1517

STATE OF OHIO
VOLUNTARY RIGHTS ARBITRATION

In The Matter of Arbitration Between:

STATE OF OHIO, DEPARTMENT OF YOUTH SERVICES, MOHICAN YOUTH CENTER,

EMPLOYER,

and

THE HEALTH CARE AND SOCIAL SERVICES UNION, SERVICE EMPLOYEES INTERNATIONAL UNION, SEIU/DISTRICT 1199,

UNION.

GRIEVANT: **BELLE DOKTER (TERMINATION)**
GRIEVANCE NO.: **35-06-20000615-0090-02-11-T**

Arbitrator's Opinion and Award
Arbitrator: Dr. David M. Pincus
Date: July 30, 2001

Appearances

For the Employer	Position
Kate Stires	Advocate
Cindy Sovell-Klein	OCB/2nd
Barry Braverman	Management Representative
Conrad L. Ames II	Superintendent
Sam Stephenson	Operations Manager
Jason Davis	Witness
Robert Hofacre	Director
For the Union	
Matt Mahoney	SEIU/1199
Belle Dokter, RN	Grievant
Terry Brennan	SWII/BSED, CCDCII PO/ SA Specialist

I. Joint Issue

The parties agreed that the issue to be decided is: Was the grievant, Belle Dokter, removed for just cause? If not, what shall the remedy be?

II. Introduction

This is a proceeding pursuant to a collective bargaining agreement between State of Ohio, Department of Youth Services, Mohican Youth Center (the Employer) and Service Employees International Union, SEIU/District 1199 (the Union). 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. The parties have submitted briefs in accordance with the guidelines agreed to at the hearing.

III. Pertinent Provisions

A. General Work Rules

		Offenses				
		1st	2nd	3rd	4th	5th
Rule 1. Neglect of Duty						
a.	Failure to follow procedures and/ or instructions and/or perform the duties/assigned tasks of the position which the employee holds.	V to W	W to 5 or xxx	10 or 15	R	

	Offenses				
	1st	2nd	3rd	4th	5th
Rule 10. Carelessness					
Failure to maintain control over tools, keys, and other equipment.	W to R or xxx	5 to R or xxx	15 or R	R	
Rule 22. Failure to Report For Duty as Scheduled					
a. Failure to follow proper call-off procedures for regular scheduled shift and/or accepted overtime.	W to 5 or xxx	1 to 5 or xxx	10 or 15	R	
Rule 33. Unauthorized Possession of Documents					
Obtaining, possession, disclosing or misusing information regarding youth, employee or the general public, or other State documents which the employee and/or the receiver is not authorized to have.	W to 5 or xxx	10 or 15	R		
Rule 42. Certification/Licensure					
a. Failure to maintain and/or keep current any certification, license, etc., that are	R				

required to perform

	Offenses				
	1st	2nd	3rd	4th	5th
duties. These requirements are established by State job specifications.					
b. Failure to adhere to current professional standards as defined by State licensing boards.	V to R or xxx	W to R or xxx	5 to R or xxx	R	

B. State of Ohio Department of Youth Services Section : Healthcare, Chapter; P, Directive P-20 Pharmaceuticals and Medical Supplies, Management of

4. Each youth receiving medication has a Medication Administration Record (MAR), DMH Form 0125.

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4.3 The nurse administering youth's medication shall sign their (sic) full name, title, and initials on the signature section of the Medication Administration Record (MAR).

a. The nurse shall initial the appropriate time block upon administration of the medication.

b. The following code is utilized to document a missing dose:

- R - Refused
- H - Held Medication
- A - Absence (AWL or AWOL)

c. The nurse shall document in the Interdisciplinary Progress

Notes and/or MAR indicating the reason for the missing dose.

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10.1 All prescription medications received from Central Pharmacy Inpatient Pharmacist are directly delivered to the Medical Departments.

a. These prescriptions medications are verified by a nurse with the Packing List. The nurse shall sign (full signature) and date the Packing List indicating that the ordered medications are labeled and inventoried.

b. After signing the Packing List, the nurse will provide the list to the Health Services Administrator.

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13. All medication errors are reported to the Health Services Administrator immediately. A statement is completed by the nurse. The report shall include what was done in correcting the error. The medication error is reviewed by the Contract Physician and Health Services Administrator. A copy of the report is sent to Central Pharmacy and the Medical Services Administrator. The Health Services Administrator shall maintain the original report in the Medical Department files.

C. Department of Youth Services Pharmacy Policy and Procedure Manual

2. Dispensing of medications by the pharmacy

A supply of medication is dispensed for each youth (patient specific) and is stored in a cassette drawer for that youth. **One youth's prescribed and dispensed medication shall not be administered to another youth. Borrowing of drugs shall be prohibited between youths.**

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H. Controlled Substances

4. Schedule II Medications

b) Schedule II medication will be patient specific and

issued with a blue CSAR. (see policy G for instructions to complete CSAR).

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I. Controlled Substance Accountability Records

4. Documentation

a) The lower portion of the form is to be completed each time a dose is administered. Documentation includes date, time, youth's name, physician's name, and name of person administering.

b) The numbers pre-printed in the *left hand column* of the form *refer to the line number.* The right hand column denotes the balance of medication remaining in the supply, as doses are being documented. Quantities issued that are less than the number of lines per form will be blocked off by the pharmacy to correctly correspond with the appropriate number in the right column.

