THE UNIVERSITY OF TOLEDO

Corrective Action / Performance Improvement Form

Name: Melanie LeMay
Job Classification: RN
Union Representation Requested: XX YES ☐ NO ☐ N/A

Date: September 10, 2012
Department: OR

Check One:

☐	Coaching	☐	*Level 3 Pre-Discharge/Written Warning with **Optional** Unpaid Suspension [# days unpaid suspension: 1 2 3 4 5]
☐	Level 1 Written Warning/Oral		
☐	Level 2 Written Warning	XX	Termination

- **Note: If you are receiving a Level 3, your next formal level of discipline is termination.**

Reason		Behavior			
1	☐	Abandonment of Job / No Call No Show	11	☐	Harassment / Fighting / Threatening Behavior
2	☐	Absenteeism/Tardiness/Lateness	12	☐	Breach of Confidentiality / HIPAA
3	☐	Failure to Timely Report Off / Late Call In	13	☐	Immoral / Unethical Conduct
4	☐	Irregular / Patterned Attendance	14	☐	Insubordination / Failure to follow a direct order
5	☐	Dishonesty/Theft/Falsification	15	☐	Alcohol Use / Abuse and/or Chemical Use/Abuse
6	X	Failure to Document Work Time	16	X	Unsafe Practices
7	☐	Loafing/Sleeping on the Job/Quitting Early	17	☐	Failure to maintain licensure / Dept. Requirements
8	X	Failure to Perform Duties / Unsatis. Performance	18	☐	Unauthorized / Improper use of MUO Property
9	☐	Failure of Good Behavior / Unprofessional	19	X	Failure to follow safety / infection control protocols
10	X	Away from Job Station/Neglect of Duties	20	X	Other Just Cause (detail below or in a letter)

Brief Description of the Facts:

On August 10, 2012 at approximately 12:13 pm, you entered Operating Room 05 at UTMC as the Circulator Relief for Judith Moore, RN. The OR team (under the leadership of Dr. Rees) was assembled to transplant a kidney [redacted] The OR team per the intraoperative record included: Dr. Bhatt, Dr. Rees, Justin Muskovich (Surgical Resident), Theresa Gallup (Surgical Resident), Roberta Shaw (Scrub /Surgical Tech), Melanie LeMay (RN/Circulator Relief), Jennifer Rybak (Scrub/Surgical Tech Relief), A. Vanzyl (Stryker Vendor) and you as the RN Circulator. It was noted in the investigatory meetings that there was also a medical student present and standing next to the Surgical Tech although the student is not mentioned in the intraoperative record.

[redacted] You stated that you were in the room for about 5 minutes before Judy left. Dr. Rees had already removed the kidney and was cleaning it at the prep table. He had it in a metal basin. Based on interviews with OR staff, it is common practice for Dr. Rees to finish cleaning and perfusing the kidney; wrap it in a lap sponge and place it in a metal basin. You stated that when Dr. Rees was finished cleaning the kidney that he took the metal basin, placed it in the slush machine and told everyone in the room not to turn the slush machine on.

Once the kidney was placed in the basin in the slush machine Dr. Rees reportedly went back to close the patient. At some point after that you asked Jennifer Rybak (Relief Surgical Tech) if you could get rid of the stuff on the prep table that Dr. Rees had used to clean the kidney. Jennifer replied "No" and told you that you should wait.

Judy returned from lunch sometime around 1:05pm according to notes from her investigatory meeting, [redacted] When Judy entered the room she immediately asked why there was a case cart in the room. You stated that you didn't realize that she had one in the hallway, so you called for an empty one. You stated that no report or handoff occurred. At that point in time Dr. Rees called for suture so you went into the hallway to get it. When you returned to the room with the suture you noticed Judy cleaning up the prep table that you had earlier been told not to clean up. You stated that at that time you assumed that Judy had asked and been given permission to do so by Jennifer Rybak (Relief Surgical Tech) while you were out of the room obtaining the suture. You stated that you then went to the computer to check your preference sheet and chart. You stated that you saw Judy walk in front of you and go behind the sterile field where the slush machine was, but that you assumed that she was just throwing the bottle from the prep table away in the sharps container.

