, 2828 Capitol Boulevard, Olympia, Washington 98501, within thirty (30) days

after the effective date stated in paragraph 1 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 and the Washington Public Employees Association/to appeal this action to the Personnel Appeals Board, you may not pursue a grievance over the same issue.

The WACS, Department policies and Collective Bargaining Agreement are available for your review upon request.

Alice Payne
Superintendent

AP:rjt

Attachments

cc: Jennie Adkins, Director, DHR (w/o/a)
Kathy Nolan, Division Chief, Labor & Personnel Division
James Blodgett, Deputy Director, Command B (w/o/a)
Donna Grazzini, Area Personnel Manager, DOC
Robert Turk, Personnel Officer, WCCW
Personnel file

c:wp\displtr\traweek.dl

STATE OF WASHINGTON
DEPARTMENT OF CORRECTIONS
WASHINGTON CORRECTIONS CENTER FOR WOMEN
P.O. Box 17 MS: WP-04 • 9601 Bujacich Rd. N.W. • Gig Harbor, Washington 98335-0017

June 1, 1995

TO: Jennie Adkins, Director, DHR
Kathy Nolan, Division Chief, Labor & Personnel Division
Eldon Vail, Assistant Director, Command B
Donna Grazzini, Area Personnel Manager, DHR

FROM: Robert Turk, Personnel Officer

SUBJECT: Beverly D. Traweek Disciplinary Letter dated October 20, 1994

The subject disciplinary letter has been reissued. Ms. Traweek's pay was not reduced during the period specified in the original letter. The attachments previously provided to you under the original letter remain the same.

Attached is a copy of the revised letter.

RT:jm

Attachment

cc: File

Jennie Adkins

STATE OF WASHINGTON
DEPARTMENT OF CORRECTIONS
WASHINGTON CORRECTIONS CENTER FOR WOMEN
P.O. BOX 17 MS:WP-04 • 9601 Bujacich Rd. N.W. • Gig Harbor, WA 98335-0017

May 26, 1995

CERTIFIED MAIL/CONFIDENTIAL
No. Z 199 508 320

Beverly D. Traweek
[redacted]

Ms. Traweek:

The disciplinary letter issued on October 20, 1994 is cancelled and superseded by this letter. This is official notification that you will be reduced in pay within your present class of Registered Nurse 2, range N45, Step P, $3,548 per month to step L, $3,216 effective June 16, 1995 through September 15, 1995.

This disciplinary action is taken pursuant to the Civil Service Law of Washington State, Chapter 41.06 RCW, and the Washington Administrative Code, Title 356 WAC (MSR), and Sections 356-34-010 (1) (a) Neglect of duty; (b) inefficiency; and (h) gross misconduct, and 356-34-020 Reduction in salary-Demotion-Procedures.

Specifically, On May 14, 1994 Offender [redacted], DOC# [redacted] who has a heart disease, presented herself to you with complaints of dizziness, lightheadness and fatigue. In response, you admittedly took her blood pressure and found abnormally low blood pressures (less than 60 in the second figure). Subsequently, you failed to record the offender's complaints or blood pressures in the medical record or chart (Primary Encounter Report, DOC 13-435). Furthermore, you did not inform Dr. Christopher Badger, Medical Duty Officer, of the complaint or low blood pressures. Instead, you dismissed the offender from the clinic, and she returned to her living unit without specific instructions. These incidents are described in more detail in the Employee Conduct Report (ECR) completed on September 8, 1994 which is attached hereto and incorporated herein as Attachment #1.

Minimum Health Record Documentation Requirements effective September 3, 1993 states in pertinent part:

> "DEFINITION:
>
> ENCOUNTER: Any face-to-face contact made by a health provider/practitioner (other than those occurring in connection with a group session) with an offender, whether for diagnostic, therapeutic or instructional purposes, which is sufficiently substantive in nature to require an entry in the clinical record, log or treatment record...
>
> HEALTH RECORD: The record which contains all health-related information about an offender to include, but not limited to, medical, mental and dental health items of an identifying nature, data bases, assessment, treatment plans, diagnosis, treatment, progress, clinical events, and discharge or other summaries...
>
> PROCEDURE:
> GENERAL DOCUMENTATION PRINCIPLES: ...
>
> 10. At the conclusion of each encounter, the health care provider/practitioner shall document diagnosis, impression, and/or assessment."

You understood it was your responsibility to thoroughly review each section of the health care manual as evidenced by your signature on the signature sheet dated October 30, 1993. Your signature on this sheet certified that you reviewed, understood and could perform each procedure outlined in the Health Care Manual. A copy is attached hereto and incorporated herein as Attachment #2.

As a Registered Nurse(RN) you have a duty to work efficiently, exercise sound medical judgement and comply with standard nursing practices which are a part of any basic nurses training. A trained RN should know that a physician should be made aware of any or all abnormal physical condition(s) found during a patient examination and that it is required to record patient contact (i.e. vital signs) in medical charts and records whenever a patient is examined or treated. Recording requirements and standards were reinforced by clinic practices regarding medical record documentation as published under "Minimum Health Record Documentation Requirements" in the nurses procedures manual at this institution as stated above.

You neglected your duty and were inefficient when you admittedly "forgot" to write the offender's complaints and blood pressure readings in her medical records on May 14, 1994 in order to be in compliance with standard nursing practices and the "Nurses Procedure Manual" located in the clinic. Forgetting to record critical medical information related to the progression of a heart patients condition and treatment places the patient at risk for severe medical complications and thereby cannot be tolerated.

You further neglected your duty, were inefficient and committed an act of gross misconduct when you failed to notify Dr. Badger, the Medical Duty Officer, of the offender's complaints and blood pressure levels. You state that you didn't contact Dr. Badger because the offender had shown abnormally low blood pressure in the past. But, according to Dr. Badger, your actions could have had serious implications as stated in his memorandum to Donna Morgan dated May 18, 1994 (Attachment #1, page 5 of 9) in pertinent part:

> "...The occurrence of this episode is extremely disturbing because Inmate [redacted] has significant ischemic heart disease for which she receives a variety of medications. The level of her blood pressure was such that she would be at risk for life threatening complication such as a heart attack or a ... (stroke) as injury from a syncopal episode if the low blood pressure continued. Fortunately, Inmate [redacted] is quite insightful regarding her illness and its treatment. She appropriately attributed this low pressure to her medication changes and discontinued the Prozac on her own. Fortunately, this was sufficient to correct the hypotension and there were no adverse consequences. Her blood pressure on May 16, 1994, was 110/80..."

A review of your personnel file was conducted to assist me in determining an appropriate sanction. Overall your work performance was rated "normal" with a few areas assessed as "exceeds". Other information from your personnel record which is pertinent to this review include:

1.) Letter of appreciation - reporting for work under extreme weather condition.
2.) Letter of commendation - actions resulting in saving a staff's life.

Your work performance has been good in some respects, however there is a previous incident in which you failed to follow established written procedures and demonstrated indifference in complying with those reporting procedures.

** CONFIDENTIAL *

DEPARTMENT OF CORRECTIONS
DISCIPLINARY ACTION AUTHORIZATION

RECEIVED
OCT 07 1994
OFFICE OF ATTORNEY GENERAL
LABOR & PERSONNEL DIVISION

RECEIVED
Secretary's Office
OCT 17 1994
Department of Corrections

RECOMMENDED ACTION:

10/4/94
Date Received at Headquarters

Reduction in Pay: 10% X 3 mths.
(Percentage/Length)

Beverly Trawick
Employee's Name

Demotion to: _____
(Job Classification)

Registered Nurse 2
Employee's Job Classification

Suspension: _____
(Length)

WCCW
Employee's Job Location

Dismissal: _____
(Effective)

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 JL	10/7/94	✓		Don't see that we've established inefficiency, but otherwise sufficient.
AAG Rise	10/12/94	w/changes		[redacted]
Appropriate Division Director TR	10/17/94	w/ noted changes		
DOC Secretary [signature]	10-18-94	w/ changes		

PLEASE HAND-DELIVER TO ALL REVIEWERS AND RETURN TO KRISTI WALTERS, DHR FLOOR, 8TH FLOOR, UPON COMPLETION.

