STATE OF OHIO/OHIO HEALTH CARE EMPLOYEES UNION DISTRICT 1199

In the Matter of Arbitration --between-- Ohio Health Care Employees Union District 1199, National Union of Hospital and Health Care Employees, AFL-CIO --and-- Ohio Department of Mental Health, Fallsview Psychiatric Hospital	Grievance No. 23-09-89-08-07-0145-02-11

ARBITRATOR'S DECISION AND AWARD

Teri Decker
For the State

Rick Kepler
For the Union

April 20, 1990

Calvin William Sharpe
Arbitrator

The Ohio Health Care Employees Union District 1199, National Union of Hospital and Health Care Employees, AFL-CIO (Union) filed a grievance against the Ohio Department of Mental Health, Fallsview Psychiatric Hospital (State) protesting the suspension of Nancy Yoho (Grievant) on August 2, 1989. The State denied the grievance. Unable to secure satisfactory relief at earlier stages of the grievance procedure, the Union has now brought the matter to arbitration. A hearing was held on February 16, 1990, in Columbus, Ohio. The parties stipulated to the arbitrability of the grievance.

I.

STATEMENT OF THE CASE

A. THE ISSUE

1. Was the Grievant's suspension on August 2, 1989 for just case?

2. If not, what is the remedy?

B. RELEVANT PROVISIONS OF THE 1986-1989 AGREEMENT

ARTICLE 8 - DISCIPLINE

Section 8.01 Standard

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

Section 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 occurrence of various disciplinary offenses.

C. BACKGROUND FACTS

The Fallsview Psychiatric Hospital is a three story, 131 bed facility of approximately 98,000 square feet located in Akron, Ohio. It provides psychological, psychiatric, medical and custodial care to male and female residents of the facility. The Akron facility is administered by the Ohio Department of Mental Health and serves patients in surrounding counties.

The Grievant is a Psychiatric Nurse II who has worked at the Fallsview Psychiatric Hospital since February 20, 1987. She works on the second shift from 3:00 - 11:00 p.m. She is a registered nurse whose duties include admitting, assessing, and counseling patients. The Grievant also designs and implements therapeutic strategies to meet patient needs and behavioral goals.

The Fallsview Psychiatric Hospital has a central stairwell used primarily by hospital staff, and a rear ward door that is reserved for use by visitors and patients who have special privileges. Hospital policy prevents nurses from using the rear ward door except for conference calls involving a patient crises or other emergencies.

As with other psychiatric hospitals Fallsview experiences a high number of absence without official leave cases (AWOLs) among its patients. A significant number of AWOLs involve escapes from the institution. Registered Nurse Vivian Norby explained that the reason for so many escapes and escape attempts is the patients' belief that they are healthy and should not be institutionalized. Fallsview had 229 AWOLs in 1987, 268 in 1988, 238 in 1989. Because of the high incidence of AWOLs and the

significant portion of such cases caused by escapes, the hospital labels patients who present a risk of escape as observational, precautionary, or isolational. Patients on observation are thought to present a lesser risk and require occasional observation. Patients on precaution are thought to present a greater risk and require checking every 15 minutes. Patients on isolation are under constant surveillance or held in conditions that make escape impossible.

On June 11, 1989, the Grievant was the charge nurse on her shift with two other staff persons working. One was a Licensed Practical Nurse (LPN) and the other was a Therapeutic Program Worker (TPW). Thirty-two patients were on the ward that evening. One patient, A.M., was considered precautionary because of his history of escapes from the hospital. At approximately 7:30 p.m. the Grievant was confronted with a delusional patient who began screaming. She could not be comforted and was beginning to excite other patients in the hospital. In order to calm the patient and to circumvent the agitation of other patients the Grievant took the delusional patient through a rear ward door and outside the hospital. Before leaving the ward floor the Grievant informed LPN Charlene Cintavy that she was leaving the floor. Since the TPW was also absent from the floor at the time the Grievant's departure left Nurse Cintavy alone with 31 patients on the ward floor. After walking around the hospital the Grievant returned with the patient to learn from Nurse Cintavy that A.M. had escaped. The Grievant called security, and the administrative wheels were set in motion to locate the patient

and return him to the hospital.

Nurse Carolyn Hix one of the two supervising nurses on the shift at the time, instituted an investigation against the Grievant for neglect of duty in permitting A.M. to escape. The security department talked to witnesses and following the investigation Nurse Hix recommended corrective action against the Grievant for neglect of duty. The hospital suspended the Grievant for six days for negligence in failing to secure the rear ward door when she took the patient out of the hospital. As a secondary matter the hospital also regarded the Grievant's use of the rear ward door as a violation of policy as contained in hospital rules.

II.

CONTENTIONS OF THE PARTIES

A. THE STATE'S POSITION

The State argues that the Grievant's suspension was for just cause based on the Grievant's prior disciplinary record, mediocre evaluation, violation of hospital policy in using the rear ward door and failing to secure the rear ward door which permitted A.M. to escape. Key among these claims of cause is the Grievant's failure to secure the rear ward door. The State argues that the evidence demonstrates the failure of Grievant to secure the door. It concludes that the six day suspension was reasonable under the State's disciplinary grid and urges that the grievance be denied.

