#1171

IN THE MATTER OF ARBITRATION

BETWEEN

DISTRICT 1199/SEIU, AFL-CIO

AND

THE STATE OF OHIO/ODMH

Before: Robert G. Stein
Panel Appointment
Case # 27-04-000726-0037-02-11
Grievant: Patricia Froehlich, RN

Principal Advocate for the UNION:

Kathy Ville, Administrative Organizer
Matt Mahoney, 2nd Chair
DISTRICT 1199/SEIU, AFL-CIO
1395 Dublin Rd.
Columbus OH 43215

Principal Advocate for the EMPLOYER:

Georgia Brokaw, Labor Relations Administrator
Malleri Myncks, 2nd Chair
OFFICE OF COLLECTIVE BARGAINING
106 N. High St. 7th Floor
Columbus OH 43215

INTRODUCTION

A hearing on the above referenced matter was held on December 19, 2000, in Cambridge, Ohio. The parties stipulated to the fact that the issue was properly before the Arbitrator. During the hearing the parties were given a full opportunity to present evidence and testimony on behalf of their positions. The parties submitted closing arguments in lieu of filing briefs. The hearing was closed on December 30, 2000. The Arbitrator's decision is to be issued by February 16, 2000.

ISSUE

The parties agreed upon the following definition of the issue:

Was the Grievant, Patricia Froehlich, removed for just cause? If not, what shall the remedy be?

RELEVANT CONTRACT LANGUAGE/

ARTICLE 5, 6.01, 8 and all other relevant articles of the Collective Bargaining Agreement

See Agreement for specific language (Joint Exhibit 1)

BACKGROUND

The Grievant in this case is Patricia Froelich, who was formerly employed as a Psych/MR Nurse Coordinator at the Appalachian Psychiatric Healthcare System's Cambridge hospital. After approximately 12 years of employment with the Department, she was removed from her position on July 27, 2000. The reason given for her removal was patient abuse.

Hospital Policy A-25 defines patient abuse and neglect as:

> *" any act or absence of action which is inconsistent with the guaranteed rights and prescribed treatment and care of a patient which results in either physical and/or emotional pain/distress to the individual. Such activity will include but is not limited to... (7) any exercise of undue restriction in the treatment and/or care of a patient (8) any use of restraints without prompt and strict compliance with the System's Policy M-7A: Seclusion and Restraint of Patients."*

The Grievant worked in a facility for severely mentally disabled patients. There are both developmentally disabled and forensic patients tested at the facility. In a

psychiatric hospital restraints are used at times in order to subdue a patient when other means of intervention are unsuccessful. The Department policies and guidelines closely govern the use of restraints. A charge nurse on a unit has the authority to place a patient in restraints and seclusion subject to a doctor's approval.

The instant offense that led to the Employer's decision to discharge the Grievant took place on February 7, 2000. The Grievant was the second shift charge nurse on the Fletcher-East unit of the hospital. At approximately 9:40 p.m., patient Kim H (hereinafter referred to as "patient Kim"), came to the nurses' station and told LPN Roberta Wilson *"good-bye, I'm going to kill myself."* Patient Kim then went to her room. Precautionary measures regarding patient Kim called for someone to check on her activities every 15 minutes and document them. TPW, Tom Vaughn, was assigned to this duty that evening. After doing his routine checks, which included his check on patient Kim, Mr. Vaughn reported to the nurses' station that patient Kim was in her bathroom with a sheet tied loosely around her neck and the other end of the sheet tied to the handrail near the toilet. Patient Kim was wedged in between the wall and the toilet.

After hearing this report, the Grievant and LPN Hillman went to patient Kim's bathroom where they found her in the same position as described by TPW Vaughn. The Grievant checked to see if patient Kim was still breathing but did not attempt to remove the sheet around her neck. Security was then called and TPWs, Cory Taylor, TPW from Fletcher-West, and Kenny Meighen, TPW from Oldham, responded to the call. When they arrived, TPW Vaughn was still with patient Kim in her bathroom, while the Grievant and LPN Hillman returned to the nurses' station. Taylor and Oldman proceeded to

patient Kim's bathroom and removed the sheet from around her neck. They pulled away from the wedge position and consulted the Grievant for further directives.