0611

SUGGESTED CHANGES TO BEVERLY TRAWEEK
DISCIPLINARY LETTER
FROM LYNN WISE

Suggest that [redacted]

TRAWEEK ECR DRAFT

DRAFT

Date

PERSONAL DELIVERY/CONFIDENTIAL

Beverly D: Traweek
[redacted]

RECEIVED
OCT 0 4 1994
Department of Corrections
Division of Human Resources

Ms. Traweek:

This is official notification that you will be reduced in pay within your present class of Registered Nurse 2, range N45, Step P, $3,548 per month to step L, $3,216 effective November 1, 1994 through January 31, 1995.

This disciplinary action is taken pursuant to the Civil Service Law of Washington State, Chapter 41.06 RCW, and the Washington Administrative Code, Title 356 WAC (MSR), and Sections 356-34-010 (1) (a) Neglect of duty; (b) inefficiency; and (h) gross misconduct, and 356-34-020 Reduction in Salary-Demotion-Procedures.

Specifically, On May 14, 1994 Offender [redacted], DOC# [redacted] who has a heart disease, presented herself to you with complaints of dizziness, lightheadedess and fatigue. In response, you admittedly took her blood pressure and found abnormally low blood pressures (less than 60 in the second figure). Subsequently, you failed to record the offender's complaints or blood pressures in the medical record or chart (Primary Encounter Report, DOC 13-435). Furthermore, you did not inform Dr. Christopher Badger, Medical Duty Officer, of the complaint or low blood pressures. Instead, you dismissed the offender from the clinic, and she returned to her living unit without specific instructions. These incidents are described in more detail in the Employee Conduct Report (ECR) completed on September 8, 1994 which is attached hereto and incorporated herein as Attachment #1.

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HEALTH RECORD: The record which contains all health-related information about an offender to include, but not limited to, medical, mental and dental health items of an identifying nature, data bases, assessment, treatment plans, diagnosis, treatment, progress, clinical events, and discharge or other summaries...

PROCEDURE:
GENERAL DOCUMENTATION PRINCIPLES: ...

10. At the conclusion of each encounter, the health care provider/practitioner shall document diagnosis, impression, and/or assessment."

The above requirements were individually distributed to all nurses and placed in the "Nurses Procedure Manual" located in the clinic. The manual is accessible to all clinic staff on all shifts. A copy is attached hereto and incorporated herein as Attachment #2.

[redacted]

As a Registered Nurse(RN) you have a duty to work efficiently, exercise sound medical judgement and comply with standard nursing practices which are a part of any basic nurses training. A trained RN should know that a physician should be made aware of any or all abnormal physical condition(s) found during a patient examination and that it is required to record patient contact (i.e. vital signs) in medical charts and records whenever a

patient is examined or treated. Recording requirements and standards were reinforced by clinic practices regarding medical record documentation as published under "Minimum Health Record Documentation Requirements" in the nurses procedures manual at this institution as stated above.

You neglected your duty and were inefficient when you admittedly "forgot" to write the offender's complaints and blood pressure readings in her medical records on May 14, 1994 in order to be in compliance with standard nursing practices and the "Nurses Procedure Manual" located in the clinic. Forgetting to record critical medical information related to the progression of a ~~patient's~~ heart patient's condition and treatment places the patient at risk ~~of~~ for severe medical complications and thereby cannot be tolerated.

You further neglected your duty, were inefficient and committed an act of gross misconduct when you failed to notify Dr. Badger, the Medical Duty Officer, of the offender's complaints and blood pressure levels. You state that you didn't contact Dr. Badger because the offender had shown abnormally low blood pressure in the past. But, according to Dr. Badger, your actions could have had serious implications as stated in his memorandum to Donna Morgan dated May 18, 1994 (Attachment #1, page 5 of 9) in pertinent part:

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this was sufficient to correct the hypotension and there were no adverse consequences. Her blood pressure on May 16, 1994, was 110/80..."

[redacted]

Dr. Badger considered your actions in the realm of malpractice. I agree, your poor judgement and carelessness jeopardized the offender's health and safety and placed the Department at risk of litigation for negligence in patient care.

[redacted]

A review of your personnel file shows that on May 18, 1993 you received a letter of reprimand because on April 5, 1993 you failed to report an offender complaint that her pregnancy was a result forced sex with an officer at this facility. Although this was not a "nursing standard" per se it demonstrates your indifference to the importance of reporting offender complaints.

[redacted]

To your credit is the fact that you acknowledged your error and accepted responsibility for your actions. This coupled with your sustained good performance record over the past 10 years [redacted] persuaded me not to take a more severe disciplinary action.

[redacted]

~~However, performance that jeopardizes patient care or safety as a result of the delivery of your health care delivery at this institution~~ cannot and will not be tolerated [redacted] ~~and justifies a reduction in your salary~~. You are warned that future acts of this nature may result in further disciplinary action including dismissal.

Under the provisions of WAC 358-20-010 and 358-20-040, you have the right to appeal this action to the Personnel Appeals Board. Your appeal must be filed in writing at the Office of the Executive Secretary, Personnel Appeals Board, 2828 Capitol Boulevard, Olympia, Washington 98501, within thirty (30) days after the effective date stated in paragraph 1 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 and the Washington Public Employees Association/to appeal this action to the Personnel Appeals Board, you may not pursue a grievance over the same issue.

The WACS, Department policies and Collective Bargaining Agreement are available for your review upon request.

Alice Payne
Superintendent

AP:rjt

Attachments

cc: Jennie Adkins, Director, DHR (w/o/a)
Kathy Nolan, Division Chief, Labor & Personnel Division
James Blodgett, Deputy Director, Command B (w/o/a)
Donna Grazzini, Area Personnel Manager, DOC
Robert Turk, Personnel Officer, WCCW
Personnel file

DEPARTMENT OF CORRECTIONS

CORRECTED COPY
EMPLOYEE PROFILE

Name	Classification
TRAWEEK, BEVERLY D.	REGISTERED NURSE 2

Status	Current Range/Step	Amount	PID Date (Affects?)
Permanent	N45/P	$3548	NA

PROPOSED ACTION: _____

DATES From 11 / 1 / 94 To 1 / 31 / 95 No. of Months 3

RANGE/STEP From 45N/P $3548 To 45N/L $3216 ($) 332

TOTAL LOSS ($) 996

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	8/20/84	DATE OF HIRE	No
2	6/24/85	Probationary Appointment	No
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)
8/20/92 to 8/20/93			A,B,C,D,E			A	
1/31/92 to 10/1/92		A	B,C,D,E			A	
11/91 to 1/31/92		C,D	A,B,E			S	
8/20/89 to 2/20/91		A,C	B,D,E			O	
8/20/88 to 8/20/89		C	A,B,D,E			A	
8/20/87 to 8/20/88		C	A,B,D,E			A	
8/20/86 to 8/20/87		D	A,B,C,E			A	
8/20/85 to 8/20/86 8/24/85 to 10/24/85		A,D D,E	B,C,E A,B,C			A P	

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

C. **OTHER DOCUMENTATION (Chronological Order)**

	DATE	CODE*	DESCRIPTION (Note here if included as part of previous disciplinary letter)
1	5/26/94	-	ECR--Jeopardizing patient safety Findings--Misconduct did occur.
2	5/18/93	-	Letter of Reprimand--Failure to complete incident report Result of ECR of 4/12/93
3	4/12/93	-	ECR--Failure to coplete indicent report Findings--Misconduct did occur
4	3/8/90	+	Letter of Appreciation--Reporting for work under extreme weather conditions
5	6/30/88	+	Letter of Commendation--Actions resulting in saving a staff's life.
6			
7			
8			

☐ Above section continued below.

* CODES: (+) = POSITIVE (Letters of commendation, etc.)
(-) = NEGATIVE (Letters of reprimand, etc.)
(=) = NEUTRAL DOCUMENTS (Training certificates, etc. -- only if relevant)

COMMENTS AND/OR SECTIONS CONTINUED FROM PAGE ONE AND/OR PAGE TWO (If needed) . . . .

THIS PROFILE PREPARED BY: Joy Myers, Clerk Typist 3
Signature

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.

