#2004 / 1206

THE STATE OF OHIO AND DISTRICT 1199
THE HEALTH CARE AND SOCIAL SERVICES
UNION, SEIU, AFL-CIO
LABOR ARBITRATION PROCEEDING

In the Matter of the Arbitration Between:

The State of Ohio, Department of Youth Services

-and-

District 1199, The Health Care and Social Service
Union, SEIU, AFL-CIO

Grievant: Debbie Spencer
Grievance: No.: 35-07 (03-20-96) 35-02-12

Arbitration's Opinion and Award
Arbitrator: David M. Pincus
Date: June 13, 1997

Appearances

For the Employer

John Luther	Superintendent
William N. Griffith	Administrative Officer
Kathy Miles	Health Services Administrator
Rob Hofacre	Medical Unit Administrator
John L. Bradley	Medical Director
Pamela Anderson	Observor
Georgia Brokaw	Second Chair
Brad Rahr	Advocate

For the Union

Debbie Spencer	Grievant
Janet Rayburn	LPN
Gertrude Love	RN
Harry W. Proctor	Advocate

Introduction

This is a proceeding under Article 7 - Grievance Procedure, Section 7.08 - Arbitration of the Agreement between the State of Ohio, Department of Youth Services, hereinafter referred to as the Employer, and District 1199, the Health Care and Social Service Union, SEIU, AFL-CIO, hereinafter referred to as the Union, for June 1, 1994 - May 31, 1997, (Joint Exhibit 16). The arbitration hearing was held on December 17, 1996 at the office of Collective Bargaining, Columbus, Ohio. The parties has selected Dr. David M. Pincus as the Arbitrator.

At the hearing, the parties were given the opportunity to present their respective positions on the grievance, to offer evidence, to present witnesses and to cross examine witnesses. At the conclusion of the hearing, the parties were asked by the Arbitrator if they planned to submit post-hearing briefs. Both parties indicated they would submit written closing arguments.

Stipulated Issue

> Was the Grievant, Debbie Spencer, removed for just cause? And if not, what shall the remedy be?

Stipulated Facts

1.) Issue is properly before the Arbitrator.
2.) There are no procedural objections to be raised in this matter.
3.) The Grievant was hired on September 6, 1994 as a Nurse 1 at Scioto Riverview Juvenile Correctional Center.
4.) The Grievant was removed from her position on March 8, 1996.
5.) The Grievant signed that she had read DYS Directive Chapter B-19 on September 19, 1994.
6.) The Grievant has no prior discipline in her personnel file.

Pertinent Contract Provisions

ARTICLE 8 - DISCIPLINE

SECTION 8.01 - STANDARD

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

SECTION 8.02 - PROGRESSIVE DISCIPLINE (First Exhibit - Pages 20-21)

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

A. Verbal Reprimand
B. Written Reprimand
C. A fine in an amount not to exceed two (2) days pay for discipline related to attendance only; to be implemented only after approval OCB.
D. Suspension
E. Removal

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

The employee's authorization shall not be required for the deduction of a disciplinary fine from the employee's paycheck.

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(JOINT EXHIBIT 16, PGS. 20-21)

Case History

Debbie Spencer, the Grievant, was hired on September 6, 1994 as a Nurse 1 at Scioto Riverview Juvenile Correctional Center (SRJCC). The Center is composed of two juvenile correctional facilities. The Scioto Riverview Operations (SRO) is physically located within the Center. It was established to provide operational support in a number of areas including a medical clinic. The Scioto Village Juvenile Correctional Center (SJCC) is a co-ed facility providing medical health treatment services. The

Riverview Juvenile Correctional Center (RJCC) is a male facility which houses sexual offenders who are sent for treatment when convicted of sexual offenses.

At the time of the disputed incidents, the Grievant was working in the Medical Clinic. The Clinic is located on the grounds of SJCC but provides medical services for both institutions.

The facts, for most part; are not in dispute. Whether or not the Grievant acted appropriately when confronted with a series of circumstances serves as a basis for the removal and the subsequent grievance.

Youth, Danielle Benning arrived at the Clinic on January 13, 1996 at approximately 2:00 p.m.; with another youth, unannounced and unescorted by any staff member. At the time, the Grievant was examining two male youths which caused her to ask Youth Benning to return to her cottage.

