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VOLUNTARY LABOR ARBITRATION TRIBUNAL

IN THE MATTER OF ARBITRATION	:	
BETWEEN	:	
STATE OF OHIO, DEPARTMENT OF MENTAL HEALTH, MASSILLON PSYCHIATRIC CENTER	:	**DECISION IN TWO DAY DISCIPLINARY SUSPENSION FOR NEGLECT OF DUTY & PATIENT ABUSE/NEGLECT (CAROLYN A. STIFFLER)**
- AND -	:	
DISTRICT 1199, THE HEALTH CARE AND SOCIAL SERVICE UNION, S.E.I.U., AFL-CIO	:	

GRIEVANCE NO.: 23-10-930504-0184-02-11

GRIEVANCE: The Grievance protests the Employer's issuance of a two (2) day disciplinary suspension for alleged neglect of duty and patient abuse/neglect as lacking just cause.

AWARD: The Grievance is sustained.

HEARING: March 25, 1994; Massillon, Ohio.

ARBITRATOR: David W. Stanton, Esq.

APPEARANCES:

FOR THE EMPLOYER

Cynthia Sovell, Labor Relations Specialist, OCB
Georgia Brokaw, Assistant Chief of Arbitration Services, OCB
Mick Musselman, Labor Relations Officer, MPC
Patricia Halter, Acting Nurse Executive, QA, QI Director
Janet A. Black, Psychiatry & Mental Retardation Nurse Coordinator
Tammy Fontes, Therapeutic Program Worker
Bernard Sandebeck, LPN

FOR THE UNION

Marcia Margevicius, 1199 Organizer
Thomas Price, 1199 Delegate
Carolyn A. Stiffler, Grievant

ADMINISTRATION

By letter dated October 1, 1992, from Tim D. Wagner, Chief of Arbitration Services for the State of Ohio, Office of Collective Bargaining, the Undersigned was notified of his mutual selection to serve on a rotating panel of Arbitrators to hear and decide disputes arising between these Parties. The instant matter involves, as the Grievant alleges, the improper issuance of a two (2) day disciplinary suspension for neglect of duty and patient abuse/neglect. On March 25, 1994, an Arbitration Hearing was conducted wherein each Party was afforded a fair and adequate opportunity to present testimonial and/or documentary evidence in support of positions advanced; and, where the Grievant appeared and testified on her own behalf. The voluminous Record of this proceeding was subsequently closed upon the Arbitrator's receipt of the Parties' Post-hearing Briefs; and, this matter is now ready for final resolution herein.

GRIEVANCE AND QUESTION TO BE RESOLVED

The following Grievance (Joint Exhibit - 7) was filed on April 29, 1993, and contains the subject matter for resolution herein:

STATE OF OHIO - DISTRICT 1199

GRIEVANCE FORM

Grievant's Name: Carolyn Stiffler, RN

Agency: MH

Delegate's Name: Thomas Price, RN

Work Site: MPC

Grievant's Classification: RN - Coordinator

Date Grievance Arose: 4-27-93

Statement of Grievance: Management imposed disciplinary action [suspension for two (2) days] upon above-mentioned Employee with no just cause.

Contract Article(s) and Section(s): Article 8, Section 8.01, et al.

Resolution Requested: (1) Dismissal of all charges; (2) Removal of all mention of incident from the Employee's records; (3) Re-payment to Employee for days of suspension; (4) To be made whole in every way.

Grievant's Signature: /s/ Carolyn A. Stiffler, RNC

Date: 4-29-93

The question to be resolved herein, as stipulated to by and between and the Parties, is as follows:

"Was the Grievant, Carolyn A. Stiffler, disciplined for just cause? If not, what shall the remedy be?"

CITED PROVISIONS OF THE PARTIES' COLLECTIVE BARGAINING AGREEMENT

The following provisions of the Parties' Collective Bargaining Agreement (Joint Exhibit - 1) were cited; and/or, are deemed relevant herein:

ARTICLE 8 - DISCIPLINE

8.01 Standard

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

8.02 Progressive Discipline

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

(A) Verbal reprimand;
(B) Written reprimand;
(C) Suspension; and,
(D) Removal.

