BEFORE THE ARBITRATOR

In the Matter of:

THE STATE OF OHIO,
DEPARTMENT OF MENTAL
RETARDATION AND
DEVELOPMENTAL DISABILITIES

Niswonger Grievance

and

OHIO HEALTH CARE EMPLOYEES
UNION DISTRICT 1199,
WV/KY/OH

OPINION AND AWARD

This arbitration proceeding arises as a result of the Employer's suspension of the grievant for twenty (20) working days for administering an improper medication to a client on February 2, 1988.

RELEVANT CONTRACT PROVISIONS

ARTICLE 8 - DISCIPLINE

§8.01 **Standard**

Disciplinary action may be imposed upon an employee for just cause.

§8.02 **Progressive Discipline**

The principles of progressive discipline shall be followed. These principles usually include:

A. Verbal Reprimand

B. Written Reprimand

C. Suspension

D. Demotion or Removal

The application of these steps is contingent upon the type and occurence of various disciplinary offenses.

MDC POLICY STATEMENT ON DISCIPLINE

II. PURPOSE:

To prescribe guidelines to be used when an employee is suspected of misconduct which may result in some form of corrective action.

III. POLICY:

It is the policy of Montgomery Developmental Center that:

The principles of progressive corrective action shall be followed as a means of modifying behavior or correcting inappropriate actions and will be reasonable, consistent with the offense and commensurate with the individual employee's disciplinary record;
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DEFINITIONS
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Major Offense - An offense which, in and of itself, may constitute grounds for the imposition of a major suspension (i.e. more than three days) or removal. Offenses in this category are included in "Category A" offenses listed in the standard disciplinary grid.
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IV. PROCEDURES
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B. For major breaches in proper behavior category A, the principles of progressive corrective action do not necessarily follow as listed above (and on page -2-). The employee shall be disciplined immediately, based upon the seriousness of the offense, in accordance with guidelines for category A offenses listed in the disciplinary grid.
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PHYSICAL ABUSE OR NEGLECT — 1ST OFFENSE

a) Harmful yes

20 day suspension
to removal

b) Harmful No

Written Reprimand
to 5 day suspension

MDC POLICY STATEMENT ON UNUSUAL INCIDENTS

II. PURPOSE:

To establish guidelines to deal efficiently and effectively with those situations classified as unusual.

III. POLICY:

It is the policy of the Montgomery Developmental Center to strictly adhere to Administrative Rule 5123-3-13, "Unusual Incidents". Unusual incidents occurring in or off-grounds shall be treated as serious matters requiring the cooperation of all staff to lead to their timely resolution. Montgomery Developmental Center will assure the prompt and accurate reporting of each occurrence of major, minor or common incident in order to provide and promote physical and emotional health and safety for all clients; to guard against future occurrences through education of the staff and clients and/or correction of problems associated with physical environment; to facilitate preventative measures through the development or revision of Center policies and procedures when indicated; to prepare for possible legal action, especially if litigation may be expected to ensure.

IV. DEFINITION OF TERMS:

1. Abuse - Any act or absence of action inconsistent with human rights which results or could result in serious physical harm or emotional (including sexual) distress to another.

2. Accident - An incident which was unplanned and which was not caused by an assault, serious medication error, abuse, mistreatment or neglect by an individual.

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6. Major Unusual Incident - An incident that results in death, serious injury, physical harm or severe emotional distress, including but not limited to:

a. Any death requiring immediate notification of the Coroner in accordance with MR/DD Rule 5123-3-11, "Death and Notification", including suspected suicide, accidental death or any suspicious or unusual death.

b. Events requiring immediate investigation by the Superintendent and/or the Chief of Security to determine whether the local law enforcement agency, and the Ohio State Highway Patrol should be notified, including:

1. Serious injury caused by another person.

2. Any alleged physical, emotional, sexual and/or verbal abuse.

3. Any alleged criminal act involving a client which may result in a felony charge and which is committed on Center grounds and/or as the result of an employee's occupational duty.

4. Medical and nursing incidents requiring immediate follow-up by the medical director and nursing director including, but not limited to:

i. Attempted suicide or other serious action of self-abuse by a client.

ii. Serious accidental injury to a client which is not caused by another person.

iii. A life-threatening adverse reaction by a client to an administered drug. A medication error that results in serious consequences to a client whether it is the result of the administration of an unprescribed drug or the improper administration of a prescription drug.