Original to Human Resources; Copies to Employee, Department File and Union Office (if applicable)

[redacted]

You were asked by Ed Hall at the second investigatory meeting, "who is responsible for report?" you replied that you initiate report if you are going into a room and also of following someone out of a room". You were asked as a follow up questions by Ed Hall : "So, is it your understanding that the nurse coming back from break is the one who is responsible?". You replied "that's what I do"... I was waiting for her to be next to me. Ed Hall asked "so you don't give report unless the person is standing next to you?" You replied that some surgeons get angry if you talk across the room. You added that you saw Judy was busy cleaning up and didn't think she was ready. You stated that you saw Judy go "back there" and assumed she was going to the sharps machine. You added "When Dr. Rees asked, where's my kidney I did not realize she was out of the room...I didn't see her leave."

At the first investigatory meeting you stated that after Dr. Rees asked where the kidney was. Everything was gone by the slush machine. You then saw Judy re-enter the room and heard her say "Oh no, oh no..I flushed it."

Ed Hall at the second investigatory meeting specifically addressed the "no report" issue further. Ed Hall asked Melanie if she did not give report was she then to be considered the "Circulator." You replied "yes". Ed asked what the responsibilities of the Circulator were relative to the "sterile field". There was discussion about the kidney was known by you to be in the slush machine which would be considered a "sterile field" yet you saw Nurse Moore go to the machine.

You were asked by Ed Hall at the second investigatory meeting about when trash goes out and there is clean up. You responded that trash does not go out until the case and counts are done. When asked what is your definition of "done" you replied" when the patient is closed and the dressing is on".

When asked how you could have missed Nurse Moore walking by you while you were charting you stated that you did not know. You thought you might have been out of the room to get sutures for one of the times Nurse Moore passed you. There is no record or testimony by those interviewed that you were asked to get sutures.

Placed On Paid Administrative Leave August 21, 2012.

Investigatory Meetings: August 14, 2012 and August 21, 2012.
Present at the 8/14 meeting were: Ed Hall (Administrator of the OR), Randy Desposito (AFSCME President), Mary Villegas (AFSCME Chief Steward), Andy Fox (Assistant Nursing Director/Nursing Administration), Tammy Renner (RN, AFSCME Steward), Erin Momenee (Lead HRTD Consultant), Linda Torbet (Interim Director of Operations) and you.
Present at the 8/23 meeting were: Ed Hall (Administrator of the OR), Randy Desposito (AFSCME President), Erin Momenee (Lead HRTD Consultant) and you.

Relevant Articles/Policies that have been Violated:

Policy # / Article #	Policy/Article Name

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3364-124-02 Counts: Sponges, Needle, Instrument 6. All counted sponges will remain within the OR suite and/or sterile field: a. Linen and trash bags are not removed from the OR Suite until the end of the procedure and patient leaves the room.
3364-124-11 Operating Room Sanitation 5. Once procedure has started, all instruments, linen, basins, etc. will be kept in the room until completion of the surgery.
3364-124-69 Electronic Documentation of Patient Care in the Operating Room 12. a. Record the name and title of all relief personnel; include accurate relief times. 12. b. Only relief personnel will have times in and out documented. 13. Record name and title of any and all students, observers, vendors, and diagnostic technologists present in the OR and their role during the procedure.
3364-25-01 Standards of conduct B. Employee are expected to become familiar with the established rules of the university and the departments in which they work. C. (4) Substandard quality or quantity of work including unsafe practices, unsatisfactory job performance, failure to perform duties and/or neglect of duties. H. (4) Failure to follow prescribed safety procedures, carelessness, inattention to duty or demonstrating negligence resulting in actual or potential loss or harm including horseplay.
National Patient Safety Goals for 2011 Review ([redacted]) 2. Improve effectiveness of communication among caregivers (e.) Implement a standardized approach to "handoff" communication, including the opportunity to ask and respond to questions.
Policy Review (3364-110-07-10): Notification of Physician of changes in Patient Condition: signed 6/7/12.
ICare Standard of Excellence Attestation of Commitment 2009: "bound to provide exemplary patient-centered service".

Prior Warnings/Coachings/Feedback:

Management's Statement of Future Expectations:

N/A

Employee's Statement (may attach written rebuttal:) Melanie Lemay

☐ I agree with above ☑ I disagree with above (explain reasons why below)

I understand that if I disagree, I may appeal using various options including: 1) filing of a workplace issues resolution form; or 2) file a written rebuttal that will be attached to this document; or 3) arrange to speak to the next level of management.

My signature below only indicates that I have received this information and understand it. I also understand that future instances may result in corrective action up to and including dismissal.

Employee Signature: Melanie Lemay Date: 9/10/12

Supervisor Signature: Edwin J. Hall Date: 9/10/12

Union Rep Signature: [signature] Date: 9/10/12

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