The application of these steps is contingent upon the

type and occurrence of various disciplinary offenses.

* * *

FACTUAL BACKGROUND

The underlying facts which gave rise to the filing of this Grievance relative to the disciplinary suspension imposed are, except as otherwise noted, essentially undisputed. Carolyn A. Stiffler, hereinafter referred to as "the Grievant," has been employed in the capacity of a Registered Nurse at the Massillon Psychiatric Center for approximately three and one half (3 1/2) years. At the time of concern, she was a "float" Nurse who was required to report to the "Central Office" prior to her shift to receive her assignment for the shift she was to perform. The Grievant testified that she reported to Central Staffing approximately seven (7) minutes late on the evening in question whereupon she learned that she was assigned Charge Nurse duties on the Intensive Psychiatric Ward or the "IPC," as it was characterized. The Grievant stated that it had been "a while" since she last worked on this unit. As the testimony of Record demonstrates, patients with mental illnesses of a high acuity level were placed on this ward. The fact she reported late for work on the evening in question is not disputed, nor was such the basis for her disciplinary action.

As Charge Nurse, one of the Grievant's many responsibilities was to assign staff members to various tasks as the Patient census/acuity level thereof warranted. On the evening in

question, March 7, 1993 - which for the third shift carried over into March 8, 1993. The Grievant worked this shift which began at approximately 10:45 p.m. Upon arriving on the ward, the Grievant was responsible for "making rounds" which required approximately five (5) minutes to perform such tasks as making a head count of the patients, etc., and then receiving the verbal "Change of Shift Report" from the off-going Charge Nurse. This report usually lasted approximately ten (10) minutes and both tasks which began at the beginning of the shift required approximately ten (10) to fifteen (15) minutes depending upon the activity on the ward; patient census; and, the acuity level of the patients.

Given the acute illness level of the patients on this ward, the Hospital had in place a policy to address suicidal, homicidal and potential escape patients. Joint Exhibit - 2 represents that policy with its noted primary purpose to provide for the safety of the patients and those providing care for them. As stated therein, the levels of intervention as they relate to this matter were as follows:

* * *

> (B) <u>One-to-one Observation</u> - Precautions or procedures followed when it is determined that a patient needs constant, one-to-one supervision. The purpose of utilizing such a procedure is for suicide threats/acts or self-injury. Staff will remain with the patient at all times. Only one (1) patient will be assigned to one (1) staff person. Documents condition of patient every fifteen (15) minutes.

* * *

(D) Close Observation - When Psychiatrist determines the patient's behavior warrants close observation due to homicidal threats, self-injurious behavior, suicidal threat by a patient not needing to be placed on suicidal precautions or an escape risk. Staff will observe the patient and document at least once each shift. One (1) staff person can be assigned to observe more than one (1) patient.

As the testimony of Record demonstrates, these characterizations of the type of patient care required for certain patients was in many respects "synonymous" even though the policy clearly differentiates the level of patient care required.

The Grievant testified that the third shift becomes responsible for patient care at 11:15 p.m. when the second shift reports off. She stated after receiving verbal report and making rounds she reviewed the "Twenty-four (24) hour report" to become familiarized with the unit since she had not worked the IPC Ward in some time. Contained therein she observed that instead of the Close Observation order as verbally reported to her by the off-going second shift Charge Nurse, Jan Black, relative to the Patient in question, she noticed therein that the Doctor had ordered a One-to-One Close Observation. Even though the levels of patient care are distinguishable with respect to their policy names, the Grievant stated that she referred to the Doctor's Orders to confirm the level of care. Rather than the Close Observation as verbally reported, this Patient was required to receive One-to-One Observation as ordered by the Physician. She stated that she learned of this discrepancy at approximately 11:25 p.m. whereupon she went to Bernie Sandebeck, an LPN, who

was already performing this duty to which she was unaware. In any event, she verbally reported to Vern Book that he was to perform the One-to-One Observation (Management Exhibit confirms this).