Upon completion of her examinations, she called Youth Benning to the Clinic. She explained to the Grievant: that she had fallen, fallen on her knees in the cafeteria and inadvertently been kicked in the abdomen by another youth who had fallen on her.

The Grievant acknowledged that she was aware Youth Benning was pregnant and designated as "high risk" based on her age, previous life style and lack of consistent pre-natal care. The Grievant examined Youth Benning and determined no redness in the abdominal area and the youth reported no injury. She also took her blood pressure and pulse.

The Grievant claimed that prior to Youth Benning's departure, she offered to examine her, in an examination room, to check for Doppler fetal heart tones. Youth

Benning purportedly refused this offer by stating, "I'm fine". She further informed Youth Benning to return to the Clinic if she had any pain or noticed anything unusual.

On January 14, 1996, at approximately 2:15 p.m., staff contacted the Clinic and informed the Grievant that Youth Benning was experiencing irregular contractions with no discharge noted. The Grievant informed the staff to monitor for changes and the time of contractions.

Monitoring of Youth Benning's condition continued on January 15, 1996. Her contractions became more regular when at approximately 2:30 p.m. she was examined by the Grievant. A series of tests were conducted disclosing that Youth Benning was in labor, the mucous plug had ruptured and her discharge was bloody. In addition to these results, Spencer checked for Doppler fetal heart tones and movement. She also purportedly asked Youth Benning whether she was aware of the absence of movement.

These various findings caused the Grievant to suspect fetal demise. She stated she offered Benning support and sent her to Ohio State University for evaluation. The Grievant, moreover, did not call for the emergency squad. Rather, Youth Benning was transported by state vehicle at approximately 3:27 p.m. because fetal demise was not considered "an emergency".

At approximately 5:15 p.m. on January 15, 1996, Kathy Miles, the Health Services Administrator, was informed by a Duty Officer about Youth Benning's condition. OSU had reported that Youth Benning's fetus was non-viable. The following day, Miles was further informed the baby was stillborn, and that Youth Benning was stable.

On February 16, 1996, the Grievant was removed from duty. The letter of removal included the following relevant particulars:

> RE: Letter of Removal
>
> On January 13, 1996, you failed to thoroughly evaluate a youth who had sustained an injury from a fall and was approximately 36 weeks pregnant. According to medical charts, the youth's blood pressure and pulse were checked, however, you failed to check for a fetal heart tone. On January 15, 1996, when you were unable to find a fetal heart tone, you failed to take emergency action.
>
> Your actions are in violation of DYS Directive chapter B-19, work Rule # 1 Neglect of Duty part b. "Failure to perform the duties of the position which the employee holds", and Work Rule #46 Violation of Ohio Revised Code 124.34 "Includes, but is not limited to such offenses as incompetency, inefficiency....".
>
> You are hereby REMOVED from your position of Nurse 1 effective:
>
> <u>3/08/96</u>

(Joint Exhibit 1)

On March 13, 1996, the Grievant formally contested her removal. She filed a grievance which contained the following relevant particulars:

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> <u>Statement of Grievance:</u> I was removed from my position as Nurse 1 without just cause.
>
> <u>Contract Article(s) and Section(s) Allegedly Violated:</u> Article 8, Article 34 and Others
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> <u>Resolution Requested:</u> To be made whole in every way including reinstatement to my position, all back pay, and any matter of discipline to be removed from my personnel file.

The Merits of the Case

The Employer's Position

The Employer opined it had just cause to remove the Grievant. On January 13, 1995, the Grievant failed to thoroughly evaluate Youth Benning because she failed to check for a fetal heart tone. On January 15, 1995, the Grievant was unable to obtain a fetal heart tone, and yet, failed to engage proper emergency action.

The Employer provided several sources in support of the charges leading to removal. Miles and Rob Hofacre, Health Services Administrator, discussed Standards of Nursing Practices contained in Chapter 4 of O.R.C. 4723 and nursing practices identified by the Ohio Nursing Board. They maintained these practices, or standards, should be known to all nurses as a function of education, licensure and periodic professional updates. In their opinion, the Grievant's actions on January 13, 1996 and January 15, 1996 did not comply with the previously enumerated standards.

On January 13, 1996, the Grievant's evaluation of Youth Benning's condition was incomplete, and therefore, violative of normal and customary nursing practices. She failed to determine the health of the patient, in this case the fetus, by examining for fetal heart tones or by using other available methods. The Grievant's assertions that Youth Benning refused this intervention is deemed spurious. She never documented this exchange or advised supervision about this exchange and Youth Benning's clearly enunciated refusal.