B. THE UNION'S POSITION

On the other hand, the Union argues that the state has not proved the Grievant was negligent on June 11, 1989. It claims

that no evidence supports the conclusion that the Grievant's use of the rear ward door permitted A.M. to escape on June 11, 1989. Furthermore, the Union argues that nurses should never be held accountable for patient escapes and likens such accountability to holding teachers responsible for the truancy of students. The Union argues that only in cases where a nurse colludes with the patient to aid an escape should the nurse be held guilty of neglect of duty. In addition the Union argues that the hospital has targeted its professional staff for poor treatment and singled out the Grievant for particularly harsh treatment. Finally, the Union argues that the imposition of discipline upon a nurse for the escape of a patients is highly unusual and not done at any other psychiatric hospitals in the state. Based on the foregoing the Union urges the sustaining of the grievance and making whole of the Grievant.

III.

DISCUSSION AND OPINION

Under Article 8 of the Agreement the parties have clearly set forth a "just cause" standard for discipline and a system of progressive discipline that seeks to correct unsatisfactory performance where possible. Under well-settled arbitral practice management has the burden of proving that it had cause for disciplining an employee. See O. Fairweather, Practice and Procedure In Labor Arbitration, 254-256 (2d. ed. 1983). In the context of this grievance management must show that the Grievant failed to exercise reasonable care in securing the rear ward door that she used to remove an agitated patient from the facility on

June 11, 1989.

Without such proof the evidence of the Grievant's discipline record and periodic performance evaluations is irrelevant. It is the proof of the alleged occurrence that may trigger the relevancy of evidence relating to performance history in mitigation or support of discipline. Without such proof performance history may not be used to bootstrap a claim of just cause.

The State at the hearing referred to the Grievant's violation of the hospital's policy against using the rear ward door. However, as reflected in the Pre-Disciplinary Hearing Officer's recommendation, the Chief Executive Officer's determination, the Third Step Response of D. Eugene Woods, Jr. and the State Advocate's representation to the Arbitrator at the hearing, the State's claim of just cause clearly rests upon the Grievant's alleged failure to properly secure the door after she exited.

The State's neglect of duty claim turns on whether the State has proven that the Grievant failed, when she used the rear ward door on June 11, 1989, to take precautions that could have reasonably been expected of a professional in her position to prevent A.M.'s escape. The Arbitrator finds that the State has not met its burden of proof.

The Grievant testified credibly that she was aware of A.M.'s history of escapes and checked him every 15 minutes during her shift on June 11, 1989. She also testified that A.M. was checked shortly before she left the building with the distraught patient and that A.M. was not in the vicinity of the rear ward door at

the time that she exited.

The Grievant was aware that the door closes automatically, unless defective. And even though the Grievant's attention was focused primarily on getting the distraught patient out of the facility, the door shut behind her on June 11, 1989, according to her testimony.

The Grievant's testimony is corroborated by the State's witness, Maintenance Supervisor Randy Rasmussen. He testified that the door was in good working order, closed automatically and required no assistance from the Grievant to completely shut after the Grievant and the patient passed through on June 11, 1989. Mr. Rasmussen did establish that a key plus pressing the crash bar were necessary to get out of the door; but this does not establish that the Grievant needed to do anything extra in order to close or secure the door. Furthermore, Mr. Rasmussen testified that the door when in good working order takes approximately 5 seconds to close.

Had A.M. not been checked shortly before the Grievant left the facility, giving her reason to question his whereabouts, the State's claim of negligence would be stronger. Similarly, if A.M. had been within view of the Grievant as she prepared to exit the rear ward door, she would not have been aided by the evidence that the door closed automatically within five seconds. A patient demonstrating A.M.'s proclivities could reasonably be expected to escape during such an interval and the Grievant would have been obliged to wait until the door locked after exiting or until A.M had cleared the area before exiting. But in the

absence of facts suggesting that the Grievant should have taken further precautions to secure the rear ward door--a door that would close on its own after a short interval--the State has simply not proved that the Grievant failed to secure the door under the circumstances.[1]

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[1] This arbitral determination should not be construed as a condonation of conduct that increases the risk of patient escape or as an adoption of the collusion standard proposed by the Union. It should only be construed as holding that the State has not met its burden of proving that the Grievant's negligence led to the escape of A.M.

Also, the Union has not shown that the Grievant was singled out, unfairly, for discipline, and her feeling that she was singled out is insufficient proof without more. Moreover, the claim that management is perceived as confrontational and hostile does not tend to show that the Grievant was singled out. On the contrary, one would expect to find a more generalized campaign against the professional staff, if such hostility existed.

IV.

AWARD

The grievance is sustained. The State shall make the Grievant whole for any losses incurred including but not limited to pay and benefits, because of her improper suspension on August 2, 3, 5, 6, 8 and 9, 1989.

CALVIN WILLIAM SHARPE
ARBITRATOR

4/20/95
DATE