As the evening progressed, the circumstances which arose can only be characterized as unfortunate. At approximately 12:30 a.m. on the morning of March 8, 1993, the Patient in question was discovered by the medical staff to have "cut his wrist." Hospital policy provides that all patients are permitted to cover themselves with a blanket while lying on their bed. As the Record demonstrates, the Patient was in fact lying on his bed with the blanket covering him prior to the time that he cut his wrist. Importantly, the Record also demonstrates that at the time of this incident the Patient was receiving One-to-One Observation as assigned by the Grievant. Management Exhibit - 3 represents the "Suicide Report;" i.e., "Incident Report," relative to this matter wherein such was either completed or the event occurred at approximately 12:50 a.m. The Patient was rushed to the Emergency Room for treatment.

The Grievant's statement of this incident, dated March 9, 1993 (See, Management Exhibit - 8), demonstrates that the Patient stated that he had obtained the razor with which he cut himself approximately two (2) weeks prior.

Subsequently, the Grievant was notified on April 1, 1993, of a Pre-disciplinary Conference to be conducted on April 7, 1993, wherein Management determined that on her shift she failed to

provide the continuity of care stemming from a Physician's Order for One-to-One patient observation as required. Subsequently the Grievant received an "Order of Suspension," wherein she was advised that she was being suspended without pay from scheduled duty for two (2) work days - April 27 and 28, 1993, respectively. As stated therein, the Hospital noted that such was a breach of its policy relative to the quality of care and neglect of duty and as such was just cause for discipline.

Consequently, the Grievant exercised her right under the Collective Bargaining Agreement between the Parties to appeal the Employer's action to final and binding arbitration. She filed this Grievance dated April 29, 1993, challenging Employer's action of assessing a two (2) day disciplinary suspension.

When the Parties' efforts to resolve this matter through the course of the Grievance Procedure proved unsuccessful, the two (2) day disciplinary suspension of Carolyn A. Stiffler for "neglect of duty and patient abuse/neglect" was appealed to Arbitration hereunder.

CONTENTIONS OF THE PARTIES

EMPLOYER CONTENTIONS

The Employer contends that the issuance of the two (2) day disciplinary suspension of the Grievant was for just cause in that she failed to assign the One-to-One coverage to a suicide patient and failed to provide the continuity of care that was required. The Employer notes that the Patient in question was

assigned pursuant to a Physician's order as set forth in Management Exhibit - 3, to receive One-to-One Observation. The One-to-One Observation requires that one staff person be assigned to continually observe that patient for the duration of the time specified in the Physician's Order. During the course of the shift change between second and third shifts, the Employer asserts that the Charge Nurse on second shift reported to the Grievant verbally, and in writing, that this Patient was to be on One-to-One Close Observation. While it notes and concedes that the terminology One-to-One Observation and Close Observation are oftentimes synonymous, they nonetheless were specific in this matter. This Patient required One-to-One Close Observation for suicide and escape precautions. The Employer notes that Union Exhibit - 1 dated March 13, 1993, sets forth that the second shift Charge Nurse did indeed report to the Grievant that the Patient was on One-to-One Observation on the evening in question. Furthermore, the Employer notes that the Grievant was fully aware of the policies and procedure for the Intensive Psychiatric Unit on which she worked and for that involving One-to-One Close Observations. In this regard, the Grievant certainly cannot contend that she was not aware of the proper procedure to follow.

To worsen matters, the Employer emphasizes that on the evening in question, the Grievant reported approximately seven (7) minutes late and inasmuch that she was a "float" nurse who had to report to Central Office, her delay in reporting for work compounded the incident and served as the proximate cause for the

suicide attempt of this Patient.