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V. Medication Error Reports

1. Medication errors include, but are not limited to:
   a) Administration errors
      - administration of a medication to a wrong person
      - administration of a medication in the wrong dosage or form
      - administration of a wrong medication to a person
      - administration of a medication to a person who is known to be allergic to the medication as noted on the chart and/or MAR
      - failure to administer a medication within one hour of the specific time ordered by the physician or by the facility's standard drug administration schedule
      - failure to chart a medication that has been administered

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3. A Medication Error Report shall be completed (see appendix N)

by the person discovering the error.

D. Law Regulating the Practice of Nursing September 29, 1999

Section 4723.02 Definitions

As used in this chapter:

(A) "Registered nurse" means an individual who holds a current, valid license issued under this chapter that authorizes the practice of nursing as a registered nurse.

(B) "Practice of nursing as a registered nurse" means providing to individuals and groups nursing care requiring specialized knowledge, judgment, and skill derived from the principles of biological, physical, behavioral, social, and nursing sciences. Such nursing care includes:

(1) Identifying patterns of human responses to actual or potential health problems amenable to a nursing regimen;
(2) Executing a nursing regimen through the selection, performance, management, and evaluation of nursing actions;
(3) Assessing health status for the purpose of providing nursing care;
(4) Providing health counseling and health teaching;
(5) Administering medications, treatments, and executing regimens prescribed by licensed physicians; dentists; optometrists; podiatrists; or, until January 1, 2010, advanced practice nurses authorized to prescribe under Section 4723.56 of the Revised Code;
(6) Teaching, administering, supervising, delegating, and evaluating nursing practice.

(D) "Assessing health status" means the collection of data through nursing assessment techniques which may include interviews, observation, and physical evaluations for the purpose of providing nursing care.

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Section 4723.28 Denial of Licensure; Discipline of License Holder; Mental or Physical Examinations; Immunity

(B) The Board of Nursing, pursuant to an adjudication conducted under Chapter 119 of the Revised Code and by a vote of a quorum, may impose one or more of the following sanctions:

deny, revoke permanently, suspend, or place restrictions on any license or certificate issued by the Board; reprimand or otherwise discipline a holder of a license or certificate; or impose a fine of not more than five hundred dollars per violation. The sanctions may be imposed for any of the following:

(19) Failure to practice in accordance with acceptable and prevailing standards of safe nursing care

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Section 4723.34 Mandatory Reporting

(A) Every employer of registered nurses or licensed practical nurses shall report to the Board of Nursing the name of any person licensed under this chapter whose employment has been terminated voluntarily or involuntarily because of conduct that would be grounds for disciplinary action by the Board under Division (B) of Section 4723.28 of the Revised Code.

(B) Nursing associations shall report to the Board the name of any registered nurse or licensed practical nurse who has been investigated and found to constitute a danger to the public health, safety, and welfare because of conduct that would be grounds for disciplinary action by the Board under Section 4723.28 of the Revised Code, except that a nursing association is not required to report the name of such a nurse if the nurse is maintaining satisfactory participation in a peer support program approved by the Board under rules adopted under Section 4723.07 of the Revised Code.

(C) If the prosecutor in a case described in Divisions (B)(3) to (5) of Section 4723.28 of the Revised Code, or in a case where the trial court issued an order of dismissal upon technical or procedural grounds of a charge of a misdemeanor committed in the course of practice, a felony charge, or a charge of gross immorality or moral turpitude, knows or has reason to believe that the person charged is licensed under this chapter to practice nursing as a registered nurse or as a licensed practical nurse, the prosecutor shall notify the Board of Nursing on forms prescribed and provided by the Board. The report shall include the name and address of the license holder, the charge, and the certified court documents recording the action.

(D) If any person fails to provide a report required by this section, the Board may seek an order from a court of competent jurisdiction compelling submission of the report.

C. Rules Promulgated from the Law Regulating the Practice of Nursing, February 1, 2000

Chapter 4 Standards of Safe Nursing Practice for Registered Nurses and Licensed Practical Nurses

4723-4-01 General Information

(A) The purpose of this chapter is to establish:
(1) Minimal acceptable standards of safe and effective nursing practice for a registered nurse and a licensed practical nurse in any setting

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4723-4-03 Standards Relating to Competent Practice as a Registered Nurse

(A) A registered nurse shall provide nursing care within the scope of practice of nursing for a registered nurse as set forth in Division (B) of Section 4723.02 of the Revised Code and the rules of the Board.

(B) A registered nurse shall maintain knowledge of the duties, responsibilities, and accountabilities of practice and shall practice in accordance with the following:
(1) the laws regulating the practice of nursing;
(2) The rules of the Board;
(3) Any other applicable federal and state laws and rules; and
(4) Position statements, standards for practice, or guidelines for practice from nationally recognized professional nursing entities; provided these statements, standards, or guidelines are consistent with existing laws or rules.

(C) A registered nurse shall demonstrate competence and accountability in all areas of practice in which the nurse is engaged which includes, but is not limited to, the following:
(1) Consistent performance of all aspects of nursing care according to acceptable and prevailing standards; and
(2) Appropriate recognition, referral or consultation, and intervention, when a complication arises during or after the performance of a specific function or procedure.

