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2022-09-02 08:55:47
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STATE OF IOWA
BEFORE THE PUBLIC EMPLOYMENT RELATIONS BOARD

AMANDA DODSON, Appellant, and STATE OF IOWA (DEPARTMENT OF CORRECTIONS-IOWA STATE PENITENTIARY), Appellee.	CASE NO. 102600 PROPOSED DECISION AND ORDER

Appellant, Amanda Dodson, filed a state employee disciplinary action appeal with the Public Employment Relations Board ("PERB") pursuant to Iowa Code section 8A.415(2)(*b*) and PERB rule 621—11.2. Dodson appeals the third-step response of the designee of the director of the Iowa Department of Administrative Services (DAS) denying the appeal of her termination.

Dodson worked as a registered nurse ("RN") for the Iowa Department of Corrections (DOC). Dodson alleges the State did not have just cause to terminate her employment on May 10, 2021. The State denies that Dodson's termination was not supported by just cause.

A closed, evidentiary hearing was held on May 17, 2022. Mark Hedberg represented Dodson. Andrew Hayes represented the State. The parties submitted post-hearing briefs on July 19, 2022. After considering the evidence and the arguments of the parties, I propose the following:

1. Summary of Arguments

The State terminated Dodson's employment after finding Dodson violated DOC rules and policies when she failed to read the instructions of a vaccine prior to administering that vaccine to 77 patients at the DOC facility. Dodson did not

prepare the vaccines, and upon receiving the vaccinations from the RN that had prepared them, Steve Sherman, Dodson questioned the dose, but Sherman told her that is what the instructions said, and Dodson did not independently verify Sherman's statement.

Dodson argues the DOC failed to establish that she violated any rule, policy, or directive. Dodson claims she was merely following the State's practice and procedure in using a team approach to administer the vaccine and therefore did not violate the DOC's rules or policies. The State argues that Dodson admitted she did not read the instructions for the vaccine prior to administering it, which means Dodson did not follow standard nursing protocols within an RN's scope of practice.

Dodson also contends she did not have forewarning or knowledge of the DOC's requirements to double check another nurse's work. The State again claims that Dodson had knowledge that she was expected to practice within the scope of nursing.

Finally, Dodson claims that given her exceptional employment record, the State's termination of her employment was excessive. Dodson alleges the State did not apply progressive discipline, did not give Dodson's employment history appropriate weight, and used her as a scapegoat for its own flawed protocols that led to the incident and created a negative public perception of the DOC and hostility from the affected patients and other offenders. The State argues termination was appropriate given the totality of the circumstances, especially given the severity of the incident.

The issue in this case is whether the State established that it had just cause to terminate Dodson's employment. Specifically, the State must demonstrate it had sufficient evidence of Dodson's guilt, show that Dodson had notice of the expected conduct, and establish that the level of discipline was appropriate given the circumstances.

2. Findings of Fact

2.1 Background of ISP Health Care Services

Dodson worked as an RN at the Iowa State Penitentiary (ISP) in Fort Madison, Iowa. ISP houses over 700 offenders. This case involves the health services provided at ISP. The medical staff are responsible for getting medicines to the 700 plus offenders every day. The patients at the DOC facilities are a unique population as those patients are offenders that depend entirely on DOC health services. That is the only healthcare service available to them. At the time relevant to this appeal, Tasha Rooks served as the nursing services director at ISP.[1] When ISP's health services was fully staffed, Rooks supervised 16 RNs, three licensed practical nurses, and worked with other various medical professionals. Rooks supervised the appellant in this case, Amanda Dodson.

2.2 Dodson's Background and Training

Dodson began employment with ISP in 2003 as an X-ray technician and pharmacy assistant. She became a licensed RN and started working as an RN at ISP in 2013. Dodson worked the 5:00 a.m. to 3:00 p.m. shift, but her days off

[1] At the time of the incident her name was Tasha Whalen. For purposes of this decision the nursing services director will be referred to as Rooks.

varied. As an RN for the facility, Dodson was required to practice nursing following the State board practice standards. Dodson signed and received the DOC and State of Iowa's various policies and rules when she began in 2003. She went through orientation on dispensing and medication administration in 2016.