Importantly, the Employer notes that through cross-examination the Grievant indicated that she failed to provide the continuity of care for this intensely ill Patient until approximately forty-five (45) minutes into her shift. Even though Licensed Practical Nurse Bernie Sandebeck testified that he was in charge of this Patient and was performing the One-to-One Observation for approximately thirty (30) minutes of the forty-five (45) minute lapse from the time the Grievant reported to work and assigned the One-to-One, the Grievant's statement, Management Exhibit - 8, indicates that Mr. Sandebeck was apparently making rounds with her at the beginning of the shift. And, he noted that he was also present at the Change of Shift Report. The Employer emphasizes that there was no physical way that Mr. Sandebeck could have made rounds with the Grievant and be present during the Change of Shift Report while simultaneously performing the One-to-One Observation with the Patient. He indicated further that he was not present with him while performing rounds with the Grievant or was he present with him during the Change of Shift Report. Mr. Sandebeck did confirm however that the Grievant did not assign him the One-to-One Observation, but that he assumed that assignment on his own.

The Employer argues that it has met its burden of proof in that the Grievant failed to make the One-to-One assignment, thereby interrupting the continuity of care for this suicidal patient. In this regard, she failed to perform an essential job

duty of the Intensive Psychiatric Ward and, as such, the imposition of the disciplinary suspension was for just cause. The Employer also notes that, under Section 8.02 of the Parties Agreement relative to progressive discipline such is contingent upon the nature and occurrence of the incident giving rise to the disciplinary action. The Employer emphasizes that when dealing with the intensely mentally ill, it is of the utmost importance that the Department of Mental Health Employees follow the rules, regulations and policies of the Department. This standard of conduct is magnified by the fact that this Grievant was a Charge Nurse assigned to the Intensive Psychiatric Ward where all Patients require the utmost care and observation.

For all of these reasons, the Employer requests that the Grievance be denied.

UNION CONTENTIONS

The Union contends that the Employer failed to meet its burden of proof by "clear and convincing" evidence that its issuance of the two (2) day disciplinary suspension was for just cause.

The Union emphasizes that the Employer's reliance on the fact that the Grievant was tardy on the evening in question is irrelevant in that the Employer elected not to impose any disciplinary action relative thereto. While the Union concedes that the Grievant reported late for work that, in and of itself, had no bearing on what occurred on the evening in question.

The Union emphasizes the testimony of Bernie Sandebeck, which was corroborated by the Grievant, wherein approximately five (5) minutes was exhausted on performing rounds and ten (10) minutes was utilized for the verbal shift report. The fact that the Grievant performed these two mandatory tasks within the thirty (30) minute overlap had no bearing on the fact that she reported approximately five (5) to seven (7) minutes tardy on that evening.

The Union notes that the Grievant reported to the Intensive Psychiatric Ward after receiving her assignment from Central Staffing, conducted her rounds, and participated in a verbal change of shift report. Upon completing the verbal shift report where the off-going shift reports significant concerns of patients, she began to read the change of shift report (Management Exhibit - 5). Even though the second shift Charge Nurse testified that she reported to the oncoming staff that the Patient in question was on One-to-One Close Observation, such was not substantiated. The Grievant testified that she did not hear the second shift state that this individual was on One-to-One Close Observation. The Union emphasizes that Union Exhibit - 3, the statement of Vern Allen Book, the TPW on that ward, indicates that he was present at the verbal shift report and stated therein that the second shift report was that this individual was on Close Observation, rather than One-to-One Observation as alleged by the second shift Charge Nurse. Moreover, the Union emphasizes that the only third shift regular staff individual assigned to

this ward was LPN Sandebeck who coincidentally was not present for the verbal shift exchange, but was aware of the One-to-One order on this Patient and therefore assumed that responsibility. The Union notes that the remainder of the staff were "float" persons who were assigned as needed on a daily basis and the Grievant in this regard would not have known that the Patient in question was on One-to-One coverage.

The Union argues that at no time on the third shift of March 7-8, 1993, was this Patient without the One-to-One coverage as ordered by the Physician. Mr. Sandebeck assumed those duties that evening as soon as second shift left and at approximately 11:25-11:30 p.m., while assessing the twenty-four (24) hour report, the Grievant discovered that this Patient required One-to-One supervision instead of Close Observation as was reported at the verbal shift change. Upon doing so, the Union notes that the Grievant immediately made the assignment and documented her actions.