(H) A registered nurse shall maintain the confidentiality of client information obtained in the course of nursing practice. The registered nurse is not precluded from communicating appropriate client information with other members of the health

care team for health care purposes only.

(J) When a registered nurse observes, advises, instructs, teaches, or evaluates nursing care, the registered nurse shall use acceptable and prevailing standards of safe nursing care as a basis for that observation, advice, instruction, teaching, or evaluation and shall communicate information which is consistent with acceptable and prevailing standards of safe nursing care with respect to the nursing care.

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4723-4-06 Standards of Nursing Practice Promoting Client Safety

(E) A licensed nurse shall completely, accurately, and timely report and document nursing assessments or observations, the care provided by the nurse for the client, and the client's response to that care.

(F) A licensed nurse shall accurately and timely report to the appropriate practitioner errors in or deviations from the prescribed regimen of care.

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4723-4-07 Standards for Implementing the Nursing Process as a Registered Nurse

(A) The following standards shall be used by a registered nurse in implementing the nursing process for each client under the registered nurse's care:

(1) Assessment: The frequency of a nursing assessment shall be based upon the registered nurse's judgment and the client's status. The registered nurse shall accurately and timely:

(a) Conduct and document a nursing assessment of the health status of the client;

(b) Collect objective and subjective data;

(c) Modify the assessment as the client's status changes; and

(d) Report assessment data as appropriate to other members of the health care team;

(2) Analysis: The registered nurse shall accurately and timely:

(a) Analyze the assessment data; and

(b) Establish, accept, or modify a nursing diagnosis to

be used as a basis for nursing interventions;

(3) Planning: The registered nurse shall accurately and timely:
  (a) Develop, maintain, or modify the nursing component of the plan of care; and
  (b) Communicate the nursing component of the plan of care and all modifications of the plan to appropriate members of the health care team;

(4) Implementation: The registered nurse shall accurately and timely implement the current nursing plan of care which may include:
  (a) Executing the current regimen prescribed by:
    (i) A licensed physician, dentist, optometrist, or podiatrist;
    (ii) An advanced practice nurse approved under Section 4723.55 of the Revised Code;
    (iii) A certified nurse-midwife, certified nurse practitioner, certified registered nurse anesthetist, or clinical nurse specialist approved under Section 4723.41 of the Revised Code; or
    (iv) A physician assistant in accordance with Chapter 4730 of the Revised Code and the rules of the Ohio State Medical Board;

(5) Evaluation: The registered nurse shall accurately and timely:
  (a) Evaluate the client's response to nursing interventions;
  (b) Document and communicate the client's response to nursing interventions to appropriate members of the health care team;
  (c) Reassess the client's health status, revise the nursing diagnosis or the nursing component of the client's plan of care, and make changes in the nursing interventions as appropriate; and
  (d) Involve as appropriate the client, family, significant others, or other members of the health care team in the evaluation.

B. Contract Provisions

ARTICLE 6 - NON-DISCRIMINATION

6.01 Non Discrimination

Neither the Employer nor the Union shall unlawfully discriminate against any employee of the bargaining units on the basis of race, sex, creed, color, religion, age, national origin, political affiliation, union affiliation and activity, handicap or sexual orientation, or discriminate in the application or interpretation of the provisions of this Agreement, except those positions which are necessarily exempted by bona fide occupational qualifications due to the uniqueness of the job, and in compliance with the existing laws of the United States or the State of Ohio. In addition, the Employer shall comply with all the requirements of the federal Americans with Disabilities Act and the regulations promulgated under that Act.

The Employer and Union hereby state a mutual commitment to equal employment opportunity, as regards job opportunities within the agencies covered by this Agreement.

6.02 Agreement Rights

No Employee shall be discriminated against, intimidated, restrained, harassed, or coerced in the exercise of rights granted by this Agreement.

ARTICLE 8 - DISCIPLINE

8.01 Standard

Disciplinary action may be imposed upon an employee only 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. A fine in an amount not to exceed five (5) days pay
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.

IV. Joint Stipulations

1. Neither party has any procedural objections, and the parties agree that the instant grievance is properly before the Arbitrator for a final and binding resolution on the merits.
2. The grievant was employed at the Mohican Juvenile Correctional Facility as a Registered Nurse from February 7, 1993 to June 15, 2000.
3. The Grievant was aware of Department of Youth Services' Directive B-19, General Work Rules, signed receipt and review on 10/18/99.
4. Youth Jason Davis was mismedicated by the Grievant on February 5, 2000.
5. The Grievant worked first shift on February 5, 2000 and was responsible for medication counts and administration.
6. The Grievant completed the mismedication form on February 6, 2000.
7. The Grievant completed the progress notes on February 6, 2000.
8. The Grievant completed the nursing communication log on February 6,

   2000.
9. The Grievant completed the interdisciplinary notes on February 6, 2000.
10. The Grievant did not follow the correct call off procedures/the call off was late.
11. The Grievant did sign off on the packing list of prescription medication received on February 17, 2000 and verified all medication counts at that time.

12. Judy Palmer completed receiving report based on grievant's initialed inventory.
13. The grievant verified the packing list and pill inventory received on February 17, 2000.
14. The Grievant worked first shift on February 18, 2000 and was responsible for medication counts and administration.
15. The grievant received a copy of the Employee Standards of Conduct and signed statement that she had read and understood same.
16. Grievant had knowledge of the mismedication on February 5, 2000 before leaving institution.