In her tenure at ISP, Dodson received exceptional evaluations and praise. She always met or exceeded expectations. After becoming a nurse at ISP the management praised Dodson's "strong self-motivation and initiative" and stated she was "passionate about nursing and always achieving a 'good job.' " Management said Dodson had the "ability to work well independently and as a team player" and that she followed "established nursing and treatment protocols." Rooks testified that Dodson was "an overachieving nurse" that "appreciate[d] extra assignments." Dodson was consistently noticed for her positive attitude.

2.3 ISP's Vaccination Protocol

At ISP, staff members, such as Dodson, in health services provide vaccinations to the offender population. For vaccination clinics, ISP often used a team approach. This team approach was achieved in various ways. One approach would be when one person would prepare the vaccine and another person would administer the vaccine. In fact, the flu shots were sometimes prepared by nurses on a different shift. The nurse preparing the vaccine would put the prepared syringe in a bag and would document the lot number and expiration date on the bag. The nurses on the next shift would use those syringes to administer the vaccine and would verify the syringe in the bag had the proper

lot number, expiration date, and medication prior to administering it. This type of team approach could not be done with the COVID vaccine because the COVID vaccines were more time-sensitive. ISP does not have a written standard for how this team vaccination approach should operate and it does not operate in a uniform manner with every type of vaccination.

In the vaccination clinics, nurses are expected to comply with applicable regulatory rules including practicing within the scope of nursing. Rooks explained that in the vaccination clinics, the nurses needed to familiarize themselves with the medicine. They needed to know the medication being given and the potential side effects to effectively monitor the patient, fill out the correct information, and document it in the electronic medical record. Multiple nurses at the facility, including the State's and the Appellant's witnesses testified that a nurse has an obligation to be familiar with the drug prior to administering it to the patient. If a nurse is not familiar with the medication, the nurse needs to stop and read the instructions and vial, and seek clarification if they have any questions. Several DOC nurses testified about the five rights within the scope of nursing. The nurse has an obligation to make sure they are delivering the right medicine, at the right site, at the right time, with the right dose, to the right patient. A nurse's failure to read the instructions to be familiar with the drug or failure to ask questions when something is unclear could lead to serious mistakes, such as overdosing. These mistakes could have adverse health effects for the patient, and could, in the worst cases, lead to the patient's death.

When working with a new drug, Rooks testified that an RN needs to read the instructions to be familiar with it. Rooks said that all three COVID vaccinations were very different, so the nurses needed to know the different instructions. The nurse administering the vaccine needed to be familiar with the medication to anticipate side effects and have the right tools regardless of whether they were working as a team or individually.

With the COVID vaccine clinics at ISP, the nurses would take all the paperwork, the vaccines, and the supplies to the offenders' housing units. One of the nurses at ISP testified that sometimes one person would prepare the vaccine and one would administer the vaccine, but sometimes one nurse would do paperwork while the other person administered the vaccine.

2.4 ISP's COVID Vaccination Plan

ISP's COVID vaccination plans began in December 2020. By December 31, 2020, Rooks sent an email to all medical staff with the pre-vaccination checklist. Rooks routinely sent out emails regarding patient care and healthcare workers' responsibilities as well as CDC updates and webinars. One of the ISP nurses testified that instruction sheets regarding the vaccines were posted everywhere and they were all emailed to the medical staff.

In January, ISP received the Moderna vaccine, and began completing staff immunizations as well as immunizations of high-risk offenders. In April, Rooks understood that ISP would receive the Pfizer vaccine and she testified she emailed the instructions about Pfizer out to the medical staff at ISP. On April 16, 2021, Dodson and Rooks conducted a Moderna COVID clinic in Housing Unit 3

(HU 3) at ISP. Dodson had already been a part of some of the staff vaccination clinics, but this was the first time she conducted a vaccination clinic with the offenders in their living units. During this clinic, Rooks prepared the syringe and Dodson administered the vaccine to roughly 40 patients in HU 3.