OYEE INVOLVED	ORGANIZATIONAL UNIT	
BEV TRAWEEK	Health Care Unit Washington Corrections Center for Women	
TION TITLE	DATE OF INCIDENT	TIME OF INCIDENT
Registered Nurse (RN)	May 14, 1994	day shift ☐ AM ☐ PM

ESCRIPTION OF INCIDENT:

On May 14, 1994, you took a blood pressure on Inmate [redacted], DOC # [redacted] who has a documented strong history of cardiac disorders, and you failed to note it on the patient's health record. Secondly, you did not notify the Medical Duty Officer (MDO) of the blood pressure (88/54) or of the inmate's complaints of dizziness or light-headedness. These acts clearly jeopardizes patient safety and indicates indifference for patient welfare which could ultimately result in a life threatening condition.

ITIATED BY:

ME (PLEASE PRINT)	POSITION TITLE	SIGNATURE	DATE
Chris Addison	RN3	Chris Addison	5/26/94

ITNESS(ES):

ME	POSITION TITLE	SIGNATURE	DATE
ME	POSITION TITLE	SIGNATURE	DATE

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

0620

ATTACHMENT (1) Page 1 of 1

ou will retui the original ...
hris Addison, RN 3, Acting ... 3 Supervisor, within 7 days of ... with your employee statement.

DATE DELIVERED TO EMPLOYEE 5/26/94 BY [signature]

YEE'S STATEMENT:

Signature of Employee: Date:

VISOR'S REPORT: DATE RECEIVED BY SUPERVISOR BY:

See attached

Signature & Title of Supervisor: [signature] Date: 6/10/94

ISTRATIVE COMMENTS: DATE RECEIVED BY OFFICE HEAD 6/11/94 BY: [signature]

meeting was held on August 18, 1994. Present were Ms. Traweek; Julie Ann, WPEA Representative; ob Turk, Personnel Officer; and myself.

s. Traweek admitted she forgot to log the inmate's blood pressure in the inmate's record and n the Primary Encounter Report, DOC 13-435.

acts substantiate misconduct did occur. Corrective/Disciplinary action will be taken.

c: Bev Traweek

copy to Bev 9/13/94

Signature of Office Head: [signature] Date: 9-8-94
Alice Payne, Superintendent

0621

ATTACHMENT (7) Page 3 of 9

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

STATE OF WASHINGTON
DEPARTMENT OF CORRECTIONS
DIVISION OF OFFENDER PROGRAMS
P.O. Box 41127 • Olympia, Washington 98504-1127

August 1, 1994

Supervisory Investigation of an ECR filed by Chris Addison, RN3 on Bev Traweek, RN.

The ECR alleges that Nurse Traweek failed to note the blood pressure reading on inmate [redacted] in the patient's health record, when, in fact, the offender's history had included cardiac problems. In addition, it alleges that she failed to notify the medical duty officer of a blood pressure in the log as 89/46, and in the ECR as 88/54.

Finally, the ECR outlined a failure on the part of Nurse Traweek to register complaints expressed by inmate [redacted] with regard to dizziness and lightheadedness. It was the feeling of the supervising nurse that patient safety, indifference toward patient welfare, and a life-threatening condition all existed as a result of these actions.

On the weekend in question, May 14 and 15, 1994, inmate [redacted] had her blood pressure taken twice on Saturday by Nurse Traweek. Initially a reading of 54/44 was obtained. Subsequently, Nurse Traweek used the wall mounted unit and recorded a reading of 88/54. Nurse Johnson took inmate [redacted] blood pressure on Sunday, with a reading of 60/52. Inmate [redacted] medications had recently been changed, with Prozac being prescribed the previous Thursday. The inmate was concerned about her symptoms, and yet there was no documentation that she had ever been seen, let alone that any blood pressures had been taken.

A memo dated May 18, 1994, by Christopher Badger, Medical Director, to Donna Morgan, Health Care Manager, expressed his strong concerns with regard to the manner in which this case had been handled. Dr. Badger went on to point out that with inmate [redacted] history of heart disease, she was at risk for life-threatening complications, such as heart attack or stroke. Inmate [redacted] herself, discontinued the Prozac which was prescribed for her. Her blood pressure is documented as being 110/80 on May 16, 1994.

In this particular case, the ECR had to be sent to the employee by Certified Mail on May 26, 1994, since she was not able to receive it at home and had some difficulty going to the post office for it, even though advised to do so by Nurse Addison. She indicates that she finally received it Monday, June 6, 1994. Nurse Traweek indicates that during the period in question, she was extremely busy, and while she did enter her findings in the 24-hour-log, she did not enter it in the medical file. She raised question with regard to the severity of the blood pressure problem, since this particular inmate has a chronic history low blood pressure and had not been, in her mind, prescribed any medication for that problem. In reality, the heart disease experienced by inmate [redacted] had led to her to be on several medications, to include: Mediprol, a calcium blocker, Nitrobid, and Prozac. These medications were technically ordered for her heart, and not specifically for hypotension, but they do effect blood pressure and Mediprol is indicated for blood pressure problems.

In summary, it can be concluded that the necessity to repeat the blood pressure test should have led to a contact with the medical duty officer, as well as a review of the file in which it would have been noted that her medications now included Prozac. The prudent course of action was not taken in this case, and therefore it can be concluded that the patient's welfare was jeopardized.

For the record, the union representative for Nurse Traweek has asked that this ECR be dismissed as a result of the institution's failure to meet established time frames associated with the report being delivered to the employee. My investigation of that situation has revealed that the institution met its obligations with regard to that issue.

Robert R. Jones, Ph.D.
Health Care Coordinator
Division of Offender Programs

STATE OF WASHINGTON

DEPARTMENT OF CORRECTIONS

WASHINGTON CORRECTIONS CENTER FOR WOMEN

P.O. BOX 17 MS:WP-04 • 9601 Bujacich Rd. N.W. • Gig Harbor, WA 98335-0017

May 18, 1994

TO: Donna Morgan, Health Care Manager

FROM: Christopher Badger, M.D., Medical Director

SUBJECT: [redacted] DOC #[redacted]

I saw inmate [redacted] on May 16, 1994, for evaluation of her right ankle ulcer which we are treating. At that time she related a very disturbing occurrence over the week-end. According to inmate [redacted] she came to the clinic both on Saturday, May 14, 1994, and Sunday, May 15, 1994, complaining of dizziness, light-headedness and fatigue. She related that her blood pressure was taken by Bev Traweek, RN, with the automatic machine and a reading of 54/44 was obtained. A repeat was 88/54. She was released from the clinic without specific instructions. She continued to be symptomatic and again came to the clinic on Sunday, May 15, 1994. Cindy Johnson, LPN took her blood pressure at that time and it was 60/52. Inmate [redacted] was particularly concerned about these low blood pressures because she had had a change in medication including an increase in a beta blocker lopressor and institution of Prozac therapy both on May 12, 1994. She was again dismissed from the clinic without specific instructions. Of particular concern is that there is no documentation in the chart that indicates the patient was even seen let alone these low blood pressures were taken. I was not informed either Saturday, May 14, 1994, or Sunday, May 15, 1994, that this had occurred.

The occurrence of this episode is extremely disturbing because Inmate [redacted] has significant ischemic heart disease for which she receives a variety of medications. The level of her blood pressure was such that she would be at risk for life threatening complication such as a heart attack or a stoke as well as injury from a syncopal episode if the low blood pressure continued. Fortunately, Inmate [redacted] is quite insightful regarding her illness and its treatment. She appropriately attributed this low pressure to her medication changes and discontinued the Prozac on her own. Fortunately, this was sufficient to correct the hypotension and there were no adverse consequences. Her blood pressure on May 16, 1994, was 110/80.

I believe this is extremely poor nursing practice on the part of both Nurse Traweek and Nurse Johnson. I would consider this malpractice.

CB:jac
IM640396.CB2

0624

DEPARTMENT OF CORRECTIONS
WASHI[illegible]ON CORRECTIONS CENTER FOR W[illegible]N

INCIDENT REPORT

PLACE/AREA OCCURRED Clinic	INMATES INVOLVED [redacted]
DATE/TIME OF INCIDENT 5/14/94	UNIT [redacted]
USE OF FORCE INCIDENT? ☐ YES ☐ NO	
WITNESSES	

DETAILS: (Who was involved, what took place, how did it happen, description of any injuries, damage, use of force, etc. Attach additional sheet, if necessary.)

