The employer, a home healthcare agency, required all employees to follow the care plan prescribed by a client's doctor and contact the employer if there were any issues with the care plan. The claimant, a nurse, chose to remove a patient from a ventilator which had been prescribed by the patient's doctor because the low-pressure alarm was continuing to sound. As the claimant understood she was supposed to follow the doctor's orders and there was no indication that the claimant's training on the ventilator instructed her to cease its use in case of a persistent alarm, there were no mitigating circumstances for the claimant's misconduct. She is disqualified from receiving unemployment benefits pursuant to G.L. c. 151A, § 25(e)(2).

Board of Review
19 Staniford St., 4th Floor
Boston, MA 02114
Phone: 617-626-6400
Fax: 617-727-5874

Paul T. Fitzgerald, Esq.
Chairman
Charlene A. Stawicki, Esq.
Member
Michael J. Albano
Member

Issue ID: 0032 7659 03

Introduction and Procedural History of this Appeal

The claimant appeals a decision by a review examiner of the Department of Unemployment Assistance (DUA) to deny unemployment benefits. We review, pursuant to our authority under G.L. c. 151A, § 41, and affirm.

The claimant separated from her position with the employer on October 23, 2019. She filed a claim for unemployment benefits with the DUA, which was denied in a determination issued on December 24, 2019. Following a hearing on the merits, the review examiner affirmed the agency's initial determination and denied unemployment benefits in a decision rendered on April 7, 2020. The claimant sought review by the Board, which denied the appeal, and the claimant appealed to the District Court pursuant to G.L. c. 151A, § 42.

On December 2, 2021, the District Court ordered the Board to obtain further evidence. Consistent with this order, we remanded the case to the review examiner to take additional evidence pertaining to the circumstances that led to the claimant's separation. The claimant attended the remand hearing. Thereafter, the review examiner issued his consolidated findings of fact. Our decision is based upon our review of the entire record.

The issue before the Board is whether the review examiner's decision, which concluded that the claimant was discharged for deliberate misconduct because she removed a client from a doctor-prescribed ventilator without consulting the employer's clinical director and failed to properly document that decision, is supported by substantial and credible evidence and is free from error of law.

Findings of Fact

The review examiner's consolidated findings of fact and credibility assessment are set forth below in their entirety:

1. The claimant worked 32 hours a week for the instant employer as a Community Health Nurse from 2/5/2018 until her last physical day of employment on 10/23/2019.

2. At the time of hire, the claimant was provided a written job description for the position of Community Health Nurse.

3. The written job description stated that the claimant was to adhere to the standards of nursing practice set forth by the State, maintain competence in performing all aspects of nursing care, request clarification/instruction for all procedures with which they are unfamiliar, implement the established plan of care under the direction of the primary care physician, complete documentation of all care in the electronic medical record, consults [sic] with the Clinical Director for case management, guidance and direction and keeps [sic] the Clinical Director informed of potential problems involving the person served.

4. Prior to the claimant's separation, a resident/patient was diagnosed with sleep apnea and oxygen deprivation by the doctor.

5. The doctor prescribed that the resident be placed on a ventilator at night to improve his health.

6. The claimant was aware of the doctor order for the resident to use the ventilator.

7. The claimant received an hour of training on how to use the "Trilogy 100" ventilator device on 10/10/2019.

8. The Chief Executive Officer and the Clinical Director did not attend the training provided to the claimant on 10/10/2019.

9. The training was provided by a 3rd party trainer from a company the employer hired called Bioscript. The training was specific to the use of the "Trilogy 100."

10. During the training, the 3rd party trainer provided the claimant with a 162-page manual on the "Trilogy 100" as well as a training video on the "Trilogy 100."

11. The training video was cre[a]ted by another company and instructs users of the ventilator to silence the low-pressure alarm if it continues to sound.

12. The training video instruct users to perform suctioning on the resident to address a potential cause of the low-pressure alarm.

13. The claimant had not been provided any training on other similar devices prior to her training on the "Trilogy 100."

14. The claimant began assisting the resident to use the ventilator starting on night of 10/13/2019 and did not have any issues that night or during her other shifts on 10/14/2019, 10/15/2019 and 10/21/2019.

15. On 10/22/2019 through 10/23/2019, the claimant was scheduled to work from 10 p.m. to 7:00 a.m.

16. At approximately 11:30 a.m., a low-pressure alarm began going off coming from the ventilator connected to the resident.

17. The claimant observed that the resident had heavy secretions that needed to be suctioned just like other nights in the past.