Furthermore, the Union questions the accuracy of the ward assignment work sheets (Union Exhibits - 2 and 4, respectively) which demonstrate that this Patient's care was One-to-One and/or One-to-One Close Observation. Even though the reports indicate that the Physician ordered One-to-One supervision for this Patient on March 3, 1993, that Order was not lifted prior to this date in question and, as the aforementioned documents demonstrate, such is questionable whether the Patient was receiving the type of care as ordered. The Union notes that it

is apparent that either the Patient did not receive the One-to-One supervision as ordered or perhaps some other larger gaps in documenting his care is evident. In this regard, this Grievant should not be held accountable for inconsistent documentation practices at this facility.

The Union submits that discipline is corrective in nature and to issue such in this matter would simply serve no purpose. The proper nursing care was rendered to the Patient on the day in question and at no time did this Patient fail to receive the One-to-One supervision as ordered by the Physician on March 7, 1993. This Grievant failed to do anything wrong, but merely carried out the orders that she received from second shift; i.e., that this individual was on Close Observation. When she discovered that this was in fact an error, she acted prudently and swiftly to rectify the mistake.

For all of these reasons, the Union requests that the Grievance be sustained; that the two (2) day disciplinary suspension; and, all attendant documentation relative thereto be removed from the Grievant's personnel file and that she be awarded attendant back pay.

DISCUSSION AND FINDINGS

The disposition of this matter hinges upon the determination of whether the Grievant's actions resulted in the failure to perform her duties as Charge Nurse and whether the Patient received the type of care as ordered by the Physician. As the

Record demonstrates, the Patient in question was on the Intensive Psychiatric Ward which undisputedly means that his level of illness is such that this type of care is not only in his best interest, but that of those around him. The following analysis is premised on the assertion that patient care and the attendant duties of those providing it, is of tantamount importance in any health care environment, especially in an Intensive Psychiatric setting where any lapse of this standard of care can be life threatening. However, and as will be addressed infra, some situations are simply unavoidable.

On the evening in question it is undisputed that the Grievant reported to work approximately seven (7) minutes past her normal start time. This aspect of this matter is not in dispute nor shall it serve as the basis for assessing the Employer's action utilizing a just cause standard negotiated by and between these Parties for the imposition of the discipline assessed. Of essential importance herein is the determination of the level of care the Patient was to receive on the evening in question. As Joint Exhibit - 2 represents, there are two (2) distinct and separate levels of care identified therein as One-to-One Observation and Close Observation. The common testimony of those staff members who testified at the Arbitration Hearing demonstrates that more often than not the titles of these levels of care were mixed. Despite the fact that they warranted two (2) separate listings in the Employer's policy relative thereto and, more importantly, one is of a higher standard of care, the manner

in which they were prescribed by the Physicians at this facility is at best confusing. As stated therein, a One-to-One Observation requires one (1) staff member to be assigned to one (1) patient. Obviously, the acuity of that patient's illness is such that to be assigned any other level of care would subject that individual to self-injury or injury to others. A Close Observation can be performed by one staff member however, that staff member can assume responsibility for more than one patient. This suggests and it is obvious that the acuity level of those types of patients is less injurious than that of a patient assigned a One-to-One Observation. Nonetheless, the Record demonstrates that the titles of these levels of care were "mixed" at this facility.

Even though the Grievant reported to work approximately seven (7) minutes tardy on the evening in question, that factor in and of itself apparently did not bear on the patient's suicide attempt. As the Record demonstrates, the Grievant candidly and credibly stated she had not worked on the Intensive Psychiatric Ward for some time. Upon receiving the verbal report, she indicated that a more thorough review of the patient census would be beneficial to her to learn "what was going on" on that unit. Upon reviewing the various documentation which is often voluminous with regard to health care and obviously so, she discovered on the twenty-four (24) hour report something that, in her assessment of the patient census, differed from what was reported to her in the verbal report. Jan Black, the off-going