STATEMENT OF FACTS

The State of Ohio's Department of Mental Retardation

and Developmental Disabilities ("Employer") is the state agency entrusted with the care, treatment and study of individuals with mental retardation or substantial developmental illnesses. The Employer operates a number of developmental treatment centers in the State of Ohio, including the Montgomery Developmental Center ("MDC") in Huber Heights, Ohio. The MDC is licensed by the state as an intermediate care facility for severe to profoundly retarded clients. Many of the facility's employees, including its registered nurses ("RN's") are represented, for purposes of collective bargaining, by the Ohio Health Care Employees Union District 1199, WV/KY/OH ("Union"), affiliated with the National Union of Hospital and Health Care Employees. The Employer and the Union are signatories to a collective bargaining agreement effective June 12, 1986 through June 11, 1989.

The grievant, Jeanne Niswonger, has been employed at the MDC as an RN since May, 1987. On Tuesday, February 2, 1988,[2] the grievant worked the 3:00 p.m. to 11:30 p.m. shift and was the RN in charge of the clients residing in cottages (the residential units) 3 and 4. As such, it was her responsibility to administer evening medications to those clients whose treatment required them, starting at

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[2] All relevant dates herein are 1988.

8:00 p.m. Among the clients to whom she administered medications that evening was James, for whom Unifibre (a stool softener) and Tavist (an antihistamine), had been prescribed.

Shortly after the start of the 7:00 a.m. to 3:30 p.m. shift on the following morning, February 3, RN Linda Gober attempted to awaken James and found him weak, lethargic and unable to walk. This condition was in stark contrast to James' usual behavior pattern, which is tactile, active, aggressive and resistant. Maggie Russel-Fitts, at the time the acting Director of Nursing Service at MDC, was notified and initiated a complete investigation. When no discernible physical cause for James' stupor could be found, a blood test including a chemistry profile was ordered. On February 4th the laboratory reported that traceable levels of Mysoline, Depakote and Tegretol, three anticonvulsive drugs, had been found in James' blood sample. These drugs had never been prescribed for James, but were the regular medications received by Cottage 4 client John, whose medication drawer is next to James' in the cottage's med cart .

Russel-Fitts questioned each of the nurses who had worked in cottage 4 on February 2 and 3. She also discussed the situation with the MDC's consulting pharmacist, who advised her that, in view of the three drugs' known peak

serum levels in the bloodstream, the medications were in all probability administered to James on the evening of February 2nd. Thus, Russel-Fitts concluded that the grievant had mistakenly administered John's antiseizure medications to James during her shift that evening. Following a predischarge hearing, the Employer characterized the incident as one of serious physical abuse and, pursuant to MDC policy, the grievant was given a twenty (20) working day suspension which she served from March 22 to April 17, 1988. The instant grievance was filed on behalf of the grievant on March 24, 1988.

Additional relevant evidence was elicited during the arbitration hearing. It is the practice at the MDC, when dispensing oral medications to individuals who have difficulty swallowing pills, to give clients a dollop of applesauce to ease the process. The grievant admitted that she routinely places medication and applesauce into small dispensing cups for each client, which she then puts into each client's individual medication drawer in the med cart prior to wheeling the cart out of the medication room. The grievant stated that she was never told not to dispense medications in this manner, and indeed claims that an unnamed MDC nurse advised her to dispense that way.

The grievant denied making any medication error on the evening of February 2nd. She asserted that she knew both James and John well enough as to not be confused as to their identities, and stated that she could not have mixed up their medications because their respective pills are visually distinct. The grievant explained that on the evening in question she prepared her med cart as described above, wheeled it into the main area of the cottage and began dispensing the medications. She recalled that Habilitation Assistant ("HA", a specialized type of orderly) Sampson Williams assisted her in administering medications to James that night: "As near as my recollection is, I believe that Sampson held his arms, because he [James] is trying to hit you, and [I] gave him his medication ..." The grievant also testified that John refused his medications three times, so she disposed of the three pills in the presence of another HA, Wanda Wolper. Wolper was not called to testify by either side at the hearing.

Sampson Williams testified that he did not help the grievant administer medications to James on the evening of February 2nd as he was engaged in other work at the time.

Russel-Fitts stated that she has gotten complaints from other nurses about the way the grievant dispenses medications and maintains the med carts. She testified that it

is against MDC policy and good nursing practice to place medications and applesauce into the dispensing cups in advance, and said she believed that the grievant had been advised on proper medication procedures during her orientation, although she could not be sure it had actually been done. Russel-Fitts testified that John and James' medication drawers are adjacent to one another on the med cart, and that she believed the grievant made the medication error by mixing up the drawers, either during preparation or dispensation, and was not able to catch her mistake because the pills were improperly pre-mixed in the applesauce. Russel-Fitts also stated that no other nurse had even been given more than a five (5) day suspension for making a medical error, but explained that there has never been such an incident at the MDC which resulted in such serious consequences for the client involved.