At approx 0730 Inmate [redacted] requested to have her B/p checked. I checked Inmate [redacted] B/p the first time with the instrument that checks both B/p and pulse at the same time and got an abnormally low B/p so I checked the B/p a second time with the wall mount B/p and got a higher B/p reading. The B/p was 89/46 is in that range. [illegible] has had B/p's this low before so this was not [illegible] to MD

IMMEDIATE ACTION TAKEN:

B/p taken x 2 to verify first reading.

REPORTING STAFF SIGNATURE	TITLE	DATE
[signature]	RN II	5/17/94

ORIGINAL REPORT TO ASSOCIATE SUPERINTENDENT'S OFFICE

DATE/TIME RECEIVED	INCIDENT NUMBER	
INVESTIGATION ASSIGNED TO:	BY	DUE

DISTRIBUTION BY ASSOCIATE SUPERINTENDENT:

- ☐ SUPERINTENDENT
- ☐ SHIFT COMMANDER
- ☐ SAFETY OFFICER
- ☐ INTELLIGENCE OFFICER
- ☐ CLINICAL DIRECTOR
- ☐ OTHER ____________
- ☐ OTHER ____________
- ☐ OTHER ____________

C625

WCCW-SS-98A DOC 23-110 (9/91)

Late Entry for Sunday 5-15-94
0730 BP 80/64.
C Johnson

DATE 5-18-94 | FACILITY WCCW 0430 | PLAN BX

Glucose tolerance test done (1 hr.)
per order Martha Check CPN

Noted 5-18-94 0555 MCheck CPN

DATE 5/19/94 | FACILITY WCCW 0945 | PLAN BX

Late Entry for 5/14/94
B/P 89/14 on Bed Mounted
B/P Machine.
E Hancock RN

5-7-47

5-7-47

5-7-47

DOC 13-435 (REV. 4/91) PRIMARY ENCOUNTER REPORT 0626

5-7-47

	Lopressor 100mg BID x30d.
	[illegible]
	Glucose tolerance test – Tues – 17th
5-12-94 1100 [illegible]	[illegible]

DATE 5/12/94 | FACILITY WCCW | 1645

	PLAN RX
Pt has written & talked about her almost life long depression. Until recently she was unwilling to try Prozac. Today we discussed Prozac & its possible benefits as well as possible side effects.	Prozac 20 mg po q AM x 90d
[illegible]	DC Imipramine 50mg q AM
	Imipramine 200mg q 12N x 3d then 150mg q 12N x 3d then 100mg q 12N x 3d then 50mg q 12N x 3d, then DC.
5/12/94 [illegible] RC	RTC 5/24

5-7-47

DATE 5/16/94 | FACILITY WCCW | 98.2 – 110/80 | 206 lb

	PLAN RX
S "my Rt. ankle is hurting worse!"	Silvadene & DSD BID to ankle.
Dizzy In twice over weekend for dizziness, light headedness, fatigue	
BP taken Sat 70/44 Sun 60/54	
Stopped taking Prozac with improvement	
Still taking Lopressor at 100mg BID	Pt has meds
O. Ulcer lag. on Rt ankle.	D/C Prozac
Large; New ratios [illegible]	
A. Ulcer	Return to get
P. Lay in 5 days. RTC on Friday	

DOC 13-435 (REV. 4/91) PRIMARY ENCOUNTER REPORT 0627

J. [illegible] RC 5-16-94 @ 1400

[illegible] RN 0800 5/17/94

purposes of this section and the persons entitled to immunity shall include:

(i) An approved monitoring treatment program;

(ii) The professional association operating the program;

(iii) Members, employees, or agents of the program or association;

(iv) Persons reporting a license holder as being impaired or providing information about the license holder's impairment; and

(v) Professionals supervising or monitoring the course of the impaired license holder's treatment or rehabilitation.

(b) The immunity provided in this section is in addition to any other immunity provided by law.

(8) In addition to health care professionals governed by this chapter, this section also applies to pharmacists under chapter 18.64 RCW and pharmacy assistants under chapter 18.64A RCW. For that purpose, the board of pharmacy shall be deemed to be the disciplining authority and the substance abuse monitoring program shall be in lieu of disciplinary action under RCW 18.64.160 or 18.64A.050. The board of pharmacy shall adjust license fees to offset the costs of this program. [1991 c 3 § 270; 1988 c 247 § 2.]

*Reviser's note: The term "approved treatment facility" was changed to "approved treatment program" by 1989 c 270 § 3, and is defined in RCW 70.96A.020(3).

Legislative intent—1988 c 247: "Existing law does not provide for a program for rehabilitation of health professionals whose competency may be impaired due to the abuse of alcohol and other drugs.

It is the intent of the legislature that the disciplining authorities seek ways to identify and support the rehabilitation of health professionals whose practice or competency may be impaired due to the abuse of drugs or alcohol. The legislature intends that such health professionals be treated so that they can return to or continue to practice their profession in a way which safeguards the public. The legislature specifically intends that the disciplining authorities establish an alternative program to the traditional administrative proceedings against such health professionals." [1988 c 247 § 1.]

18.130.180 Unprofessional conduct. The following conduct, acts, or conditions constitute unprofessional conduct for any license holder or applicant under the jurisdiction of this chapter:

(1) The commission of any act involving moral turpitude, dishonesty, or corruption relating to the practice of the person's profession, whether the act constitutes a crime or not. If the act constitutes a crime, conviction in a criminal proceeding is not a condition precedent to disciplinary action. Upon such a conviction, however, the judgment and sentence is conclusive evidence at the ensuing disciplinary hearing of the guilt of the license holder or applicant of the crime described in the indictment or information, and of the person's violation of the statute on which it is based. For the purposes of this section, conviction includes all instances in which a plea of guilty or nolo contendere is the basis for the conviction and all proceedings in which the sentence has been deferred or suspended. Nothing in this section abrogates rights guaranteed under chapter 9.96A RCW;

(2) Misrepresentation or concealment of a material fact in obtaining a license or in reinstatement thereof;

(3) All advertising which is false, fraudulent, or misleading;

(4) Incompetence, negligence, or malpractice which results in injury to a patient or which creates an unreasonable risk that a patient may be harmed. The use of a nontraditional treatment by itself shall not constitute unprofessional conduct, provided that it does not result in injury to a patient or create an unreasonable risk that a patient may be harmed;

(5) Suspension, revocation, or restriction of the individual's license to practice the profession by competent authority in any state, federal, or foreign jurisdiction, a certified copy of the order, stipulation, or agreement being conclusive evidence of the revocation, suspension, or restriction;

(6) The possession, use, prescription for use, or distribution of controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes, diversion of controlled substances or legend drugs, the violation of any drug law, or prescribing controlled substances for oneself;

(7) Violation of any state or federal statute or administrative rule regulating the profession in question, including any statute or rule defining or establishing standards of patient care or professional conduct or practice;

(8) Failure to cooperate with the disciplining authority by:

(a) Not furnishing any papers or documents;

(b) Not furnishing in writing a full and complete explanation covering the matter contained in the complaint filed with the disciplining authority; or

(c) Not responding to subpoenas issued by the disciplining authority, whether or not the recipient of the subpoena is the accused in the proceeding;

(9) Failure to comply with an order issued by the disciplining authority or an assurance of discontinuance entered into with the disciplining authority;

(10) Aiding or abetting an unlicensed person to practice when a license is required;

(11) Violations of rules established by any health agency;

(12) Practice beyond the scope of practice as defined by law or rule;

(13) Misrepresentation or fraud in any aspect of the conduct of the business or profession;

(14) Failure to adequately supervise auxiliary staff to the extent that the consumer's health or safety is at risk;

(15) Engaging in a profession involving contact with the public while suffering from a contagious or infectious disease involving serious risk to public health;

(16) Promotion for personal gain of any unnecessary or inefficacious drug, device, treatment, procedure, or service;