18. The alarm was so loud that it was hurting the claimant's ears and the claimant silenced the alarm and performed suctioning on the resident believing low suction due to secretions had caused the alarm.

19. Suctioning secretion use was part of the training video provided by the claimant.

20. The low-pressure alarm continued to go off every 15 minutes stating low-pressure even after suctioning the secretions. Each time, the claimant shut off the alarm.

21. The claimant shut off the ventilator around 1:15 a.m. because she did not feel it was medically needed.

22. In the training video, the claimant is told to call the respiratory therapist company and they will assist with troubleshooting.

23. The 3rd party respiratory company that provided the training has troubleshooting support available 24/7 via telephone.

24. The training video does not instruct users to switch off and cease use of the ventilator in a situation where the low-pressure alarm continues to sound.

25. The claimant used a paper sheet titled "Ventilator" to record ventilator use for the resident.

26. The name of the ventilator being used on 10/22/2019 was the "Trilogy 100" which was is listed on the paper sheet titled "Ventilator."

27. The employer created this document for nurses to hand write patient medical notes which cannot be immediately entered into the electronic records system.

28. The employer created document is commonly used when a medical professional is monitoring a patient on a ventilator and is not specific to the "Trilogy 100" ventilator.

29. The employer requires the claimant and other nurses to hand in their written medical notes to their supervisor at the end of the shift. The supervisor then enters the handwritten notes into the electronic system on behalf of the nurse.

30. The employer retains and maintains the handwritten patient notes.

31. The claimant hand wrote ventilator alarm events every 15 minutes from 9:00 p.m. on 10/22/2019 until 1:15 a.m. on 10/23/2019 on the "Ventilator" sheet.

32. The claimant wrote the word "Stop" after 1:15 p.m. and did not document any more events because the claimant had shut off the ventilator.

33. The claimant gave the "Ventilator" sheet to her supervisor at the end of her shift and the notes from the sheet were entered in the patient's electronic medical record.

34. The claimant did not personally enter any notes in the electronic medical records about the low-pressure alarm going off continuously.

35. The claimant did not call the Clinical Director for any assistance with the low-pressure alarms.

36. The family of the patient notified the employer to remove the claimant from their child's care because they felt she was disorganized, lied and did not get along with the other nurses.

37. Upon further research, the employer discovered that on 10/22/2019 through 10/23/2019, the low-pressure alarm was sounding after 1:15 a.m. and never documented by the claimant on the paper sheet or in the electronic medical chart. It was also discovered that the claimant removed the resident from the ventilator.

38. On 11/5/2019, the CEO and Clinical Director informed the claimant that she was terminated for endangering a resident by failing to perform her job duties when she removed the resident from the ventilator without [sic] doctor's order, without notifying a supervisor and without entering any documentation into the resident's medical records.

Credibility Assessment:

The claimant produced a training video for the "Trilogy 100" ventilator. The claimant provided firsthand testimony that she was provided this training video on 10/10/2019 when trained on the "Trilogy 100" by a 3rd party respiratory company hired by the employer. The CEO and the Clinical Director contended that the claimant was not provided this training video by the 3rd party respiratory company, however such contention was hearsay since they did not attend the training on

> 10/10/2019, thus the claimant's firsthand testimony is this contested area is accepted as credible.
>
> The claimant contended that the training video for the "Trilogy 100" ventilator instructed users to switch off and cease use of the ventilator in a situation where the low-pressure alarm continues to sound. Upon review of the training video produced by the claimant at the hearing, the training video does not instruct users to switch off and cease use of the ventilator in a situation where the low-pressure alarm continues to sound. As a result, the claimant's testimony is this contested area is not deemed credible

Ruling of the Board

In accordance with our statutory obligation, we review the record and the decision made by the review examiner to determine: (1) whether the consolidated findings are supported by substantial and credible evidence; and (2) whether the review examiner's conclusion is free from error of law. Upon such review, the Board adopts the review examiner's consolidated findings of fact and deems them to be supported by substantial and credible evidence. We further believe that the review examiner's credibility assessment is reasonable in relation to the evidence presented. As discussed more fully below, we believe the review examiner properly concluded that the claimant was discharged for deliberate misconduct in wilful disregard of the employer's interest.