The Grievant directed TPWs Taylor and Oldham to pull the patient to her bedroom, and the Grievant checked her vital signs. The Grievant then ordered the TPWs to take patient Kim to the Quiet Room. According to the Employer, the Grievant ordered the TPWs to drag the patient to the Quiet Room. Upon arriving at the Quiet Room, Taylor and Oldham were met by Security Officers, Nick Savage and Joe Oliver. The two TPWs and the two Security Officers then carried patient Kim into the Quiet Room and placed her onto a bed. Upon the directive of the Grievant, patient Kim was placed in four-point leather restraints.

The Grievant then called Dr. Vellanki, the psychiatrist on duty, and reported to him that patient Kim attempted suicide and was combative when she was removed from her room and taken to the Quiet Room. The Grievant stated to the doctor that patient Kim was kicking and fighting the staff who were trying to move her. The doctor arrived on the unit, Fletcher-East, approximately 30 to 40 minutes later. Dr. Vellanki confirmed the order for four-point restraints and ordered an injection of Loxataine to be given to the patient to reduce her agitation. LPN Wilson administered the injection at approximately 10:00 p.m. and the patient was placed on one-to-one observation for the next four hours. The leather restraints were removed at 10:45 p.m.

The central issue in this case is whether there was justification for the Grievant to direct the use of restraints on patient Kim. The Employer contends that patient Kim was not combative as was portrayed by the Grievant. It asserts that patient Kim has had a history of abuse, which is one of the main reasons she was a patient in the hospital. The

Employer was convinced that the Grievant's actions were punitive in nature and not justified by the circumstances. It discharged the Grievant for not using other intervention techniques short of restraint.

The Grievant and the Union view the actions of the Grievant very differently. They filed a grievance contending that patient Kim was combative, attempted to hit and kick staff, and that placing her in restraints was a reasonable course of action given the circumstances that occured on February 7, 2000.

EMPLOYER'S POSITION

The Employer argues that the Grievant knew and stated to APHS police officers that the patient's attempted suicide was not serious. This was underscored by the fact that TPWs Vaughn, Taylor, and Meighen testified that patient Kim did not display any aggressive behavior during the time they were involved with her, argues the Employer. The Employer contends that the position of the Department is to avoid the use of restraints. It contends that each episode of using restraints should be evaluated independently and should be based upon behavior occurring at the time, and not on what is anticipated based upon the past behavior of the patient. To subject a patient to unnecessary restraint and medication that always accompanies the use of restraints is patient abuse, asserts the Employer.

Based upon the evidence and testimony, the Employer requests that the grievance be denied.

UNION'S POSITION

The Union flatly refuses to accept the Employer's contention that what happened on February 7, 2000 rises to the level of patient abuse. The Union points to the testimony of Dr. Vellanki, who stated *"patient abuse is a very strong word"* and that in his opinion this incident did not represent patient abuse. The Union also argues that the conflicting testimony of the Employer's witnesses weakens their case. The Union also cites the fact that a Grand Jury dismissed this case for lack of evidence.

The Union also points out that the Employer allowed the Grievant to continue working during the six month period of the investigation, including approximately 250 hours of overtime work. In addition, the Grievant is a long-term employee who has never been disciplined, contends the Union. The Union asserts that patient Kim had a long history of violent or self-abusive behavior that has caused her to be placed in restraints on numerous occasions. Union witness Marjorie Bay testified that in the past she placed patient Kim in restraints under similar circumstances that existed in the instant matter (patient Kim had gone limp and would not cooperate).

Based upon the evidence and testimony, the Union requests that the grievance be sustained.

DISCUSSION

The Employer has the burden of proof in this matter. It must demonstrate with clear and convincing evidence that the Grievant is guilty of patient abuse. As stated above, patient abuse is defined in pertinent part as *"(7) any exercise of undue restriction*

in the treatment and/or care of a patient; (8) any use of restraints without prompt and strict compliance with the System's Policy M-7A: Seclusion and Restraint of Patients."

While I strongly support the Department's desire to vigorously pursue any inhumane treatment of patients, I find that in this matter the Employer failed to meet its burden of proof. The events of February 7, 2000 cannot be viewed in isolation. When the events and actions of February 7, 2000 are evaluated and are placed in the greater context of patient Kim's psychiatric history, the Grievant's actions represented an exercise of professional judgment and did not rise to the level of patient abuse.