(17) Conviction of any gross misdemeanor or felony relating to the practice of the person's profession. For the purposes of this subsection, conviction includes all instances in which a plea of guilty or nolo contendere is the basis for conviction and all proceedings in which the sentence has been deferred or suspended. Nothing in this section abrogates rights guaranteed under chapter 9.96A RCW;

(18) The procuring, or aiding or abetting in procuring, a criminal abortion;

(19) The offering, undertaking, or agreeing to cure or treat disease by a secret method, procedure, treatment, or medicine, or the treating, operating, or prescribing for any health condition by a method, means, or procedure which the licensee refuses to divulge upon demand of the disciplining authority;

MINIMUM HEALTH RECORD DOCUMENTATION REQUIREMENTS

PURPOSE:

1. To serve as a basis for documentation, planning patient care and to insure continuity in evaluations of offender condition and treatment. The health record shall contain all significant health information as related to inpatient care, outpatient care, emergency care, dental care and treatment, mental health care/assessment, specialty consultations, other related health information.
2. The record shall contain sufficient information to identify, support the diagnosis, justify the treatment and document the results accurately, and in a timely manner.
3. To furnish documented evidence of the course of the offender's medical/dental/mental health care treatment and changing conditions during the offender's period of incarceration.
4. To provide a vehicle of communication between the providers/practitioners and other health care staff who contribute to the offender's well-being.
5. To assist and protect the legal interest of offenders, the institution, and the Health Care Unit staff responsible for the offender's health care.
6. To provide a comprehensive health information system and additional health data when requested for outside resources.
7. To provide data for continuing education of Health Care Unit staff and research for audits and studies.
8. To insure the maximum possible information is available for the professional Health Care Unit staff providing care using a unit records system.

DEFINITION:

ENCOUNTER: Any face-to-face contact made by a health provider/practitioner (other than those occurring in connection with a group session) with an offender, whether for diagnostic, therapeutic or instructional purposes, which is sufficiently substantive in nature to require an entry in the clinical record, log or treatment record."

HEALTH CARE: The parts or sums of all actions taken to provide for the medical, dental, or mental health or an offender to include preventive, assessment, and therapeutic.

HEALTH CARE PROVIDER: A person licensed by the state to provide health care or related services including, but not limited to, dentist, dental hygienist, nurse, optometrist, podiatrist, chiropractor, physical therapist, occupational therapist, psychologist, pharmacist, and optician.

PRACTITIONER: A licensed physician or mid-level practitioner (PA-C, PA, or ARNP).

HEALTH RECORD: The record which contains all health-related information about an offender to include, but not limited to, medical, mental and dental health items of an identifying nature, data bases, assessment, treatment plans, diagnosis, treatment, progress, clinical events, and discharge or other summaries.

INPATIENT: An individual receiving room, board, and continuous general nursing service.

OUTPATIENT: An individual receiving, in person, sick call/outpatient clinic based health care services for which the Health Care Unit is responsible.

PROCEDURE:

GENERAL DOCUMENTATION PRINCIPLES:

1. Health record shall be identified by offender name and DOC number.
2. Documented notes shall include the date and time.
3. All entries shall be documented in the SOAP format. (Subjective, objective, assessment, and plan).
4. Vital signs shall be taken on all offenders unless being seen only for treatment such as ear wash, dressing change, etc.
5. Weigh each offender to establish baseline weight.
6. Time and date of laboratory tests and/or x-rays shall be documented as well as the specific test(s).
7. Date of last tetanus shall be documented whenever there is a break in the skin.
8. Allergy status should be clearly identified on the problem list of each offender, as well as on the outside of the health record, and medication records.
9. Note the mode of arrival and departure to the clinic when applicable (i.e., ambulance, wheelchair, gurney, etc.).
10. At the conclusion of each encounter, the health care provider/practitioner shall document diagnosis, impression, and/or assessment.
11. Follow-up plans shall be documented and shall include any verbal or written instructions the offender received.
12. Staff shall document disposition of offender i.e., living unit, community hospital, etc.
13. An informed consent shall be completed and signed for any invasive procedure unless the situation is declared an emergency. The attending practitioner is responsible to inform the offender of a procedure or treatment and document this activity.
14. Offenders shall receive initial health screening at time of entry into the facility including but not limited to:
    a. Inquiry regarding present health status.
    b. Review medical requirements.
    c. Review available health record(s).

d. Physical assessment for recent trauma or sign of illness.
e. Limited mental status examination for obvious psychological disorders, alterations in level of conscious, or conditions needing close observation.
f. Screen for communicable diseases.

15. Record all trips to and from outside consultants, emergency treatments, etc. Include time left and time returned.

MEDICATION ORDERS:

1. Transcription to medication card: The drug will be identified by the name, strength, dose, date of order, prescriber, start and stop date, and the initials of the transcribing nurse. The signature identification slot must identify the nurses initials.
2. A prescription renewal or extension shall be considered a new order and will be transcribed as above in section 2.
3. Whenever a choice of doses is given i.e. 50 to 75 mg, it must be written as two separate orders with a specific reason for each order (i.e. Demerol 50 mg po for pain, Demerol 75 mg po for severe pain).
4. All prn medications must state the reason prescribed (i.e. Motrin 60 mg po q6h prn headache). The Motrin may not be administered for any other reason.
6. All medication cards must indicate any known allergies to medication.
7. All medication orders must have the practitioners signature and title within the segment of the form sent to the Pharmacy.
8. Document sites of all medications given by injection on the medication record.

PRACTITIONER ORDERS:

1. All orders will be noted by a full signature and title, date and time of the nurse "noting the order". With multiple orders, each order must be checked.
2. All telephone calls to a health care provider/practitioner regarding an offender's condition will be documented in the progress notes or primary encounter reports with the reason for the call. The provider's/practitioner's response will be written as a telephone order. Note date, time, health care provider's/practitioner's name and title, what was communicated in regards to verbal orders, follow-up, etc.
3. All verbal and telephone orders will be signed by the practitioner within 24 hours. It is a nursing responsibility to obtain this signature.
4. Carefully document all questions and/or concerns on orders and note that this has been discussed with the attending practitioner.

5. The practitioners orders must be written clearly, legibly, and completely. The use of "renew", "repeat", and "continue orders" are not acceptable.

PROGRESS NOTES OR ENCOUNTER NOTE

1. All documentation will be done in the SOAP format.
2. All entries will be dated, timed, and signed with a full signature and title.
3. All entries will be written in ink (preferably black).
4. No portion of the health record is to be obliterated, ~~erased~~, altered or destroyed. No white-out or correction tape will be used in the medical record.
5. No blank spaces are to be left on forms designated for chronological sequential notes.
6. Each form must have the patient identification including last name, first name, and DOC number. On forms perforated in sections, each segment must be identified.
7. All entries must identify the facility.
8. If it becomes necessary to document out of sequence during a normal shift, document the date, and time of occurrence as well as the actual time of entry.
9. When documenting an entry at a later date, clearly identify the date and time of the entry. Write "Late entry" and date and time of occurrence (i.e. 3/10/93 2:00 pm late entry for 3/9/93 1:00 pm).
10. Do not document an entry before an event occurs.
11. Write a concise and accurate record of nursing care administered. Document pertinent observations, psychosocial and physical manifestations, incidents, unusual occurrences and abnormal behavior. Document non-compliance with medications or treatments.
12. Document all refusals of treatments on DOC form 13-48. In addition, chart on the progress notes or primary encounter record the exact instructions given to the patient or the likely medical consequences of the refusal. Cite the specific medication or treatment refused.
13. Sign the bottom of every page when a progress note continues onto a second page. Repeat date, time and continued on the second page.
14. Document facts; avoid generalizations, vague comments, speculation and suppositions.
15. Avoid flippant remarks, judgmental remarks, and remarks intended to settle grudges.
16. Use only approved DOC abbreviations.
17. Document precautionary, protective, or preventive measures and teaching efforts.

18. Document medication errors, notification of health care provider/practitioner and patient condition and follow-up. Complete all reports and/or forms required by DOC Policy or Field Instructions.

19. Correcting errors.
    1. Draw single line through error.
    2. Initial and date.
    3. Chart corrected information.
    4. Do not write the word "error".
20. An entry is documented each time the responsible health care provider/practitioner is contacted by telephone, requests information from another source, etc. regarding the offender's condition. The note shall include:
    a. Date.
    b. Time.
    c. What was communicated.
    d. Instructions given.
    e. Follow-up as appropriate.