Because the claimant was discharged from her employment, her qualification for benefits is governed by G.L. c. 151A, § 25(e)(2), which provides, in pertinent part, as follows:

> [No waiting period shall be allowed and no benefits shall be paid to an individual under this chapter] . . . (e) For the period of unemployment next ensuing . . . after the individual has left work . . . (2) by discharge shown to the satisfaction of the commissioner by substantial and credible evidence to be attributable to deliberate misconduct in wilful disregard of the employing unit's interest, or to a knowing violation of a reasonable and uniformly enforced rule or policy of the employer, provided that such violation is not shown to be as a result of the employee's incompetence . . . .

"[T]he grounds for disqualification in § 25(e)(2) are considered to be exceptions or defenses to an eligible employee's right to benefits, and the burdens of production and persuasion rest with the employer." Still v. Comm'r of Department of Employment and Training, 423 Mass. 805, 809 (1996) (citations omitted).

As an initial matter, there is insufficient evidence in the record for us to conclude that the claimant took action that violated a uniformly enforced policy. As such, we consider only whether the claimant engaged in deliberate misconduct in wilful disregard of the employer's interest.

In order to determine whether an employee's actions constitute deliberate misconduct, the proper factual inquiry is to ascertain the employee's state of mind at the time of the behavior. Grise v. Dir. of Division of Employment Security, 393 Mass. 271, 275 (1984). In order to evaluate the claimant's state of mind, we must "take into account the worker's knowledge of the employer's

expectation, the reasonableness of that expectation and the presence of any mitigating factors." Garfield v. Dir. of Division of Employment Security, 377 Mass. 94, 97 (1979).

As a threshold matter, the employer must show that the claimant engaged in the conduct for which she was discharged. There was no dispute that the claimant removed the resident from the physician-prescribed ventilator on the morning of October 23, 2019, without contacting her Clinical Director. Consolidated Findings ## 5, 6, 21, and 35. Accordingly, there is no question the claimant took action that was inconsistent with the employer's expectations regarding standards of care. *See* Consolidated Findings ## 3 and 5. Further, as the claimant chose to remove the ventilator based on her own assessment of the resident's needs, it is clear her actions in so doing were deliberate. *See* Consolidated Finding # 21.

While the claimant did not dispute that she removed the resident from the ventilator, the dispositive issue in this case is whether the claimant understood such action was contrary to the employer's expectations. The claimant understood her employer expected her to follow all doctor's orders or otherwise consult with the employer's Clinical Director before taking any action contrary to a resident's care plan. *See* Consolidated Findings ## 3, 5, and 6. While she acknowledged that her decision to remove the resident from the ventilator was inconsistent with the prescribed care plan, the claimant contended that she did not believe her actions were contrary to the employer's expectations because she was acting in accordance with the training she had received.

Assuming the claimant had received training that instructed her to cease use of the ventilator in response to a persistent low-pressure alarm, the claimant's reliance on this training might constitute circumstances mitigating her decision to willfully disregard the prescribed care plan. However, the training provided to the claimant gave no such instructions. *See* Consolidated Findings ## 9–12, and 22–24. Therefore, in the absence of any mitigating factors, we conclude that the claimant acted in wilful disregard of the employer's expectations when she removed the resident from the ventilator on the morning of October 23, 2019.

We, therefore, conclude as a matter of law that the employer has met its burden to show that the claimant was discharged for deliberate misconduct in wilful disregard of the employer's interest pursuant to G.L. c. 151A, § 25(e)(2).

The review examiner's decision is affirmed. The claimant is denied benefits beginning November 5, 2019, and for subsequent weeks, until such time as she has had at least eight weeks of work and has earned an amount equivalent to or in excess of eight times her weekly benefit amount.

BOSTON, MASSACHUSETTS
DATE OF DECISION - December 15, 2022

Charlene A. Stawicki, Esq.
Member

Michael J. Albano
Member

Chairman Paul T. Fitzgerald, Esq. did not participate in this decision.

ANY FURTHER APPEAL WOULD BE TO A MASSACHUSETTS STATE DISTRICT COURT
(See Section 42, Chapter 151A, General Laws Enclosed)

The last day to appeal this decision to a Massachusetts District Court is thirty days from the mail date on the first page of this decision. If that thirtieth day falls on a Saturday, Sunday, or legal holiday, the last day to appeal this decision is the business day next following the thirtieth day.

To locate the nearest Massachusetts District Court, see:
www.mass.gov/courts/court-info/courthouses

Please be advised that fees for services rendered by an attorney or agent to a claimant in connection with an appeal to the Board of Review are not payable unless submitted to the Board of Review for approval, under G.L. c. 151A, § 37.

LSW/rh