Both the Employer and the Union presented licensed pharmacists as witnesses in support of their respective cases. In essence, their testimony was not conflicting. Apparently medical literature establishes that peak blood levels of the three antiseizure drugs involved are reached in a range of one-half (½) to nine (9) hours, with an average of about three (3) to four (4) hours. Both pharmacists

explained that the timing of the peak serum levels and the onset of the resulting symptomatology could vary considerably from individual to individual. Nevertheless, the pharmacist presented by the Employer felt confident in stating, based on the laboratory results obtained by the Employer, that the drugs in question were administered to James sometime between 4:00 p.m. on February 2nd to 6:00 a.m. on February 3rd.[2] The pharmacist called by the Union would not give an estimated time frame.

POSITIONS OF THE PARTIES

Company Argument

The Employer contends that the weight of the evidence presented in this case conclusively establishes that it was the grievant who gave James the improper medication, causing him severe physical consequences and disrupting his treatment program. It asserts that the grievant's medication practices are improper and likely contributed to her mistake. The Employer argues that as an RN given responsibility in the care and health of clients who are little able to look after themselves, the grievant was charged with the duty to use professional judgment in all her dealings

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[2] It is undisputed that James went to bed during the grievant's shift and remained asleep until awaken shortly after 7:00 a.m. the next day.

with her clients. Given the fact that she failed to maintain this duty of care and in light of the grave consequences suffered by the client in question, the Employer asserts, the twenty (20) day disciplinary suspension imposed on the grievant was proper and should be upheld.

Union Argument

The Union contends that the evidence establishes that the medication error at issue could have been made during a wide range of time and by any number of people. It asserts that given the grievant's credible denial of the error and the lack of anything but circumstantial evidence identifying her as the culprit, the grievant was not disciplined for just cause. The Union argues that even if the grievant did make the mistake it was obviously not a deliberate act. It also points out that other nurses who have made such medication errors have not been disciplined so severely. Thus, the Union contends, even if the grievant is found to have committed the error in question, the twenty (20) day suspension is too harsh a penalty.

DISCUSSION

Does the evidence in this case establish that it was the grievant who mistakenly administered the wrong medications to James which resulted in his debilitated condition? After

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DISCUSSION

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careful consideration of the entire record and the arguments of the parties, it is the Arbitrator's opinion that the grievant was responsible for giving James the medication of John.

It is obvious that James' ingestion of Mysoline, Depakote and Tegretol was the result of a simple mixup during the regularly scheduled passage of medications in cottage 4. That the three (3) drugs in question are the exact medications prescribed for John, whose medication drawer is next to James in the med cart satifies the Arbitrator that this incident happened just that way.[2] Although there were no witnesses to the improper administration of the drugs to James, the circumstantial evidence present is more than sufficient to establish the grievant as the person responsible for the error. The testimony of the two pharmacists makes clear that, given the known time range for the medications in question to reach their peak levels in a person's blood-stream, the lab report on James' blood test indicates that he very likely ingested the drugs during the evening medication passage on February 2, 1988; that is, when the grievant

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[2] Thus there is no indication, and the Union does not suggest, that the drugs were intentionally administered by someone or otherwise given at a time other than the regularly scheduled passage of medication.

passed out medications. Although both pharmacists stated that the absorption time and onset of physical effects can vary greatly from individual to individual, several factors convince the Arbitrator that the grievant indeed made the medication error.

First, despite the possibility that James was given the medications before 3:00 p.m. on February 2nd or after being awakened the following day, the statistical probabilities overwhelmingly point to the incident occurring during the evening of the 2nd. In the context of labor arbitration, an employer is not required to prove employee misconduct beyond a shadow of a doubt. A preponderance of the evidence is sufficient. In the instant case, the Arbitrator may properly rely on probabilities (in this case, high probabilities) and discount remote (although possible) alternatives. The medical evidence, then, establishes that in all probability James was given the wrong medications during the grievant's shift.