MISCELLANEOUS FORMS AND CHARTING

1. Initiate Health Status Report form DOC 13-41 on all patients requiring some exception to rules because of medical condition, or for equipment issued, pre-op or post-op instructions, discharge instructions, food handlers clearance or health status change.
2. Initiate Communicable Infectious Disease form DOC 13-163 for all patients on precaution and/or isolation according to DOC policy 670.016.
3. Initiate Incident Report (DOC 23-110) for all altercations, "inmate down" calls, unusual behaviors, accidental injuries. Also, Field Instruction 400.301 must be followed and forms completed.
4. Initiate Labor and Industries forms and complete A Report of Employee Personal Injury DOC 3-133 when appropriate.
5. Initiate consultation report for inmates going to community facilities for consultation, or emergency trips to emergency room. Each Consultation Request/Report shall contain a written opinion by the requestor/consultant that reflects, when appropriate, an actual examination of the offender and impression/diagnosis. All diagnostic/therapeutic procedures are recorded and authenticated in the health record. When a Consultation Request is completed, the report shall be reviewed and initialed by the requesting health care provider prior to being filed in the health record.
6. Record PPD, VDRL, TB testing on problem list.
7. A written consent DOC 13-35 is required for the release of medical information unless otherwise authorized by the Uniform Health Care Information Act to receive information.

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8. An Informed consent form 13-250 must be completed prior to any surgical procedures. The attending health care provider/practitioner is responsible to inform the offender of the procedure and complete the form. Each appropriate section of the Informed Consent form shall be completed to verify the offender has been informed and agrees to the procedure/treatment. Changes on the Informed Consent form shall be acknowledged by the offender's signature or initials.
9. Health Record of Inmate in Transit 13-22 is required on all inter-institutional transfers.
10. The Informed Consent form DOC 13-138 is required prior to all HTLV III testing.
11. Original reports of pathology, lab tests, radiology reports, treatment reports, and other diagnostic/therapeutic reports shall be filed in the health record. All original reports must be reviewed and initialed by the requesting provider/practitioner prior to being filed.

INPATIENT REQUIREMENTS

1. An admission note is required by the practitioner and nurse for each admission. The condition of the offender being admitted shall be clearly described.
   a. The admission note shall be completed by the admitting practitioner and done at the time of admission.
   b. For administrative/custody admission, floor staff can complete the necessary note.
2. An admission note shall include, but is not limited to:
   a. Identification of problem/mental health status.
   b. Date of onset and details of present problem including the offender's emotional/behavior status.
   c. Any findings related to the problem.
   d. Factual information related to the problem.
   e. Admitting diagnosis.
   f. Initial treatment plan.
3. If the offender is being readmitted with the same diagnosis within one month of discharge date, an interim note is sufficient.
4. A complete History & Physical shall be completed for each admission over 72 hours. This is done by an approved designated practitioner. If the offender is being readmitted within one month of discharge date, an interim note is sufficient.
5. For an offender on the unit less than 72 hours, the Short Stay form DOC 13-85 shall be used and completed.
6. A discharge note, discharge summary, and face sheet, must be completed by the attending practitioner.

The discharge summary and face sheet are self-explanatory and each point shall be completed for all admissions over 72 hours.

The progress note should include a concise recapitulation of the care and response to treatment for the offender's stay.

All relevant diagnoses established by the time of discharge shall be recorded, using acceptable terminology that includes etiology, as appropriate.

7. Inpatient unit staff shall also do a final discharge note. Information should include, but is not limited to:
   a. Condition of offender on discharge in terms that permit a specific measurable comparison with the condition on admission. Vague, relative terminology, such as "improved" should be avoided.
   b. All instructions given to the offender relating to physical activity, restrictions, medication, diet, and follow-up care.
   c. Identify the living unit the offender is being transferred to.
8. A comprehensive discharge summary is not required on the patients admitted for less than 72 hours. The Short Stay form DOC 13-85 should be completed including the Short Stay discharge summary.
9. Progress and response to treatment should be documented within 24-48 hours of admission and authenticated by the admitting practitioner.
10. Progress notes should be made at least daily and more frequently, if necessary, on serious cases and no less than every 48 hours for patients that are under continuous care. Offenders that are placed in the inpatient units as boarders or for housing to accommodate special needs such as stairs, but require little service, minimal charting will be required. If served meals, medication, etc. charting can be done on the flow sheet.
11. Entries in the progress note section should include but are not limited to:
    a. Pertinent observations and problems.
    b. Source.
    c. Incidents.
    d. Unusual occurrences.
    e. Psychological changes.
    f. Abnormal behavior.
    g. any physical problems or significant physical findings.
    h. When health education is provided, it should be noted in the progress notes.
    i. Other.

12. A note covering the transfer of responsibility shall be entered on the progress note or the inpatient orders.
13. All patients admitted to the inpatient unit will be seen within 24 hours by the admitting physician and every day of hospitalization except the day of discharge.
14. A provisional diagnosis or valid reason for admission shall be recorded at the time of admission except in emergencies. In the case of an emergency such statement shall be recorded as soon as possible.
15. The attending practitioner is required to document the need for continued hospitalization. The documentation must contain: a. Written record of the reason for continued hospitalization. A simple reconfirmation of the patient's diagnosis is not sufficient.
    b. The estimated period of time the patient will need to remain in the hospital.
    c. Plans for post-discharge care.
16. Patients shall be discharged only on a written order of the provider.

INPATIENT NURSING SERVICES

1. A complete health record will be initiated on all inpatient unit admissions.
2. A nursing history and physical will be completed on all admissions.
3. A nursing care plan will be initiated on admission.
4. Nursing staff will chart notes on each patient at least every shift and whenever else necessary.
5. A nursing admission note will be done by the admitting nurse.
6. A nursing admission/discharge plan will be done on the nursing history and assessment form.
7. All new admissions will have vital signs, height and weight charted on the general purpose flow sheet DOC 13-422. If a weight is not possible, a "stated" weight should be charted. Obtain the weight as soon as the medical condition permits.
8. All patients on special diets will have at least a weekly weight recorded on the general purpose flow sheet.
9. All patients on antibiotics will have a temperature recorded every shift during the course of the antibiotics and for 24 hours after the discontinuance of the medications.
10. All patient with intravenous fluid administration, nasogastric feedings, or urinary catheters will have intake and output recorded on the general purpose flow sheet.

When administering an IV the following shall be documented:
a. Amount of solution/medication dose.
b. Site of injection.
c. Type of needle or catheter.
d. Medications added.

e. Rate of flow.
f. Changes in the rate of flow.
g. Change of site and reason.
h. Document vital signs that are taken prior to administration of medication and changes in vital signs as a result of medication.
i. Changes to IV tubing, blood filters, etc. are noted by nursing staff.
j. When documenting IV medication use only approved symbols and abbreviations when charting or transcribing practitioners orders.

Document any adverse reaction experienced as a result of medication or IVs including but not limited to:

a. Infiltration.
b. Rashes.
c. Other.

Notify the attending practitioner immediately if there is an adverse reaction and chart this notification.

When a medication error is made:

a. Document the occurrence in a factual way in the health record.
b. Document observation of the offender's condition.
c. Document the notification of the provider in the inpatient health record.
d. An Accident/Incident Report (DOC 13-42) form shall always be completed and submitted to the immediate supervisor. **An incident report shall never be filed in the health record.** Field Instruction 400.301 shall be followed to complete the Institution Incident Report.

11. All patients admitted on diuretics will have a daily weight recorded on the general purpose flow sheet.
12. All diabetics will have a record of each meal recorded on the general purpose flow sheet.
13. Add patients on hypertensive medication will have at least a daily blood pressure recorded on the general purpose flow sheet.
14. All patients who have goals in nursing care plans to increase or decrease dietary intake will have intake recorded on general purpose flow sheet.
15. Routine vital signs will be noted on every shift and documented on the general purpose flow sheet.
16. All patients on mechanical restraints will have documentation of who gave the order, type, time of application, observation and removal time. Leather restraints require every 15 minute observation and charting.
17. All discharged patients must have a record of all discharge instructions given to the patient and patients acceptance and understanding of those instructions charted on the progress

notes. Written instructions are given to the patient on DOC form DOC 13-41 Health Status Report. Have patient sign the form and place a copy in the medical record.