2.5 Overdose Incident on April 20, 2021

On Tuesday, April 20, 2021, Dodson reported to work at her normal 5:00 a.m. start time. Five nurses worked that shift including three regular nurses and two nurses that were on-the-job-training (OJT) nurses.[2] Dodson checked her emails to determine her tasks for the day. Rooks instructed Dodson, via email, to pass pills and do insulin IN HU 3 and then to go to HU 3 around 8:30 a.m. to finish the vaccines. The vaccine available that day was the Pfizer vaccine, rather than the Moderna vaccine that Dodson had administered previously. In this email, Rooks also instructed Dodson to take one of the OJT nurses with her. Dodson took OJT nurse Steve Sherman with her. Sherman had been an RN for over three decades, but had only been at ISP for seven or eight days. He had started employment at ISP that April and had not gone through training yet. Dodson and Sherman had not worked with each other before.

Dodson and Sherman went to HU 3 to pass pills and do insulins, as instructed. After completing this, Dodson and Sherman began preparing for the COVID vaccine clinic. Rooks had sent a follow-up email to Dodson stating HU 3 was locked down, so Dodson and Sherman should go to Housing Unit 2 (HU 2) to administer the Pfizer vaccines.

[2] The OJT nurses on this shift had not yet completed orientation.

Dodson and Sherman collected the necessary supplies and paperwork to administer the vaccines in HU 2. ISP had approximately 500 doses of Pfizer vaccine that they could administer. Dodson had to go to Rooks' office when preparing supplies, and Rooks stated she told Dodson to read the instructions as the Pfizer vaccine was different from the Moderna vaccine they had worked with on Friday. Included in the supplies was a box that contained the needles, dilution, and the Pfizer vaccination instructions. The instructions stated in part that Pfizer is administered "as a series of two doses (.3 mL each) 3 weeks apart." The instructions also provided administration instructions that directed the person administering the vaccine to "verify the final dosing volume of .3 mL." The vaccines were in the ISP pharmacy fridge in one big baggie with all the vials together. The vial of Pfizer vaccine stated in bold, but small print, "After dilution, vial contains 6 doses." When preparing the supplies, Dodson did look at the instructions in the box, but did not read the instructions in full.

Dodson and Sherman proceeded to HU 2 to administer the vaccines. As there are always time constraints in prisons, they did need to work efficiently. Dodson and Sherman went to the triage room. Dodson asked Sherman whether he wanted to prepare the vaccine or administer the vaccine and do the paperwork. She then asked him if he was comfortable drawing up the vaccine and he responded affirmatively. Dodson knew Sherman was an experienced nurse and she did not have a reason to believe he could not perform this task.

Dodson contended she told Sherman all she knew about the vaccine is that it needed to be diluted and she gave him the information packet to read.

During his investigation, Sherman claimed Dodson said she would let him know what to do, but he seemingly did not ask any questions when she did not provide him with oral instructions. Dodson was at the exam table with the forms and the patients would come to her to fill out the forms. While she did this, Sherman prepared the syringe in a different area of the room with his back to her. Dodson did not see Sherman preparing the vaccine. In each syringe, Sherman drew up the entire vial of vaccine, which was intended to contain six separate doses.

Sherman drew up the vaccine and gave Dodson the syringe. She asked Sherman why there was so much in the syringe as it seemed far more than the Moderna vaccine, but Sherman told her that is what the paperwork said. Dodson did not read the instructions or the vials prior to administering the vaccine. She felt she was not obligated to read the instructions or vial herself as she believed she could rely on Sherman.

Dodson and Sherman began administering the vaccine in HU 2 around 8:00 and stopped around 10:40 for the offenders' lunch break. They went back to the healthcare unit and medication storage room. Since they were going to go back to HU 2 after lunch to administer more vaccines, Dodson looked in the pharmacy fridge and freezer for the rest of the vaccines, but there were none left. Dodson then looked at one of the vials of medicine and saw the error.