Even if one concurs with the Grievant's "refusal" defense, Youth Benning's condition required an alternative course of action. She should have sent her to Ohio State University 's Labor and Delivery Department for further evaluation.

Similar concerns were raised about the Grievant's conduct on January 15, 1996. The absence of a fetal heart tone was an obvious emergency requiring immediate transport by the emergency squad to Ohio State University's Labor and Delivery Department. The use of the normal transportation services was inappropriate. Miles also maintained standards were violated when she failed to inform other staff members about Youth Benning's condition. The Grievant, moreover, failed to provide Miles with proper notice during her shift or prior to leaving the facility the day of the incident.

The Grievant's actions on January 15, 1996 violated another medical axiom. Dr. John Bradley, Medical Director, testified that the Grievant engaged in an action outside the scope of her authority. By making a diagnosis of fetal demise, she diagnosed a circumstance reserved for licensed physicians. A diagnosis of this type cannot be made without the use of an ultra-sound machine; a devise not in the possession of the Employer. The absence of fetal heart tones, however, is a clear emergency requiring transportation by an emergency squad. Also, the Grievant should have engaged in additional efforts to ascertain whether or not the fetus was in distress.

Various arguments proposed by the Union were rebutted by the Employer. First, the Union maintained the Grievant did nothing more than her job. And yet, nothing was placed into the record to support this contention.

Second, blame was placed for the resultant problems on the Employer's poor management practices; especially in the areas dealing with hospital visitations and record keeping. Employer representatives adequately addressed the visitation issue by providing reasonable explanations for any deviations. For example, some of these scheduled visits were unnecessary or excused based on the length of pregnancy, bad weather or vacations. Even if some discrepancies did take place, the Union was unable to provide any testimony as to why the Grievant was unable to perform her duties on January 13, 1996 and January 15, 1996.

Third, the Union raised a working alone argument to justify some of the Grievant's actions. This circumstance might have been the case on January 13, 1996. It was not, however, the case on January 15, 1996 because the Unions' own witnesses testified they were on the grounds on January 15, 1996, and that everything appeared normal. The Grievant never told anyone that something was wrong. The Union, moreover, explained how working alone, which is a common happenstance within these institutions, caused an inability to perform her duties.

Fourth, the Union claimed that the Grievant could not reach Miles on January 15, 1996. Testimony at the hearing clearly acknowledged that as early as November of 1995, an emergency protocol had been established. Staff was to contact the squad and then Miles. Even if she could not contact Miles, the Union was unable to explain how this prohibited the Grievant from taking actions necessary to ensure that Youth Benning and the fetus were properly cared for.

<u>The Union's Position</u>

The Union opined the Employer did not have just cause to remove the Grievant. This conclusion was based on inconsistent practices engaged in by the Employer and the proper and adequate treatment provided by the Grievant.

Quite damaging to the Employer's case was the testimony and evidence dealing with the standards and policies utilized by the Employer, Miles, surprisingly could not testify to the existence of institutional policies or directives that were staff specific. She stated she did not place any emphasis on these matters; but acknowledged she and the Grievant had differences regarding proper nursing practices.

Other general problems regarding nursing practices were raised by the Union. The record indicated that the Medical Clinic had two overlapping nursing shift schedules. Yet, even though Youth Benning was a known high risk patient, the nursing chart and related notes clearly identified the Grievant as the sole staff regularly making entries during the contested period. On January 14, 1996, Youth Benning's chart shows an entry authored by the Grievant suggesting that Youth Benning needs to be monitored. The chart indicates no additional entries.

Gertrude Love, a nurse working at the facility, provided probative testimony regarding the Employer's loose record keeping requirements. She testified that prior to January 13, 1996, Youth Benning fell on some ice and was evaluated by Love. Love maintained she authored an incident report, but failed to enter any notes on Youth Benning's chart. Love was never disciplined for not making these entries in the chart of a high risk youth. She was, however, eventually promoted from her pool nursing status to a full time position.