18. All prn medications or treatments given must have a corresponding note on the progress sheet with the result of the medication or treatment as given.
19. All care plan revisions, updates, or amendments, or discontinuations of goals should have a corresponding note on the patient care plan.

OUTPATIENT NURSING SERVICES

1. All sick call appointments and emergencies will have vital signs, blood pressure, and weight recorded.
2. All emergency triage will contain documentation of encounter in SOAP format.
3. All appointments the patient does not keep will have a progress note entry, date, time, "no show", full signature and title of person making entry.
4. All "inmate down" situations require an incident report.
5. Medication cards will be checked weekly for non-compliance. A memo will be sent to the practitioner with a copy to the nursing supervisor and health care manager.
6. All laboratory draws will be documented on the laboratory log sheet.
7. All inmates presenting to the Outpatient Clinic as an emergency shall have an appropriate nursing note charted, even if it is decided that no emergency exists and she is not seen by a practitioner. If required, the MOD shall be contacted for orders and follow-up care.

Submitted By:

Approved By:

Effective September 3, 1993

cc: Donna Morgan, Health Care Manager
Philip Stubenrauch, MD
Gary Hurlburt, PA-C
Sene Stankovic, PA
Shelly Petrinovich, RN3 Nursing Supervisor
Chris Addison, RN3 Infection Control
Health Records Staff
~~Nursing Staff~~
Nurses Procedure Manual
~~Sue Beck, Secretary~~

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

STATE OF WASHINGTON

PERSONNEL APPEALS BOARD

(360) 586-1481
FAX (360) 753-0139

cc: C-APM PO

September 19, 1995

Marion G. M. Leach
124 10th Avenue S.W.
Olympia, Washington 98501

Re: Beverly Traweek v. Department Of Corrections, Reduction-In-Salary Appeal, Case No. RED-95-0036

Dear Ms. Leach:

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 September 19, 1995.

Sincerely,

Kenneth J. Latsch
Executive Secretary

KJL/gmh

Enclosure

cc: Beverly Traweek, APP
Lynn Wise, AAG
Jennie Adkins, PO
Rick Hall, WPEA

BEFORE THE PERSONNEL APPEALS BOARD

STATE OF WASHINGTON

BEVERLY TRAWEEK, Appellant, v. DEPARTMENT OF CORRECTIONS, Respondent.	Case No. RED 95-0036 MOTION AND ORDER OF DISMISSAL

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

DATED September 11, 1995.

MARION G. M. LEACH, WSBA #15201
Attorney for Appellant
WPEA Staff Attorney

This matter came on regularly before the Personnel Appeals Board on the consideration of the request of the Appellant to withdraw her appeal. The Board having reviewed the files and

MARION G. M. LEACH
WPEA Staff Attorney
Washington Public Employees Association
124 10th Avenue S.W.
Olympia, Washington 98501
Telephone 943-1121

records herein, being fully advised in the premises, and it appearing to the Board that the Appellant has requested to withdraw her appeal, now enters the following:

ORDER

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

DATED this 19th day of September, 1995.

WASHINGTON STATE PERSONNEL APPEALS BOARD

(sj/btl-mod/s-m-7/9-11-95)

MARION G. M. LEACH
WPEA Staff Attorney
Washington Public Employees Association
124 10th Avenue S.W.
Olympia, Washington 98501
Telephone 943-1121

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

STATE OF WASHINGTON
PERSONNEL APPEALS BOARD

(360) 586-1481
FAX (360) 753-0139

WCCC
C-APM
PO

September 19, 1995

Marion G. M. Leach
124 10th Avenue S.W.
Olympia, Washington 98501

Re: Beverly Traweek v. Department Of Corrections, Reduction-In-Salary Appeal, Case No. RED-95-0036

Dear Ms. Leach:

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 September 19, 1995.

Sincerely,

Kenneth J. Latsch
Executive Secretary

KJL/gmh

Enclosure

cc: Beverly Traweek, APP
Lynn Wise, AAG
Jennie Adkins, PO
Rick Hall, WPEA

0643

BEFORE THE PERSONNEL APPEALS BOARD

STATE OF WASHINGTON

BEVERLY TRAWEEK, Appellant, v. DEPARTMENT OF CORRECTIONS, Respondent.	Case No. RED 95-0036 MOTION AND ORDER OF DISMISSAL

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

DATED September 11, 1995.

MARION G. M. LEACH, WSBA #15201
Attorney for Appellant
WPEA Staff Attorney

This matter came on regularly before the Personnel Appeals Board on the consideration of the request of the Appellant to withdraw her appeal. The Board having reviewed the files and

644

MARION G. M. LEACH
WPEA Staff Attorney
Washington Public Employees Association
124 10th Avenue S.W.
Olympia, Washington 98501
Telephone 943-1121

records herein, being fully advised in the premises, and it appearing to the Board that the Appellant has requested to withdraw her appeal, now enters the following:

ORDER

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

DATED this 19th day of September, 1995.

WASHINGTON STATE PERSONNEL APPEALS BOARD

(sj/btl-mod/s-m-7/9-11-95)

MARION G. M. LEACH
WPEA Staff Attorney
Washington Public Employees Association
124 10th Avenue S.W.
Olympia, Washington 98501
Telephone 943-1121

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

STATE OF WASHINGTON
PERSONNEL APPEALS BOARD

Department of Corrections
Division of Human Resources
(360) 586-1481
FAX (360) 753-0139

RECEIVED
SEP 21 1995

C-APM
PO

September 19, 1995

Marion G. M. Leach
124 10th Avenue S.W.
Olympia, Washington 98501

Re: Beverly Traweek v. Department Of Corrections, Reduction-In-Salary Appeal, Case No. D94-177

Dear Ms. Leach:

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 September 19, 1995.

Sincerely,

Kenneth J. Latsch
Executive Secretary

KJL/gmh

Enclosure

cc: Beverly Traweek, APP
Lynn Wise, AAG
Jennie Adkins, PO
Rick Hall, WPEA

0646

BEFORE THE PERSONNEL APPEALS BOARD

STATE OF WASHINGTON

BEVERLY TRAWEEK, Appellant, v. DEPARTMENT OF CORRECTIONS, Respondent.	No. D94-177 MOTION AND ORDER OF DISMISSAL

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

DATED September 11, 1995.

MARION G. M. LEACH, WSBA #15201
Attorney for Appellant
WPEA Staff Attorney

This matter came on regularly before the Personnel Appeals Board on the consideration of the request of the Appellant to withdraw her appeal. The Board having reviewed the files and

647
MARION G. M. LEACH
WPEA Staff Attorney
Washington Public Employees Association
124 10th Avenue S.W.
Olympia, Washington 98501
Telephone 943-1121

records herein, being fully advised in the premises, and it appearing to the Board that the Appellant has requested to withdraw her appeal, now enters the following:

ORDER

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

DATED this 19th day of September, 1995.

WASHINGTON STATE PERSONNEL APPEALS BOARD

(sj/b12-mod/s-m-7/9-11-95)

0618

MARION G. M. LEACH
WPEA Staff Attorney
Washington Public Employees Association
124 10th Avenue S.W.
Olympia, Washington 98501
Telephone 943-1121

BEFORE THE PERSONNEL APPEALS BOARD

STATE OF WASHINGTON

BEVERLY TRAWEEK, Appellant, vs. DEPARTMENT OF CORRECTIONS, Respondent.	Case No. RED 95-0036 NOTICE OF SCHEDULING APPELLANT'S MOTION FOR SUMMARY JUDGMENT

Notice is hereby given of scheduling the hearing on the appeal before the Personnel Appeals Board. The hearing will be held in the Personnel Appeals Board Hearing Room, 2828 Capitol Boulevard, Olympia, Washington, on **Monday, September 11, 1995, beginning at 1:30 p.m.**

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 17th day of July, 1995.