Dodson immediately went to Rooks' office and explained the situation. Dodson was panicked. Rooks stated that Dodson was very upset and tearful and had a hard time getting words out before she said, " 'Fire me now. We just made, you know, a med error.' " Rooks was not sure she understood what Dodson was

saying so Dodson got out the vial and sodium chloride and explained that Sherman drew up diluent and the entire vial into the syringe. Dodson told Rooks she had administered the entire vial to multiple offenders when the bottle says after dilution, the bottle contains six doses of only .3 mL.

Rooks sent Dodson to get Dr. Kuiper, the physician on site. Dodson also sent a couple of nurses to HU 2 immediately with EpiPens to monitor the affected patients for adverse reactions and to obtain vital signs, and administer ice, Gatorade, and Tylenol as needed. Dodson also filled out the medication error form and looked at the patients' diagnoses to see if they might have blood clotting issues. Dodson and Rooks later agreed that Dodson would go to HU 2 and speak with all the affected patients. Dodson did so. The patients were upset and they screamed at and threatened her. Rooks also met with the patients that evening. She also stated the patients were very upset. They threatened and called names, and Rooks had to call security on a few of the patients because of the threats.

Rooks notified various internal DOC administrators about the situation. She texted Kathy Weiss, the administrator of nursing for the DOC, Dr. Greenfield, the health services administrator, Dr. Morris, the medical administrator, Susan Shield, the state pharmacist, and Tyson Yoe, the pharmacist at Oakdale, as well as Deputy Director Bill Sperfslage. Rooks, Morris, and Greenfield talked on the phone as they were confused about what had happened. They discussed first, how to immediately monitor and take care of the individuals, and second, how to gain additional information to establish a plan going forward and what to expect for side effects. Rooks and other internal

administrators had a zoom meeting to confirm the situation and to develop a monitoring plan.

Rooks also called the CDC and Pfizer. Neither could provide any advice on how to deal with the situation as they had never heard of that high of an overdose before. They simply told Rooks not to administer a second dose. DOC administrators contacted various other sources including the Iowa Department of Public Health, the University of Iowa, the local health department, and different state and national departments. As there were no other cases where something of this magnitude had occurred, no one could provide any guidance to the DOC and ISP.

2.6 Events following April 20, 2021, Incident and ISP's response

The April 20, 2021, incident resulted in 77 patients receiving roughly six times the recommended dosage. Seventy-five of the patients had vaccine symptoms. Only one had a fever above 100.4 degrees. No patients showed symptoms considered more severe.

Dr. Morris, the DOC medical administrator, and Dr. Kuiper, the physician on site, evaluated all 77 affected patients on April 21. ISP had to call in a K-9 unit because some of the patients were upset and threatening. Some patients relayed that they believed the DOC was trying to kill them. Others believed this overdose was in retaliation to external events such as the recent lethal event at Anamosa State Penitentiary. The medical staff received "chaotic, violent threats." Morris and Kuiper followed up the following week with the patients. They

continued to obtain labs as needed. Kuiper managed the patients' care over a period of weeks and months following the incident.

The April 20 overdose incident led to a series of internal consequences for the DOC. Other offenders were not able to get the vaccine at that time because there was not enough. The response from the various entities that ISP and DOC contacted for guidance lasted weeks. ISP assigned one RN full time from 8-4 Monday through Friday in the pharmacy merely to respond to calls from family members of offenders and the media. DOC had additional cost for overtime staffing. The DOC health services were still dealing with reporting the incident a year later.

ISP also sent out an email on April 29, 2021, stating that all those involved in preparing and administering vaccinations needed to watch a vaccine information video. Additionally, after this incident, ISP required that nurses drawing up the medication would show the other nurse that was administering the medication to ensure double verification that health services had the correct drug and dose. After April 20, instructions were always provided for every individual involved in performing vaccinations.