V. Case History

The Employer, the Mohican Youth Center (MYC), is one of thirteen youth centers within the Department of Youth Services (DYS), located in Loudonville, Ohio. The DYS's primary mission is the confinement of the high-risk, violent, serious juvenile offenders in secure facilities for public safety and offender rehabilitation.

The DYS is further obligated to provide safe, secure, humane, and industrious environments in each of its institutions and is committed to the delivery of the appropriate medical, educational, psychological, and vocational services based on the individual needs of the adjudicated youth.

The MYC in particular is an accredited medium security juvenile corrections facility housing adjudicated male felons with substance abuse problems in a comprehensive, six-month therapeutic community program. Juvenile youth enter the MYC program from other DYS institutions, spending the last six months of their commitment exposed to the concepts of right living principles for a drug- and crime-free life. The program is

divided into three phases: orientation, core treatment, and relapse prevention.

The grievant, Belle Dokter, was a Nurse 1 at the MYC. The Employer terminated her on June 15, 2000 for violation of DYS Directive, Chapter B19 - General Work Rules, Rule Number 1(a), Neglect of Duty; Rule Number 10, Carelessness; Rule Number 33, Unauthorized Possession of Documents; Rule Number 42, Failure to Adhere to Current Professional Standards as Defined by State Licensing Boards; and Rule Number 22, Failure to Report for Duty as Scheduled.

At the time of her termination, the grievant had been employed at the MYC for seven years, and had a total of ten years with the State. She had a five day fine active in her personnel file for violation of Rule Number 10, Carelessness, which was ultimately modified to a written reprimand by Arbitrator Robert Stein.

The first grounds for the grievant's termination occurred on February 5, 2000, when the grievant left the MYC without documenting a medication error of a youth or performing any of the necessary steps to ensure the youth's safety. An investigation regarding this misconduct took place that day by Duty Officer, Sam Stephenson, which indicated that one of the youths, Jason Davis, filed a grievance on February 6, 2000 stating that the grievant had overmedicated him both during the morning and afternoon medication rounds on February 5, despite the youth's protest that he was receiving too much medication.

The youth received twenty milligrams of "Buspar" for a time when he was supposed to receive only ten milligrams. Later in the day on February 5, the same youth was given ten milligrams of "Buspar," when he was supposed to only have received five milligrams.

Even after the youth had told the grievant that the medication was wrong, she failed to check the medication dosage against the doctor's orders, the medication administration record (MAR), and the prescription bottle. A medication error report and the interdisciplinary progress notes were not completed until the following day, February 6, 2000, and only then when the grievant was questioned about the over-medication.

In addition, contrary to existing rules, the Health Service Administrator and the treating doctor were not notified as soon as the error occurred.

The next incident involving the grievant occurred at 5:44 a.m. on February 16, 2000 when the grievant called off requesting emergency personal leave for one hour. This request was made just sixteen minutes before her scheduled time to work and violated the institutional call-off procedure of one hour prior to the start of the shift.

According to the grievant, the request was made as soon as she became aware of the emergency, but no documentation was ever submitted to support the existence of an emergency as is required by institutional policy.

Another incident involving the grievant occurred on February 18, 2000, when youth Jason Davis again received too much medication. At the breakfast medication pass, he received another youth's "Buspar." At the lunch medication pass, Davis received his own medication, but it was 22.5 milligrams rather than the prescribed fifteen milligrams.

An investigation was again conducted by Duty Officer, Sam Stephenson, when Davis reported the medication error during the evening medication rounds. Mr. Stephenson confirmed that while Davis' morning dosage was correct, the lunch medication pass resulted again in an

over-medication. Also, during the course of the investigation, the grievant acknowledged that she copied a medication envelope that included confidential information regarding Davis and had taken it home, in violation of the Standard Nursing Practices.

Finally, on February 27, 2000, the grievant failed to document dispensing Ritalin, a Schedule II medication, upon administration pursuant to the Controlled Substance Accountability Record and Standard Nursing Practices. The grievant admitted that she did not sign out the medication and states that she simply forgot to make the notation after the medication was administered. She claimed that it was a busy weekend and she was working alone and was pressed for time and no harm was done. The Employer viewed these actions as violative of DYS Directive B19, General Work Rules, Rule Number 1, Neglect of Duty; Rule Number 10, Carelessness; and Rule Number 42(b), Certification/Licensure.

On March 29, 2000 the DYS Superintendent, Robert H. Trowbridge, sent the grievant a notice of a predisciplinary meeting outlining the four allegations as discussed above for purposes of discipline:

> March 29, 2000
>
> TO: Belle Dokter, R.N.
>
> FROM: Robert H. Trowbridge
> Superintendent
>
> SUBJECT: PRE-DISCIPLINARY MEETING
>
> It is alleged that on **February 5, 2000,** youth Jason Davis received 20 mgm of Buspar for a time when he was supposed to receive 10 mgm of Buspar. Later that day, the same youth was given 10 mgm of Buspar when he was supposed to receive 5 mgm of Buspar. Even after the youth told you the medication was wrong, you failed to check the medication dosage against doctor's orders and the

prescription bottle. A medication error report was not completed until February 6, 2000. The progress report regarding this incident was not filled out until after you were questioned about the over medication. The doctor was not notified as soon as the error was realized.