Joint Exhibit 10 reveals that patient Kim has an extensive history of inpatient psychiatric treatment.. From January 29, 2000 to the incident of February 7th, she had four episodes during which staff had to place her in restraints. She was placed in restraints on February 7th, which is the subject of the instant grievance. However, it is noteworthy that the next time it was determined she had to be placed in restraints was February 12, 2000, just five days later. Moreover, from February 7, 2000 through August 12, 2000, she had to be placed in restraints an additional 27 times. On three of these days, 2/16/00, 2/25/00, 8/8/00 she had to be placed in restraints twice on the same day. On 8/12/00, she had to be placed in restraints 3 times in one day. Presumably, but for the decision to restrain patient Kim on February 7th, all the other decisions to restrain her were not considered to be improper by the Employer. This is substantial evidence of a patient who is difficult to control and who needs protection from her self-destructive behaviors. On the day prior to February 7, 2000, patient Kim had been on one to one observation.

In order to obtain an overall perspective on the events of February 7, 2000 the following testimony is noted.

It was reported by LPN (now RN) Robbie Wilson and the Grievant that on February 7th, at about 9:40 p.m., patient Kim came to the nurse's station from her room and said, *"Robbie [referring to Robbie Wilson] I came up to say good-bye...I'm going to go kill myself."* TPW, Tom Vaughn found the Grievant at about 9:45 p.m. on her bathroom floor, wedged between the toilet and the floor with a towel around her neck. She had a sheet loosely tied around her neck and the other end was tied to the handicap rail. In her own words patient Kim stated,

> *"It all started earlier in the day when I told them I was having suicidal thoughts and it had progressively gotten worse. They had to give me meds to quiet me down and then they sent me to the Quiet Room. After I calmed down, I came out and told them it was over and I said, "goodbye." So then I went to the bathroom (mine) and tied a sheet to a support thing That was right next to the toilet and then I tied it around my neck. Then I Laid down on the floor so my weight would choke me." (JX 5)*

When interviewed about the incident of February 7, 2000, in response to the question why was Kim placed in restraints the Grievant stated, *"This usually is the only thing that works for her if she has gone this far"*(JX 3). Witness Tom Vaughn, a TPW for 17 years stated the following about patient Kim when interviewed by Lt. Sherby, *" You have to watch her [Kim] if she's not cause she's always trying something when you least expect it"* (JX 3). During his testimony in the hearing Witness Vaughn also stated, *"she has attempted suicide before and every time she was placed in restraints... We normally put patients in quiet room for their own protection as soon as possible" (See Vaughn testimony).*

Witness, Jane Krason, Product Line Director and Nurse Executive at the time of the incident, stated that patient Kim is *"bipolar and is schizophrenic...She had been restrained a number of times before for choking another patient, kicking, hitting, and biting staff...she was unable to gain control. She has made a number of other suicide attempts or hit her head strongly against the wall..."* Dr. Roy P. Vellanki, the attending physician stated in the hearing, *"I know the patient and I have admitted her twice...I have been involved with Kim when she had to be restrained. She was running away from one-to-one staff observation and was banging her head against the wall."*

Based upon the above, is it impossible to determine how serious patient Kim was about bringing harm to herself? She announced she was going to kill herself which she has stated many times in the past. Was she serious or just attempting to gain attention? However, it is a matter of record that she wrapped a towel around her neck and attached it to the handicapped rail. And, she stated, *"Then I laid down on the floor so my weight would choke me."* The patient is a heavy person. If she did not intend to commit suicide, it is certainly possible that she could have harmed herself.

There is no disagreement that patient Kim was passively aggressive regarding any attempts to go to the Quiet Room. She would not move according to all the witnesses. She was totally uncooperative and therefore unable to be directed or diverted. Cory Taylor and Kenny Meighen denied that patient Kim was combative. However, it is noted that Kenny Meighen stated he did not know what the situation was prior to his arrival (See JX 3). Thomas Vaughn stated that patient Kim *"...didn't fight or do anything."* Among the statements of Meighen, Taylor, and Vaughn, there was inconsistency in their description about when and with whom they arrived at the patient's bathroom. Meighen