The events of April 20 also led to distrust of health services from the offenders within the facility. The offenders were hostile, filed internal grievances, threatened lawsuits, and had family members that were also upset. The offenders questioned this large-scale error and how it could have happened. Morris testified that the offender population has issues with trust in general and in the health services field they tried to bridge that rapport, but this incident

really shook that rapport and trust. Weiss and Rooks both testified that offenders became suspicious of being treated by the DOC health services after this. This breached the trust between the DOC and the inmate population. Weiss testified this event impacted ISP and the other institutions as well and required more patient education because of the loss of trust. Weiss also stated the event had the effect of the erosion of public trust.

2.7 Administrative Leave and Investigation

ISP placed Dodson and Sherman on administrative leave on April 21, pending an investigation. Chris Tripp, the acting warden at ISP, notified the executive leadership at DOC and started the investigation. The DOC assigned Weiss and Darin Cox, the investigator at the DOC central office, to complete the investigation. Weiss and Cox interviewed Rooks, then Sherman, then Dodson, and then re-interviewed Rooks. Weiss and Cox conducted all the interviews on April 23. Weiss and Cox also looked at other evidence, including the box of supplies, the Pfizer vial, the syringes, and some video surveillance camera recordings.

The investigators issued the investigation results on April 29, 2021. The investigation found that 77 patients were overdosed with six times the dosage and that Sherman prepared and Dodson administered the vaccine. The investigation also found that the instructions for the vaccine and its dosage were provided to Sherman and Dodson, and Dodson did not read the totality of the instructions or read the vial prior to administering the vaccine. Dodson also did not stop the process when she questioned Sherman because she thought there

was too much in the syringe. The investigation determined Dodson did not follow the patient's five rights, which is part of the scope of practice for registered nurses licensed with the Iowa Board of Nursing.

2.8 Imposition of Discipline

After the investigation was complete, the DOC developed a work rule violation worksheet for Dodson on May 3, 2021. In this document, the DOC determined Dodson did not read the proper instructions on preparation and administration of the Pfizer vaccine, did not stop the process or reach out for clarification, and did not follow the five rights of medication administration which is part of the scope of practice of being a nurse. The DOC found various violations of policy including of general rules and personal ethics. The DOC concluded Dodson's inattentiveness caused her to overlook established procedures causing irreversible error that negatively impacted the welfare of 77 patients and adversely affected public confidence in the DOC and health services. The DOC acknowledged that Dodson did report the medication error immediately. The DOC also noted that one other person was terminated in 2014 for giving the incorrect amount of insulin to one individual.

Acting Warden, Tripp, reviewed the investigation results and discussed it with the DOC executive level individuals. Weiss was not involved in the discipline determination. The executive leadership at DOC and Tripp decided termination was the correct course of action after reviewing the investigation, the public outcry, the news media, the nation-wide calls from offenders' families, and the

threats of litigation. Tripp did not believe that Dodson could be effective in her role because of the incident. Sherman was also terminated.

Tripp issued the letter to terminate Dodson's employment on May 10, 2021. In the letter the DOC said an investigatory interview was held "to discuss the improper COVID vaccination procedures that took place on April 20, 2021." The DOC claimed Dodson violated the following rules:

- IDOC AD-PR-11, IV, C1, C2, & C3, General Rules of Employee Conduct, Code of Conduct
- IDOC AD-PR-11, IV, D2, D3, D4, General Rules of Employee Conduct, General Explanation of Work Rules and Policies
- IDOC AD-PR-11, IV, E1, E2, E4, General Rules of Employee Conduct, Personal Ethics
- IDOC AD-PR-11 IV, G8, General Rules of Employee Conduct, Reporting for work and Alertness on Post
- IDOC HSP 101, IV, H, 8d, 8h (regarding nursing staff procedures)
- IDOC HSP 201 IV, B (regarding medical staff procedures)
- IDOC HSP 409, IV, I, II, II, IV (regarding medication incident reporting procedures)

Most relevant here are the following provisions:

IDOC General Rules of Employee Conduct, AD-PR-11

- IV. Procedures
- C. Code of Conduct

. . . .