It is also alleged that on February 18, 2000, youth Jason Davis again received too much medication. At the breakfast med pass, youth Davis received another Youth's Buspar. At the lunch med pass, youth Davis received his own medication, but it was 22.5 mgm, rather than the prescribed 15 mgm of Buspar.

Furthermore, it is alleged that during the course of the investigation, you acknowledged you copied a medication envelope and took it home. You also refused to answer questions regarding state laws and nursing practices.

It is alleged that your actions violate standard nursing care and practice, as you were informed of the medication error by the youth and did not make the standard checks against a medication error.

On February 16, 2000, it is alleged that you failed to follow proper call-off procedure. You called the institution at 5:44 a.m. and requested emergency personal leave. Your call off notification is 1 hour prior to your start time of 6:00 a.m.

It is alleged that on the 2/27/00 Controlled Substance Accountability Record, you did not follow established procedure for the documentation of administration of a Schedule II drug, Ritalin.

If proved, your actions are a violation of **DYS Directive B-19, "General Work Rules,"** specifically:

RULE #1: NEGLECT OF DUTY
(a) Failure to follow procedures and/or instructions and/or perform the duties/assigned tasks of the positions which the employee holds;

RULE #7: INTERFERENCE IN AN INVESTIGATION
Interfering with an investigation by . . . misrepresenting, threatening, obstructing, attempting to intimidate or alter the statements of witnesses;

RULE #10: CARELESSNESS
Failure to maintain control over tools, keys, and other equipment;

RULE #22: FAILURE TO REPORT FOR DUTY AS SCHEDULED
(a) Failure to follow proper call-off procedures for regular scheduled shift and/or accepted overtime;

RULE #30: DESTRUCTION, DAMAGE, MISUSE OR THEFT OF PROPERTY
Destroying, damaging, concealing, removing and/or stealing the property of the State, other employees, the youth, or visitors;

RULE #33: UNAUTHORIZED POSSESSIONS OF DOCUMENTS
Obtaining, possession, disclosing or misusing information regarding youth, employee or the general public, or other State documents which the employee and/or receiver is not authorized to have;

RULE #41: VIOLATION OF O.R.C. 124.34;

AND

RULE #42: CERTIFICATION/LICENSURE
(b) Failure to adhere to current professional standards as defined by State licensing boards.

The possible discipline being considered for this infraction is a fine or suspension, up to and including removal.

Bob Wagner, has been selected to serve as the Superintendent's designee to conduct a pre-disciplinary meeting. The meeting will be held in the Superintendent's conference room on **Tuesday, April 4, 2000 at 10:00 a.m.** to determine whether there is just cause for discipline.

You may not call witnesses; however, you will be given the opportunity to present documentation, ask questions, comment, refute or rebut the allegations against you.

This letter is your formal notice of the meeting. You are expected to attend the meeting as scheduled. Failure to attend this meeting will result in a waiver of your rights to a pre-disciplinary meeting.

You have the right to have a union representative present at this meeting. If you choose to waive this right, you must do so in writing.

Attached for your information is a list of witnesses and documents known at this time that will be used to support the possible disciplinary action.

ACKNOWLEDGMENT OF RECEIPT:

Belle Dokter, R.N. *s/s* 3/30/00

Union Representative *s/s*

A predisciplinary hearing was ultimately held at the MYC on May 4, 2000 before predisciplinary hearing officer, Colleen Ryan. On May 11, 2000, Ms. Ryan issued her conclusions that the evidence supported violations of the Employer's policies and practices that warranted the grievant's discipline:

PRE-DISCIPLINARY HEARING REPORT
May 11, 2000

A Pre-Disciplinary meeting was held at Mohican Youth Center (MYC) on **Thursday, May 4, 2000,** on several allegations that **Belle Dokter, R.N.,** violated work rules contained in **DYS Directive B-19, "GENERAL WORK RULES,"** specifically:

RULE #1: NEGLECT OF DUTY
(a) Failure to follow procedures and/or instructions and/or perform the duties/assigned tasks of the positions which the employee holds;

RULE #7: INTERFERENCE IN AN INVESTIGATION
Interfering with an investigation by . . . misrepresenting, threatening, obstructing, attempting to intimidate or alter the statements of witnesses;

RULE #10: CARELESSNESS
Failure to maintain control over tools, keys, and other equipment.

RULE #22: FAILURE TO REPORT FOR DUTY AS SCHEDULED

Failure to follow proper call-off procedures for regular scheduled shift and/or accepted overtime;

RULE #30: DESTRUCTION, DAMAGE, MISUSE OR THEFT OF PROPERTY

Destroying, damaging, concealing, removing and/or stealing the property of the State, other employees, the youth, or visitors;

RULE #33: UNAUTHORIZED POSSESSION OF DOCUMENTS

Obtaining, possession, disclosing or misusing information regarding youth, employee or the general public, or other State documents which the employee and/or receiver is not authorized to have;

RULE #41: VIOLATION OF O.R.C. 124.34; and

RULE #42: CERTIFICATION/LICENSURE

(b) Failure to adhere to current professional standards as defined by State licensing boards.