This conclusion is also supported by other relevant evidence. First, the grievant's admitted practice of mixing medications and applesauce in the medication room prior to approaching the clients for administration undoubtedly enhanced the chances that she might put the prepared medication cups in the wrong medication drawer or, alternatively,

give a client medication from the wrong drawer without noticing (as the pills in the applesauce would not be so easily identified). Further, Russel-Fitts testified that she had received complaints from other nurses concerning the grievant's failure to maintain the med cart in a clean, orderly condition. In short, the evidence establishes that the grievant's method of preparing and administering medications were such as to increase the likelihood that she would commit a medication error without realizing it.[2]

Finally, the grievant's testimony was such as to cast doubt on the accuracy of her recall of the events of February 2nd. Specifically, the Arbitrator found it impossible to reconcile her recollection that HA Williams assisted her in administering medication to James that evening with William's own credible testimony that he was not present when James received his medication. Williams' testimony in this regard seemed straightforward and believable. The grievant, on the other hand, did not seem to sure of herself,

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[2] Russel-Fitts testified that standard nursing practice and MDC policy require that nurses not dispense medications into cups, spoons, etc. until they approach and positively identify the patient to whom they are to be administered. There was no substantive evidence, however, that the grievant was ever instructed in this procedure by anyone while at the MDC. Thus, while the grievant may be properly disciplined for making the medication error, she may not be charged in this instance with violating MDC policy as to the proper administration of drugs.

stating, "As near as my recollection is, I believe that Sampson held his arms ..." The unavoidable implication is not necessarily that the grievant was less than candid in her testimony, but instead that she could not clearly remember the events of the evening in question. Consequently, her assertion that she made no medication errors that night may be based on faulty, although not necessarily dishonest, recall.

It is the Arbitrator's conclusion, then, based on the reasoning above, that it was the grievant who was responsible for the medication error. Such a breach in a nurse's duty of care to her charges is certainly subject to disciplinary action. The only question remaining is whether the twenty (20) day disciplinary suspension actually imposed on the grievant was proper under the circumstances.

The Employer admits that no nurse has ever been disciplined so severely for medication errors which have occurred in the past. It justifies the disparity by pointing to the severe physical reaction suffered by James as a result of the incident. This differential, based on the severity of the consequences, is reflected in the Employer's Disciplinary Policy (i.e., it distinguishes between "physical abuse or neglect" which is "harmful" and that which is not).

The Arbitrator does not believe that this distinction is valid in the context of inadvertent medication errors. All medication errors are serious. The nature of mistake is not altered by gravity of consequences thereto. In other words, when a nurse inadvertently misadministers medications, his or her culpability and need for corrective action should not depend on whether Lady Luck saw that the incident involved aspirin or a highly toxic drug. In Ohio Valley Hospital Association, 79 LA 929 (1982), Arbitrator Roger I. Abrams considered the discharge of a nurse who nearly caused the death of a patient when she failed to follow correct medication procedures:

> The Hospital discharged [the grievant] because the patient nearly died. Her mistakes, however, would have been just as serious had the patient suffered no ill effects.

Noting that in a past incident a nurse who negligently removed a tube from a patient was not disciplined "perhaps because that patient did not 'nearly die'," Arbitrator Abrams explained that

> [i]t seems clear that if [the patient] had not suffered as seriously (or not suffered at all), [the grievant]'s omission would have lead to counselling or at worse, a disciplinary suspension. The Hospital responds that it is under no obligation to discipline in a consistent manner. That claim is clearly without merit. "Just cause" - the standard which controls under the parties' Agreement - necessarily means that like cases will be treated alike. See Township of Dover, 76 LA 1251 (Gray, 1981).

79 LA 934. See also, Titusville Hospital, 86 LA 597, 599-600 (Hannan, 1985).

The Arbitrator finds this reasoning equally applicable to the instant case. The grievant clearly committed a very serious medical error. However, she testified without contradiction that she had never been disciplined during her employment at the DMC, although her tenure there had been relatively short and her probationary review was only fair. It is undisputed that the most severe discipline ever imposed by the Employer for medication errors has been a five (5) day suspension. Unfortunately, the Arbitrator is not privy to the details of these other incidents. Nonetheless, in light of these circumstances, the grievant's twenty (20) day suspension clearly amounts to disparate treatment of employees by the Employer. Therefore, the Arbitrator finds that the "just cause" standard of the collective bargaining agreement requires that the grievant's suspension be reduced to ten (10) days. This change is to be noted on the grievant's personnel records and she shall be made whole for the ten (10) additional days she actually served.

In closing, the Arbitrator wishes to stress that the modification ordered above is based solely on the principle of equal treatment of employees under similar circumstances.

As stated above, medication errors are very serious mistakes and may be punished severely (including twenty [20] day suspensions) so long as all such inadvertent errors result in like discipline. Thus the Employer may choose to discipline such incidents in the future with severe disciplinary suspensions if the nursing staff is notified in advance that medication errors will be dealt with in this way.

AWARD

For all the reasons detailed above, this grievance is upheld in part. The grievant's suspension is modified to ten (10) days, and she shall be made whole as explained above.

JONAS B. KATZ, Arbitrator

Issued at Cincinnati, Hamilton County, Ohio, this 9th day of February, 1989.