2. Employees are charged with the responsibility of complying with IDOC's Institution, and Judicial District Department's work rules, orders, policies and procedures, along with municipal, county, state, and federal laws, and the applicable rules of regulatory agencies that apply to them.
3. Employees are expected to be familiar with their job description, essential functions, performance standards and job duties.

. . . .

IDOC General Rules of Employee Conduct, AD-PR-11

- IV. Procedures
- E. Personal Ethics

. . . .

2. Employees shall avoid any action that might adversely affect the public confidence in the state criminal justice system.

. . . .

IDOC General Rules of Employee Conduct, AD-PR-11,

- IV. Procedures
- G. Reporting for work and Alertness on Post

8. Remain fully alert and attentive to duties at the assigned post until properly relieved.

Dodson grieved her termination in May 2021. DAS issued its' third step decision denying the grievance on June 11, 2021.

3. Conclusions of Law and Analysis

Dodson filed this appeal pursuant to Iowa Code section 8A.415(2), which states:

> 2. *Discipline Resolution*
>
> *a.* A merit system employee . . . who is discharged, suspended, demoted, or otherwise receives a reduction in pay, except during the employee's probationary period, may bypass steps one and two of the grievance procedure and appeal the disciplinary action to the director within seven calendar days following the effective date of the action. The director shall respond within thirty calendar days following receipt of the appeal.
>
> *b.* If not satisfied, the employee may, within thirty calendar days following the director's response, file an appeal with the public employment relations board . . . If the public employment relations board finds that the action taken by the appointing authority was for political, religious, racial, national origin, sex, age, or other reasons not constituting just cause, the employee may be reinstated without loss of pay or benefits for the elapsed period, or the public employment relations board may provide other appropriate remedies.

DAS rules provide specific discipline measures and procedures for disciplining employees. Those rules are as follows:

> 11—60.2(8A) Disciplinary actions. Except as otherwise provided, in addition to less severe progressive discipline measures, any employee is subject to any of the following disciplinary actions when

> the action is based on a standard of just cause: suspension, reduction of pay within the same pay grade, disciplinary demotion, or discharge . . . . Disciplinary action shall be based on any of the following reasons: inefficiency, insubordination, less than competent job performance, refusal of a reassignment, failure to perform assigned duties, inadequacy in the performance of assigned duties, dishonesty, improper use of leave, unrehabilitated substance abuse, negligence, conduct which adversely affects the employee's job performance of the agency of employment, conviction of a crime involving moral turpitude, conduct unbecoming a public employee, misconduct, or any other just cause.

Iowa Administrative Rule 11—60.2(8A). *See also* Iowa Administrative Code 11—60.2(4) (discussing discharge procedures).

The State bears the burden of establishing that just cause supports the discipline imposed. *Stein and State of Iowa (Iowa Workforce Development)*, 2020 PERB 102304 at 16. The term "just cause" when used in section 8A.415(2) and in administrative rule is undefined. *Stockbridge and State of Iowa (Dep't of Corr.)*, 06-MA-06 at 21 (internal citations omitted). PERB determines whether management has just cause to discipline an employee on a case-by-case basis. *Id.* at 20.

When determining the existence of just cause, PERB examines the totality of the circumstances and rejects "a mechanical, inflexible application of fixed elements." *Stein*, 2020 PERB 102304 at 15. Although just cause requires examination on a case-by-case basis, the Board has declared the following factors may be relevant to the just cause determination:

> While there is no fixed test to be applied, examples of some of the types of factors which may be relevant to a just cause determination, depending on the circumstances, include, but are not limited to: whether the employee has been given forewarning or has knowledge of the employer's rules and expected conduct; whether a sufficient and fair investigation was conducted by the employer; whether

> reasons for the discipline were adequately communicated to the employee; whether sufficient evidence or proof of the employee's guilt of the offense is established; whether progressive discipline was followed, or not applicable under the circumstances; whether the punishment imposed is proportionate to the offense; whether the employee's employment record, including years of service, performance, and disciplinary record, have been given due consideration; and whether there are other mitigating circumstances which would justify a lesser penalty.