Present at the hearing were:

Colleen Ryan, Hearing Officer
Belle Dokter, R.N.

This meeting was scheduled originally on April 4, 2000. The meeting was rescheduled approximately four times, each at the request of Ms. Dokter or her union representative, due to conflicting schedules. Ms. Dokter was expecting the #1199 Organizer to represent her but he failed to show. Management offered a postponement. Nurse Dokter wanted to proceed.

The first of four incidents concerns the allegation of **February 5, 2000.** On this date, management alleges that Nurse Dokter gave double dosages of Buspar to Youth Jason Davis at both breakfast and lunch medication passes. Furthermore, management alleges that the medication error report was not timely completed, as required, and that a doctor was not notified of the overdose by Nurse Dokter.

Nurse Dokter acknowledges the medication errors of February 5, 2000. She admits that the report was not completed until February 6, 2000. She stated that she did not fill out the report because it was the end of her shift that she realized the error. She filled it out the

next morning. She stated that Nurse Jackie Martin and she had a conversation regarding the error and Nurse Martin indicated she would contact the Doctor. According to Nurse Dokter, the physician was notified because he called her the next morning.

Management alleges that on **February 16, 2000,** Ms. Dokter called in at 5:44 a.m. and requested emergency personal leave for one hour. Ms. Dokter's shift begins at 6:00 a.m. and she has a call-off requirement of one hour prior to the start of the shift.

Nurse Dokter agreed that the incident occurred as management alleges. However, she stated that she called in as soon as she became aware of the emergency and could not be at work. She indicated that this is the first time this has transpired.

The third incident at issue occurred on **February 27, 2000,** Nurse Dokter did not sign out a dose of Ritalin (a Schedule II drug) upon administration, pursuant to the Controlled Substance Accountability Record and standard nursing practices.

Nurse Dokter acknowledges that the omission occurred. She stated, however, that all nurses occasionally forget to sign off a medication and usually go back later in the day and sign it. She pointed out that usually if another nurse forget to sign the Record, it would be pointed out and get signed off.

Finally, Management alleges that on the morning of **February 18, 2000,** Youth Jason Davis was given the medication that was marked in an envelope for Youth Zachary Davis. the morning dosage was correct. At the lunch medication pass, the youth's medication dosage resulted in an over-medication.

Nurse Dokter denies this incident completely. She stated that Nurse Martin created this falsehood because she is a part-time employee and wants to become full-time. She indicated that she could not address the issues raised by this incident because they did not occur. Furthermore, she questioned the fact that if she mismedicated-medicated the youth on February 6, she would be less likely to do it again to the same youth within such a short time span. Ms. Dokter did acknowledge that she copied the medication envelope and took it home with her due to the investigation.

CONCLUSIONS

Through her own admissions, Nurse Dokter over-medicated a youth on at least two medication passes. She failed to complete the required medication error report and to contact the physician when she realized the error. Ms. Dokter acknowledged calling off late for her shift on February 16, 2000. Nurse Dokter also accepted responsibility for the failure to record the administration of a Schedule II drug on the Controlled Substance Accountability Record. Though she denies the final incident of medication error, having reviewed the package and the statements contained therein, I find that Ms. Dokter did, again, mismedicated-medicate Youth Davis on February 18, 2000. Furthermore, she took home a copy of a medical document and violated standard nursing practices during three of these four events.

Taking all the allegations and admissions into consideration, I find just cause for violation DYS Directive B-19, General Work Rules, #1(a), Neglect of Duty; #10, Carelessness; #22(a), Failure to Report for Duty as Scheduled; #33, Unauthorized Possession of Documents and #42(b), certification/Licensure, failure to adhered to current professional standards as defined by state licensing boards.

Colleen Ryan s/s
Pre-Disciplinary Hearing Officer

On June 15, 2000, the grievant grieved her discipline and the parties jointly addressed the issues in a July 5, 2000 Step 3 meeting. The result of that meeting was memorialized in a memo to the grievant from Colleen Ryan indicating that the Union's grievance had been denied:

TO: BELLE DOKTER
FROM: COLLEEN RYAN, LABOR RELATIONS OFFICER
SUBJECT: STEP 3 GRIEVANCE RESPONSE
GRIEVANCE #35-06-000615-0090-02-11

DATE: 08/01/00

The Step 3 meeting regarding the above-referenced grievance was held on July 5, 2000 at the District 1199/SEIU Office in Columbus. In

attendance at the meeting were Colleen Ryan, Matt Mahoney and Belle Dokter.

Articles Cited: 6.01, 6.02, 8.01, and 8.02

Union Contention

The union contends that the removal was without cause. The union argues that the February 5 medication error did occur, but that removal is disparate compared with a nurse out of the Department of Mental Health. The grievant stated that Nurse Martin did contact the physician that day as evidenced by his return phone call the next morning. The union further questioned how Carelessness applied to the charges. The grievant stated that med errors happen routinely and discipline does not get issued, especially nothing this severe. The union cited union animus as a reason for the removal.

Regarding the February 16 call off, the grievant replied that she called off as soon as she knew of the emergency.

In response to the February 18 incident, the grievant completely denies that it occurred. The grievant believes Nurse Jackie Martin staged the incident in order to obtain the grievant's full-time position.

In regards to the medical documents the grievant took home, her defense is that it was only a copy of an envelope that was going to be disposed of if she did not preserve it as evidence.