WASHINGTON STATE PERSONNEL APPEALS BOARD

Kenneth J. Larsch, Executive Secretary
(360) 586-1481 or SCAN 321-1481

cc: Beverly Traweek, Appellant
Marion G.M. Leach, Attorney
Lynn Wise, AAG
Rick Hall, WPEA
Jennie Adkins, DOC

0619

Personnel Appeals Board
2828 Capitol Boulevard
Olympia, Washington 98504
(360) 586-1481

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

STATE OF WASHINGTON
PERSONNEL APPEALS BOARD

(360) 586-1481
FAX (360) 753-0139

Ltr 94

C-PAAPM
Sent 6/30/95

June 27, 1995

Marion G. Leach
Washington Public Employees Assoc.
124 10th Avenue SW
Olympia, WA 98501

RE: Beverly Traweek v. Department of Corrections, Reduction in Salary Appeal, Case No. RED-95-0036

Dear Ms. Leach:

This letter is to acknowledge receipt of your appeal by the Personnel Appeals Board on June 16, 1995.

Sincerely,

Paulette Young for
Kenneth J. Latsch
Executive Secretary

KJL:py
cc: Beverly Traweek
Linda A. Dalton, AAG
Jennie Adkins, PO
Rick Hall, Rep.

0650

RECEIVED

JUN 16 1995

PERSONNEL APPEALS BOARD

APPEAL FORM

WASHINGTON STATE PERSONNEL APPEALS BOARD
2828 Capitol Boulevard
P.O. Box 40911
Olympia, WA 98504-0911

PH: SCAN 321-1481
(206) 586-1481
FAX: (206) 753-0139

This form will help you provide necessary information to the Personnel Appeals Board when you file an appeal. You are not required to use this form; however, appeals must be filed in accordance with the requirements set forth in Chapter 358-20 WAC.

If the space on the form is insufficient or if you wish to provide additional information, you may attach additional pages.

PRINT OR TYPE — SIGN ON PAGE 2

PART I. APPELLANT IDENTIFICATION

NAME: TRAWEEK, BEVERLY A.
(Last name, first name, middle initial)

HOME ADDRESS: [redacted]
(Number and street)

[redacted]
(City, state and ZIP code)

PHONE NUMBERS: SCAN: _____ Off-SCAN: (206) 858-4262

HOME: (Include area code) [redacted]

EMPLOYING AGENCY: DEPARTMENT OF CORRECTIONS

Name of agency or agencies that took action you are appealing:

_____

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

MARION G. M. LEACH
WPEA STAFF ATTORNEY
124 10TH AVE SW
OLYMPIA WA 98501
TELEPHONE: (360) 943-1121

An Appellant may authorize a representative to act in his/her behalf. The Board must be notified of any change in representation.

PART 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 Pay.
- ___ b. Disability Separation
- ___ c. Merit System Rule or State Civil Service Law Violation
  (complete PART IV. of this form)
- ___ d. Reduction in Force
  (complete PART IV. of this form)
- ___ e. Allocation (position classification)
  (complete PART V. of this form)
- ___ f. Declaratory Ruling (see WAC 358-20-050)

0651

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PO Box 40911
Olympia, WA 98504-0911

STATE OF WASHINGTON
PERSONNEL APPEALS BOARD

(206) 586-1481
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C-PO+APM 12/9/95 DONE

December 23, 1994

Rick Hall
Washington Public Employees Association
124 - 10th Avenue SW
Olympia, WA 98501

RE: Beverly Traweek v. Department of Corrections, Reduction in Salary, Case No. D94-177

Dear Mr. Hall:

This letter is to acknowledge receipt of your appeal by the Personnel Appeals Board on December 21, 1994.

Sincerely,

Kenneth J. Latsch
Executive Secretary

KJL:ph
cc: Beverly Traweek
Kathy L. Nolan, AAG
Jennie Adkins, PO

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DEC 2 - 1994

PERSONNEL
APPEALS BOARD

APPEAL FORM

WASHINGTON STATE PERSONNEL APPEALS BOARD
2828 Capitol Boulevard
P.O. Box 40911
Olympia, WA 98504-0911

PH: SCAN 321-1481
(206) 586-1481
FAX: (206) 753-0139

This form will help you provide necessary information to the Personnel Appeals Board when you file an appeal. You are not required to use this form; however, appeals must be filed in accordance with the requirements set forth in Chapter 358-20 WAC.

If the space on the form is insufficient or if you wish to provide additional information, you may attach additional pages.

PRINT OR TYPE — SIGN ON PAGE 2

PART I. APPELLANT IDENTIFICATION

NAME: TRAWeek, Beverly
(Last name, first name, middle initial)

HOME ADDRESS: [redacted]
(Number and street)

[redacted]
(City, state and ZIP code)

PHONE NUMBERS: SCAN: _____ Off-SCAN: _____

HOME: (Include area code) [redacted]

EMPLOYING AGENCY: Department of Corrections WCCW

Name of agency or agencies that took action you are appealing:
Department of Corrections

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

Rick Hall
Washington Public Employees Association 124-10th Ave S.W Olympia 98501

An Appellant may authorize a representative to act in his/her behalf.
The Board must be notified of any change in representation.

PART III. TYPE OF APPEAL

Check one of the following to indicate the type of appeal you are filing:

- ✓ a. Disciplinary: (check applicable action(s)).
  ___ Dismissal, ___ Suspension, ___ Demotion, ✓ Reduction in Pay.
- ___ b. Disability Separation
- ___ c. Merit System Rule or State Civil Service Law Violation
  (complete PART IV. of this form)
- ___ d. Reduction in Force
  (complete PART IV. of this form)
- ___ e. Allocation (position classification)
  (complete PART V. of this form)
- ___ f. Declaratory Ruling (see WAC 358-20-050)

0653

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PO Box 40911
Olympia, WA 98504-0911

STATE OF WASHINGTON
PERSONNEL APPEALS BOARD

(206) 586-1481
(SCAN) 321-1481
(FAX) 753-0139

C-PO+APM

December 23, 1994

Rick Hall
Washington Public Employees Association
124 - 10th Avenue SW
Olympia, WA 98501

RE: Robert Love v. Department of Corrections, Demotion Appeal,
Case No. D94-182

Dear Mr. Hall:

This letter is to acknowledge receipt of your appeal by the Personnel Appeals Board on December 22, 1994.

Sincerely,

Kenneth J. Latsch
Executive Secretary

KJL:ph
cc: Robert Love
Kathy L. Nolan, AAG
Jennie Adkins, PO

0654

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APPEAL FORM

WASHINGTON STATE PERSONNEL APPEALS BOARD
2828 Capitol Boulevard
P.O. Box 40911
Olympia, WA 98504-0911

PH: SCAN 321-1481
(206) 586-1481
FAX: (206) 753-0139

This form will help you provide necessary information to the Personnel Appeals Board when you file an appeal. You are not required to use this form; however, appeals must be filed in accordance with the requirements set forth in Chapter 358-20 WAC.

If the space on the form is insufficient or if you wish to provide additional information, you may attach additional pages.

PRINT OR TYPE — SIGN ON PAGE 2

PART I. APPELLANT IDENTIFICATION

NAME: LOVE, Robert
(Last name, first name, middle initial)

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

PHONE NUMBERS: SCAN: _____ Off-SCAN: 588-5281

HOME: (Include area code) _____

EMPLOYING AGENCY: Department of Corrections MICC

Name of agency or agencies that took action you are appealing:
Department of Corrections

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

Rick Hall
Washington Public Employee Association
124 - 10th Ave S.
Olympia, WA. 98501

An Appellant may authorize a representative to act in his/her behalf. The Board must be notified of any change in representation.

PART III. TYPE OF APPEAL

Check one of the following to indicate the type of appeal you are filing:

- ✓ a. Disciplinary: (check applicable action(s))
  ___ Dismissal, ___ Suspension, ✓ Demotion, ___ Reduction in Pay.
- ___ b. Disability Separation
- ___ c. Merit System Rule or State Civil Service Law Violation
  (complete PART IV. of this form)
- ___ d. Reduction in Force
  (complete PART IV. of this form)
- ___ e. Allocation (position classification)
  (complete PART V. of this form)
- ___ f. Declaratory Ruling (see WAC 358-20-050)

0655