Hoffmann and State of Iowa (Dep't of Transp.), 93-MA-21 at 23; *see Stein*, 2020 PERB 102304 at 15–16. The Board also considers how other similarly situated employees have been treated. *Stein*, 2020 PERB 102304 at 16.

Iowa Code section 8A.413(19)(*b*) and DAS rule require the State to provide the employee being disciplined with a written statement of the reasons for the discipline. *See Krieger and State of Iowa (Dep't of Transp.)*, 2020 PERB 102243 at 6; *Hunsaker and State of Iowa (Dep't of Emp't Servs.)*, 90-MA-13 at 46, n.27. PERB determines the presence or absence of just cause rests on the reasons stated in the disciplinary letter alone. *Krieger*, 2020 PERB 102243 at 6.

3.1 Sufficient Evidence or Proof of Guilt

Dodson claims the State failed to demonstrate she violated a rule or policy. Dodson argues that she followed ISP's practice and procedure in using a team approach to administer the COVID vaccine. Thus, Dodson contends she did not have any duty or obligation to read the instructions of the vaccine she administered and she was not required to investigate further when she questioned Sherman about the dosage of the vaccine and he responded that he had followed the paperwork. The State argues that Dodson admitted to failing to read the instructions prior to administering a vaccine to 77 patients and in doing

so, she violated the duty to follow standard nursing protocols as set out by Iowa administrative law and the DOC's rules and policies.

The relevant DOC rules and policies cited in the termination letter require Dodson to comply with applicable rules of regulatory agencies that apply to her. She also must be familiar with her essential functions and job duties. Dodson is also required to remain fully alert and attentive to her duties. Dodson must avoid actions that adversely affect the public confidence in the state criminal justice system.

Dodson's argument that she was not required to read the instructions for the vaccine she was administering due to ISP's "team" concept is not tenable. Whether ISP's protocol in administering vaccines by using a team approach is the best practice is not at issue in this case. Dodson's conduct is at issue. Regardless of the division of duties for administering vaccines, the evidence in the record supports the finding that Dodson had an obligation to read the instructions prior to administering the vaccine. Both the State's witnesses and Dodson's own witness testified that prior to administering a vaccine, the nurse administering it needs to be familiar with the drug. Three nurses testified that when administering new vaccines, or some medication a nurse is unfamiliar with, that nurse needs to read the instructions.

Due to her status as a licensed RN, the evidence demonstrates Dodson had an obligation to follow the scope of nursing under the DOC rules cited. She failed to follow the required scope of nursing when she did not read the instructions on a vaccine she administered and a vaccine with which she was

not familiar. *See* Iowa Administrative Code 655—6.2 (regarding the standards of nursing practice for registered nurses). The State also demonstrated that Dodson's actions adversely affected the public confidence in the state criminal justice system and health services at the DOC. The State has shown with sufficient evidence that Dodson violated various rules and policies cited in the termination letter.

3.2 Notice of Expected Conduct

Dodson argues her discipline was excessive as she did not have forewarning or knowledge of ISP's requirements to double check Sherman's work. The State contends Dodson had notice of the need to practice within the standards of nursing, which required her to be familiar with any new medications prior to administering the medication to patients.

Dodson's argument is not persuasive. The evidence in the record demonstrates the nurses at ISP knew of the requirement to read the instructions and be familiar with medication prior to administering it. Regardless of whether Dodson should have been checking Sherman's work, she needed to read the instructions herself. Dodson had her own obligations in administering the vaccine as a licensed nurse, and assigning the preparation of the medication to Sherman did not relieve her of that obligation. Dodson contends she should have been able to rely on Sherman as he was an experienced nurse. This argument is not convincing as Dodson had never worked with Sherman before. Even if he was an experienced nurse, Dodson had no knowledge of Sherman's expertise or

capabilities. Additionally, reliance on any other nurse in this instance was not acceptable based on the facts in the record.