The Grievant's actions on January 13, 1996 and January 15, 1996 were proper and well within nursing standards. On the former date, the Grievant took Youth Benning's vitals and checked her for possible injury. Unfortunately, though the Grievant attempted to take a Doppler reading, Youth Benning refused any additional diagnostics. In fact, she never truly understood why staff had sent her to the medical clinic for further evaluations. Only as a consequence of the Grievant's consistent cajoling did Youth Benning allow the Grievant to take her vital signs.

Criticism of the care provided on January 13, 1996, was rebutted by the Union. The record clearly established that youths can refuse treatment. A nurse can only attempt to change their mind concerning any form of diagnostic by engaging in persuasive efforts.

Testimony provided at the hearing clearly established that the Doppler device used at the Clinic was highly unreliable. Nurse Janet Rayburn emphasized the device was not operational on many occasions; repairs were quite frequent and often failed to produce desired results. Even Dr. John L. Bradley, the Medical Director, admitted Doppler readings were not always credible or reliable.

Similar arguments were raised concerning the treatment provided on January 15, 1996. The Grievant did feel an emergency situation was taking place. She did everything she could to provide Youth Benning with proper and sufficient care. Vitals were taken and diagnostic tests were administered including Doppler readings. These results caused the Grievant to make an attempt to page Miles regarding Youth Benning's condition. The page proved to be unsuccessful. Only Love's attempt to page Miles finally engendered a positive response.

Youth Benning was eventually transported to Ohio State University's Hospital which was 35 to 45 minute from the facility. This hospital had a contract with the facility because it had no OB/Gyn physician on staff, or on call, at the time of the disputed incidents.

The Union viewed the Employer's transportation argument as nonsensical. Transporting Youth Benning by regular transport rather than the emergency squad did not place Youth Benning in harms way. She arrived at Ohio State University Hospital within an hour. Several Union witnesses noted the safety squad typically took an inordinate amount of time to get to the medical facility. Even though the safety squad was housed in a near by facility, the fencing around the institution and the squad's inability to expeditiously locate locations on grounds caused its response time to suffer.

The Grievant's fetal demise observation should not be viewed negatively. She merely gave an opinion which should not be viewed as a diagnosis.

Notwithstanding the Employer's assertion that the Grievant's removal was not based on the baby's death, many of the arguments used in support of removal veiled this circumstance and the Employer's own negligent conduct. Miles admitted that at the time of the disputed incidents she had not established a prenatal care and emergency policy. Interestingly, a policy was indeed, promulgated after the January, 1996 incidents on February 7, 1996.

If, in fact, nursing conduct is governed by standards established and issued by the Ohio Nursing Board, then the discipline in question should never have been imposed. A document introduced at the hearing indicated the Grievant's conduct and actions were investigated by the Board, but the file was closed and she retained her certification.

The Arbitrator's Opinion and Award

From the evidence and testimony introduced at the hearing, a complete and impartial review of the record including pertinent contract provisions, it is this Arbitrator's opinion that the Employer had just cause to discipline the Grievant. The discipline imposed, however, was too severe and unsupported by the record. This finding is based on conduct engaged in by the Grievant; but also, conduct engaged in by the Employer regarding the administration of certain purported policies and standards.

The Employer placed a great deal of emphasis on the Grievant's lack of compliance with standards of nursing conduct. References were also made to a decision making model (Employer Exhibit 2) in an attempt to highlight areas of misconduct engaged in on January 13 and 15, 1996. The specific purported misconduct was never, however, linked to any particular standard. Misconduct, moreover, was never linked to specific policies and practices promulgated on or before the incidents in question to provide staff with notice regarding certain required protocols.

Probably the most glaring piece of evidence regarding this particular defect deals with the protocols promulgated on or about early February of 1996. Miles and Luther established and distributed the Procedure for Monitoring Pregnant Youth (Joint Exhibit 1). The protocols contained therein, and testimony provided by Miles and Luther, contradict the Employer's professed theory that the Grievant's actions violated commonly understood nursing standards. If the matters were so clearly understood by all, then why was it necessary to promulgate a procedure, which without any doubt, addressed some of the very issues used to support the Grievant's removal?.

The previously mentioned procedure includes a number of interesting mandates. It establishes a document trail with various decision alternatives to be decided during the course of a pregnancy. Of specific import are: a clinic visitation schedule based on gestational stage; fetal heart monitoring and definition of emergency situations requiring mandatory transportation by ambulance; and a determination of obstetrical status "anytime (Document's emphasis) a pregnant youth is injured or seriously ill."