Finally, the union responded to the February 27 incident regarding the failure to document dispensing of a Schedule II medication. The grievant stated that such things happen regularly. The Department's Directive is never followed. She stated that day was a busy weekend and she was working alone. She simply forgot to make the notation after the medication was administered. The next nurse checked with the youth to make sure he received the medication. There was no harm. The union again asked what the carelessness charge covered in this instance and the neglect of duty. The union raised an issue of disparate treatment because of a lost syringe on March 15 with no resulting discipline.

The union requests reinstatement to the grievant's position/shift held at the time of the removal, compensation in full for all lost wages and benefits, including lost overtime opportunities and holidays.

Discussion

The grievant's acknowledged medication error on 2/5 leaves little open to debate. The carelessness charge is just that. The grievant was careless in conducting her duties. She failed to check on the youth when she realized the medication error. She did not properly document the error when she realized it occurred. She did not properly contact the doctor. She requested that somebody else perform that duty. In her haste to exit the facility, the grievant determined that she would worry about the med error the next day. Unfortunately for the youth, he had to worry about it from the time he swallowed the pills.

Regarding the 2/16 late call-off, the grievant has yet to this day provided documentation, as required by institutional policy, to support the existence of an emergency. There is no dispute that the call-off was late. Even at the Step 3 meeting, the grievant did not want to disclose the purpose of the call-off.

Regarding the 2/18 medication error, it is management's opinion, after reviewing the evidence and the statements, that the error did occur. There is no evidence that Nurse Martin conjured up the event in order to obtain a full-time position.

Regarding the copy the grievant took home. It does not appear to matter whether the envelope was trash or not. The envelope containing the medication does not belong to the grievant. It was part of the youth's medical treatment and had no place in the grievant's personal possession regardless of the purpose for preserving it. If I were a patient in a hospital or of a clinic, I would be offended at the thought of someone taking home a copy of a prescription that was specific to me, or a dosage envelope. It is unethical behavior for a registered nurse to behave in such a manner.

Finally, the issue of documenting the administration of a Schedule II medication. The grievant's flippancy regarding the alleged practice of not documenting the medication and the failure of her to recognize it as a problem is, again, a symptom of behavior that led to the removal.

Conclusion

The union requested a copy of the nursing board standards. At the meeting, I did not have a copy available to me. Those standards are rather lengthy. They may be found on the Board of Nursing web site

at www.state.oh.us/nur. The standards clearly state that it is the nurse's responsibility to know and apply those standards.

The grievant and the union seemed to miss the overall picture regarding this removal. The medication error, by itself, is not why the grievant was removed. The Department encourages reporting medication errors in order to enable monitoring the youth and administering proper medical services. It is the grievant's failure to follow up on the medication errors that are so egregious.
The union offered no evidence of discrimination. Its' offering of an arbitration decision from another agency has no bearing on this issue. This is a different agency with differing work rules. In addition, the facts leading to the discipline in both instances are distinct enough to be of limited relevance. I find no violation of Article 6.

Similarly, I find no violation of Article 8. The investigation clearly shows a violation of Directive B-19. Given the grievant's prior suspension and the seriousness of the incidents in such a short period of time, the removal was warranted.

The grievance is denied in its entirety.

This matter is now before this Arbitrator on the merits.

VI. The Merits of the Grievance

The Employer's Position

The grievant was removed for just cause. At the time of her removal, she had a five day fine active in her personnel file for violation of Rule #10, Carelessness, which was later modified to a written reprimand by an arbitrator.

The evidence firmly establishes that the grievant, after knowingly mismedicating a patient, left the MYC facility on February 5, 2000 without documenting the medication error or performing any of the necessary steps to ensure the patient's safety. She also tried to cover up her error by backdating a shift communication sheet.

The grievant mismedicated the same patient on February 18, 2000, and again did nothing to document this mistake. She also took home the patient's medication envelope that contained confidential information, suggesting that she was going to attempt to finesse her second mistake.

The grievant also called off on February 16, 2000 and did not follow call-off procedures. She never provided reasons for her call off. Finally, on February 27, 2000, the grievant failed to document dispensing Ritalin, a Schedule II medication. These actions are all clearly violations of standard nursing practices. All of these transgressions happened within a short period of time and are cumulative grounds for the grievant's removal.

The Union's Position

The Employer's removal of the grievant was an arbitrary and egregious action that is unsupported by the facts.

With respect to the grievant's alleged February 5, 2000 mismedication of Youth Jason Davis, the grievant left the MYC but first notified Nurse Jackie Martin that there was a possibility of mismedication of the youth. Martin was to call the doctor. The next day the doctor called the medical unit and stated that the med error was fine. There was nothing to worry about.

With respect to the grievant's alleged failure to call-off in a timely manner on February 16, 2000, the grievant called off as soon as possible in accordance with the collective bargaining agreement. An emergency in the family existed and she had the right to take the time off.

The allegations that the grievant mismedicated Youth Davis again on February 18, 2000 are unsupported. The grievant was not aware of any mismedication and Youth Davis never said anything to her. The error was

only discovered after Davis said something to Nurse Martin, and Nurse Martin encouraged the youth to file a grievance. This is in direct contradiction to the policy of the Agency wherein employees do not solicit youth grievances. In any event, the med count does not determine whether the error occurred on February 18 or not. The results do not determine with certainty that the grievant mismedicated Youth Davis.