The State has demonstrated that Dodson knew or should have known of her obligation to be familiar with a vaccine prior to administering that vaccine to patients as a licensed RN.

3.3 Imposition of Discipline

Dodson argues the DOC's determination to terminate her employment is not proportionate to her actions, especially given her excellent work history. She also contends the State should have followed progressive discipline in this case. The State argues that termination was appropriate based on the totality of the circumstances and the unprecedented number of affected patients as well as the degree of the overdose.

Progressive discipline is a system where measures of increasing severity are applied to repeated offenses until the behavior is corrected or it becomes clear that it cannot be corrected. *Nimry and State of Iowa (Dep't of Nat. Res.)*, 08-MA-09, 08-MA-18, at App. 30. The purpose of progressive discipline is to correct an employee's behavior, rather than merely to punish the employee. *Stein and State of Iowa (Iowa Workforce Dev.)*, 2020 PERB 102304. Progressive discipline addresses employee's behavior over time through escalating penalties. *Phillips and State of Iowa (Dep't of Human Servs.)*, 12-MA-05 at App. 16 (citing Norman Brand, *Discipline and Discharge in Arbitration* at 57 (BNA Books 1998)). Progressive discipline may be inapplicable when the conduct underlying the

discipline was a serious offense. *See Phillips and State of Iowa (Dep't of Human Servs.)*, 12-MA-05 at App. 1, 13, 16-18.

When determining the appropriate discipline and use of progressive discipline, PERB considers the circumstances of the case. *Hoffmann and State of Iowa (Dep't of Transp.)*, 93-MA-21, at 26. PERB examines the severity and extent of violations, the position of responsibility held by the employee, the employee's prior work record, and whether the employer has developed a lack of trust and confidence in the employee to allow the employee to continue in that position, taking into account the conduct at the basis of the disciplinary action. *Phillips and State of Iowa (Dep't of Corr.)*, 98 H.O. 09 at 15; *Estate of Salier and State of Iowa (Dep't of Corr.)*, 95-HO-05 at 17.

In this instance, the severity of the violation and the State's lack of trust and confidence in Dodson's ability to continue in her position outweighs Dodson's exemplary employment record. Dodson erred in her failure to read the instructions prior to administering a vaccine. This error was magnified when she proceeded to administer the vaccine 77 patients when she had not read the instructions and did not know critical information about the vaccine. Further, Dodson was not sure the dosage was correct and questioned Sherman about it. She chose then to proceed upon only the assurance of an experienced RN that she had never worked with before. Dodson's actions placed the health of 77 patients in jeopardy. Dodson's actions also resulted in serious consequences for the DOC and ISP. Although the record demonstrates that Dodson was an

excellent employee and the error was unintentional, the seriousness of this preventable error outweighs her excellent employment record.

Dodson alleges she was a scapegoat for ISP's flawed vaccination protocols. Based on the record, that argument is not persuasive. The State demonstrated its termination of Dodson's employment stemmed from Dodson's actions in administering an unfamiliar vaccine at six times the recommended dosage to 77 individuals after failing to read the instructions of the vaccine. The State showed that Dodson had an obligation to those patients to familiarize herself with the vaccination, and she did not do so. The State established just cause to terminate Dodson's employment due to her actions.

ORDER

Dodson's state employee merit appeal is dismissed.

The costs of reporting and of the agency-requested transcript in the amount of $1,167.15 are assessed against the Appellant pursuant to Iowa Code section 20.6(6) and PERB rule 621—11.9. A bill of costs will be issued to the Appellant in accordance with PERB subrule 621—11.9(3).

The proposed decision and order will become PERB's final agency action on the merits of Dodson's appeal pursuant to PERB rule 621—9.1 unless, within 20 days of the date below, a party files a petition for review with the Public Employment Relations Board or the Board determines to review the proposed decision on its own merits.

DATED at Des Moines, Iowa this 2nd day of September, 2022.

/s/ Amber DeSmet

Administrative Law Judge

Filed electronically.
Parties served via eFlex.