Luther and Miles admitted no formal policies were in place prior to the ones previously specified. They provided interesting justifications for the policies or procedures. Luther testified that some of the nursing staff was unfamiliar with these procedures. Miles offered that the procedures were established because the staff was not intuitive. At another point during the hearing, Miles noted that her prior expectations of the nursing staff were based on certain "philosophies" reflected in nursing standards. It should be noted, however, that these "philosophies" were not articulated until February of 1996. These various justifications muddied the record in terms of which nursing standards are so obvious that specification is not required, versus the guidelines articulated in the procedure requiring clear and unambiguous notice.

These distinctions are not matters which this Arbitrator could readily distinguish based on the record. A cleaner delineation might have caused an alternative finding.

The Grievant was accused of not taking a Doppler reading while evaluating Youth Benning on January 13, 1996. And yet, Nurse Love admitted that she examined the youth after she fell on the ice prior to January 13, 1996 without initiating a Doppler procedure. She filled out an incident report which should have placed the Employer on notice that she too was negligent in performance of her duties. Miles and Luther should have had equal expectations of both members of their nursing staff. Whether expectations or actual nursing standards were used as the appropriate benchmark, both nurses should have been required to use the Doppler device, if in fact this was the proper intervention.

The appropriate approach when a youth refuses a Doppler exam is quite ambiguous. Miles provided here view on the rights of the pregnant youths and those of an unborn fetus as patient. She admitted there was no policy surrounding matters of this sort, and that youths could refuse treatment at the facility and Ohio State University Hospital. She felt that youths would be much more hesitant to refuse treatment at the hospital; that is why she preferred this approach. Again, the specified protocol was not in place on January 13, 1996. There is, moreover, a question whether this distinction is articulated in the nursing standards.

Obviously, the Grievant should have adequately documented the youth's refusal. It would have lessened the propriety of the Employer's charge. The charge itself, is improper based on the ambiguity surrounding proper refusal and related appropriate actions.

The Grievant's actions on January 15, 1996, are not, however, viewed totally as proper by the Arbitrator. The Grievant was faced with an obvious emergency situation and should have called the emergency squad rather than using normal transportation. She knew she was dealing with a "high risk" client, and her readings raised a red flag. On the other hand, this Arbitrator finds it quite difficult to comprehend how an emergency situation can be responded to quickly enough by transporting a patient to a hospital approximately forty minutes from the facility. A contractual relationship with a hospital should not result in such limited alternatives.

Similarly, the Grievant's fetal demise finding, or nursing diagnosis was premature and potentially outside the scope of her authority. She did, however, initiate a course of action to save the pregnancy. Her analysis and response should not be minimized.

From information contained in the postpartem report, (Joint Exhibit 7), it appears that regardless of the Grievant's actions the newborn's life could not have been saved. Time of death was estimated to be approximately 48-72 hours prior to delivery which took place on January 16, 1996. The presumed underlying cause of death was placental. The impaired placenta was insufficient to support the growth of a 36 week gestational age fetus.

Like the Employer, this Arbitrator has not focused his ruling on the outcome or death of the fetus. Further, I have focused on both the Employer's and the Grievant's actions which preceded the fatal outcome. In my opinion, both parties were at fault. The Grievant's actions were partially a function of her own mishandling of the situation, and partially a function of the Employer's tardy formulation of needed protocols. My decision to modify the penalty, moreover, is partially based on the collateral investigation and finding conducted by the Board of Nursing (Union Exhibit 1). The complaint which precipitated the investigation was closed. With all the emphasis placed on standards promulgated by this august body, some reliance must be placed on their finding when considering the propriety of the pentalty.

The circumstances surrounding this matter were highly unusual and distinct. The following Award should not lead me to believe that this Arbitrator totally condones the Grievant's actions on January 15, 1996. These actions, within the context of these unique circumstances, require a modification of the imposed penalty. And yet, the notified penalty should be severe enough to thwart similar types of future misconduct.

Award

The removal should be converted to a time served suspension. The Grievant shall be returned to her former position with no back pay. Her seniority status shall be restored to the date of removal with all appropriate benefit levels handled in a similar fashion. The Arbitrator retains jurisdiction over the matter for thirty (30) days for the issuance of this Award.

June 13, 1997
Date

Dr. David M. Pincus
Arbitrator