and Taylor stated they met the Grievant at the nurse's station, and she led them back to the patient's bathroom along with several others. However, Vaughn stated that he, Wilson, and the Grievant went to the patient's bathroom and that Taylor and Meighen came in together when the sheet was being taken off the patient's neck (JX 3 statements). Taylor stated he took the sheet off her neck. The Grievant verified this act. Other witnesses, including the Grievant, concurred with this behavior, but added she was also combative and attempted to strike them (See Hillman, Froelich, Wilson). The Grievant stated in the hearing that she attempted to remove the towel from around the patient's neck and she attempted to strike her with her arm. Mary Hillman stated she dropped the patient's leg when she perceived the patient was rearing her leg back to strike her. Furthermore, these three witnesses, in stark contrast to Taylor, Meighen, and Vaughn, stated that the patient displayed active physical resistance. The Employer contends the testimony regarding patient Kim's combative behavior is untrue and self-serving.

Arguably, the Grievant may have concluded that the patient needed to be restrained more in a precautionary sense than in a response to combative behavior that was far more passive than it was active. However, Kim's psychiatric record demonstrates she is a danger to herself and to others. The testimony of RNs Marjorie Bay and Carol Fisher substantiated the unpredictability and physical harm Kim has inflicted on staff and others. Furthermore, their description of Kim's mixture of passiveness (going limp) and closing her eyes followed by sudden physical outbursts was consistent with much of the behavior that was displayed on February 7, 2000.

The Grievant dismissed the patient's suicide attempt as an attention getting act and did not make a record of it. Was the Grievant's order to place restrants on Kim

uncalled for? Was it a mean spirited and intentional act to punish Kim, or was it a precautionary measure, given Kim's propensity for explosive behavior? The extensive record of Kim being restrained prior to and well after this incident strongly suggests that to get her under control restraints have been routinely used. Maybe they are used too often, yet there was no evidence presented by the Employer that any other forms of intervention have been successful with Kim. In fact, Kim's psychiatric record following February 7th suggests the opposite is true. Other medical professionals had to resort to this methodology at least 27 times during the next 6 months, and there was no evidence presented that other employees were given corrective action for these decisions.

The Grievant stated under cross-examination, "*Kim had been in restraints so many times, sometimes 2 to 3 times per day and it was so often that I and other nurses have become lax.*" This is a revealing statement regarding how the medical community viewed Kim and how she was handled. If it was incorrect to resort to an often-used strategy of physical restraints, the Grievant was the only one who appeared to be singled out for punishment for using it. Professionals don't make judgments in a vacuum. Their judgments are informed decisions based upon the application of experience, education, and understanding to a set of circumstances. The Grievant's employment record contains no hint of negligence or incompetence. In fact in her June 2000 evaluation (which occurred several months after this incident), she received an above average rating in the quality of her work. In the comments section of her 1997, 1998, and 1999 evaluations she was consistently cited for being able to competently handle difficult situations. Furthermore, the Employer kept her employed doing the same work for several months following the February 7th incident. One of the Employer's main witnesses and former

nurse executive, Jane Krason, stated during the hearing that Fletcher-West was an especially challenging unit to manage because it contained several difficult patients who required close supervision.

It was within this difficult context that the Grievant made a decision to place patient Kim in restraints after the patient's declaration and attempt to commit suicide. In the words of Jane Karam, *"If a patient admits they want to commit suicide, you have to assess how serious the patient is"* (hearing testimony). The Grievant made a judgment that Kim needed to be restrained in addition to being watched one on one. It was a decision that many other people in her position had previously and subsequently made without repercussions. I find the Grievant should have done a better job of documentation, for which she admitted she was lax, but this does not amount to sufficient cause to support a termination from employment.

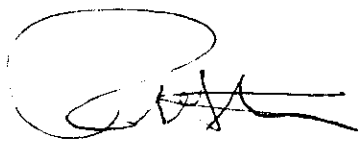
AWARD

The Grievance is sustained.

The Grievant is to be reinstated to her former position and shift and is to be made whole for all back pay (minus W-2 income or unemployment benefits), benefits, and seniority within two pay periods from the date of this Award. Her termination and all records connected with it shall be removed from her personnel record. It shall be replaced with a written reprimand for failure to document an attempted suicide and it shall be back-dated to the date the termination was issued. It shall be retained in the file in accordance with the provisions of the Collective Bargaining Agreement.

The Arbitrator shall maintain jurisdiction over the implementation of this Award for a period of 60 calendar days.

Respectfully submitted to the parties this 16th day of February, 2001.



Robert G. Stein, Arbitrator