second shift Charge Nurse, reported in the verbal report that the patient in question was on Close Observation. Such was corroborated by Vern Book who indicates that Black stated that this Patient on a One-to-One Close Observation. Again, as stated supra, a One-to-One Observation, according to the Hospital Policy, requires a different level of care than does the Close Observation. The Grievant testified that upon observing the discrepancy she referred to the Doctor's Orders to confirm what type of care this Patient was to receive. She learned at approximately 11:25 p.m. that, instead of the Close Observation as reported by Jan Black and which was corroborated by Vern Book who was present for the verbal Change of Shift Report, the Doctor had ordered a One-to-One Observation. She indicated that she immediately checked the staffing clip board to see if in fact this was being performed and if not, immediately make the assignment. She testified that she was unaware that Bernie Sandebeck was already performing the One-to-One. In any event, she verbally assigned such to Vern Book at approximately 11:25 to 11:30 p.m.

As the evidence of Record clearly demonstrates, the Patient in question received a One-to-One Observation from the second shift performed by Tammy Fontes at 11:00 p.m. and Bernie Sandebeck was performing the One-to-One from 11:00 to 11:15 p.m. At that point, it is clear that no break in the continuity of care occurred as a result of the Grievant reporting seven (7) minutes late for work. Nor does the Record demonstrate that the

Grievant's reliance on the change of shift report, which was apparently inaccurate, resulted in the attempted suicide. The Record does demonstrate that this Patient did receive the One-to-One Observation, as ordered, on the evening in question.

Of critical importance is the fact that the Patient did not attempt the suicide until approximately 12:30 a.m. on the morning of March 8, 1993. This occurrence was reported by the Grievant and noted on Management Exhibit - 3. Despite the allegations that the Grievant failed to assign the One-to-One Observation as opposed to the Close Observation as was, based on the Record, reported at the Change of Shift Report, the point of time when the Patient attempted suicide occurred some sixty-five (65) minutes after the discrepancy was discovered by the Grievant. It can hardly be viewed to have had any impact on the unfortunate event that occurred. While I do not condone the fact that any lapse in patient care, especially that of this acute nature, should ever occur, it seems apparent that what transpired on that evening did not result from this Patient receiving anything less than was ordered.

What seems apparent is that some Management directive should be made to address the policy relative to acute patients. As Joint Exhibit - 2 demonstrates, there are two (2) distinct levels of patient care and, as the Record demonstrates, the titles thereof were used synonymously by the Physicians ordering such care. Given the fact that the Grievant had not worked on this unit for some time, and the obvious confusion that may and did

result in this matter given the mixing of terms relative to the level of patient care, it would seem that an explicit explanation or policy clarification to verify the level of care is warranted in volatile situations.

Under these circumstances, I fail to see that the Grievant can be held accountable for a discrepancy that, the Record demonstrates, occurred with regard to how this level of care was communicated. Upon careful and thorough review of the supporting documentation concerning previous levels of care this Patient received, the Grievant acted promptly and prudently to rectify the problem. She did so at approximately 11:25 p.m., but the attempted suicide did not occur until approximately 12:30 a.m. on the morning of March 8, 1993. The Record fails to demonstrate that the type of care that this Patient received in any way resulted in the suicide attempted by him. In fact, in the Grievant's unrefuted statement, she quotes the Patient as saying that he obtained the razor with which he attempted suicide approximately two (2) weeks prior. In this regard, I fail to see that the type of care and/or the continuity of care this Patient received in any way jeopardized his safety on the evening in question. At the time he attempted the suicide, there was an individual - a TPW - sitting outside his door. The Patient, in accordance with Hospital policy, was lying on his bed with the cover over him. That individual can hardly be held accountable for permitting such to occur given the fact that this Patient was only exercising that which Hospital policy permitted. The Record

supports the conclusion that this incident was unavoidable, and did not result from any break in the continuity of care as ordered.

In conclusion, the documentary and testimonial evidence of Record herein suggests that the Employer's action to impose a two-day disciplinary suspension was not for just cause and, accordingly, the Grievant shall be made whole with respect to the time lost; and, any and all documentation relative to this event be expunged from her personnel file.

AWARD

The Grievance is sustained.

David W. Stanton, Esq.
Arbitrator

June 5, 1994
Cincinnati, Ohio