Finally, the grievant admits to not noting a Ritalin pass on February 27, 2000, but this action, as noted by Rob Hofacre, does not constitute a removal. The environment at MYC was busy and active, and on the day in question the grievant was working alone and it was easy to make a mistake. Mistakes are made often and are overlooked.

The Union claims disparate treatment and animus toward the grievant. The grievant has previously reported to investigators and other officials on poor treatment of the youths at the MYC facility. The Employer is essentially attempting to build a cumulative case and take action against the nurse that has dedicated herself and worked hard for the State of Ohio for ten years.

VII. The Arbitrator's Opinion and Award Regarding the Merits of the Grievance

From the evidence and the testimony introduced at the hearing, including pertinent contract provisions, work rules, the parties' exhibits, and the record of the arbitration proceeding, it is this Arbitrator's opinion that the grievant was terminated for just cause. In this Arbitrator's view, based on the record here, the Employer met its quantum of proof to sustain the grievant's termination for various violations of standards and procedures.

VIII. The Analysis

The quantum of required proof in discipline cases for employee misconduct is unsettled. In some cases, proof beyond a reasonable doubt has been required. *Vista Chem Co.*, 104 LA 818 (Nicholas, 1995). Some arbitrators also have used a "preponderance of the evidence standard," *Wholesale Produce Supply Co*, 101 LA 1101 (Bognanno, 1993), while others have required evidence "sufficient to convince a reasonable mind of guilt." *Stockham Pipefittings Co.*, 1 ALAA Par. 67,460 (1946).

Arbitrators have not justified a strict standard of proof for terminations based on performance reasons, as opposed to terminations for misconduct. The reasoning is that misconduct of a kind which carries a stigma of general social disapproval under accepted canons of employment discipline should be clearly and convincingly established by the evidence. *Kroger Co.*, 25 LA 906 (Smith, 1955).

In this case, the issue deals primarily with the grievant's work performance rather than misconduct. While this Arbitrator is not going to hold the Employer to a quantum of proof beyond a reasonable doubt, he has analyzed the record based on more than a preponderance of the evidence. The Arbitrator viewed the record for proof sufficient to convince a reasonable mind of the grievant's poor work performance.

The first part of this Arbitrator's analysis is a review of the standards that govern the grievant's misconduct. Here, the grievant was terminated essentially for four cumulative reasons: (1) mismedicating a youth on February 5, 2000 without proper documentation of the error; (2) failing to properly call off work on February 16, 2000; (3) mismedicating a youth on February 18, 2000 and mistakenly providing a youth with another youth's medication; and (4) failure to document the dispensing of Ritalin on

February 27, 2000 upon administration pursuant to the controlled substance accountability record and standard nursing practices.

In general, for having committed all of these cumulative offenses, the Employer cited the grievant with violations of policies and procedures, DYS Directive, Chapter B19-General Work Rules, Rule #1 (a), Neglect of Duty; Rule #10, Carelessness; Rule #33, Unauthorized Possession of Documents; Rule #42, Failure to Adhere to Current Professional Standards as Defined by State Licensing Boards; and Rule #22, Failure to Report for Duty as Scheduled. This Arbitrator will therefore address the allegations against the grievant in turn, based upon the background of these policies and procedures.

1. The February 5, 2000 Mismedication.

Not much discussion needs to occur here. The grievant has stipulated to her misconduct. Joint Stipulation 4 admits that "Youth Jason Davis was mismedicated by the grievant on February 5, 2000." The grievant then stipulates in Joint Stipulation 5 that she "worked first shift on February 5, 2000 and was responsible for medication counts and administration." The grievant also admits that she "had knowledge of the mismedication on February 5, 2000 before leaving the institution. [MYC]." Finally, the grievant admits in Joint Stipulations 6 through 8, that she neither documented nor reported any of her errors until the following day, February 6, 2000.

Based on these stipulations, the grievant indisputably violated the policies and procedures relative to medicating patients and reporting known errors of medication.

The grievant attempts to mitigate her error by alleging that she had reported a potential mismedication of Davis to Nurse Jackie Martin before

the end of the grievant's shift. But at the arbitration hearing, upon direct examination, the grievant failed to provide any specific recollection of what she had told Nurse Martin about the mismedication. All the grievant could say was that "I really can't remember it in great detail."

The grievant also vaguely referred to a "shift communication sheet" that allegedly indicated something about a potential mismedication, but this document was never introduced into evidence. This Arbitrator is therefore unpersuaded by the grievant's proposed mitigation of her error.

Also very troubling to this Arbitrator is the unrebuted testimony of Sam Stephenson, the investigator of the February 5 mismedication incident. Stephenson testified that in an attempt to corroborate the grievant's comment that she notified Nurse Martin of a potential mismedication, he checked the routine shift progress notes for February 5 that should have reflected these comments between the grievant and Nurse Martin. His initial investigation did not reveal any such comments. The grievant was aware of Stephenson's concern that no such documentation was on the progress notes.

But then after Stephenson went back to make a copy of the progress notes, he found that documentation dated 2/5 and 2/6 existed on the progress notes with comments about the grievant's alleged conversation with Nurse Martin about the potential mismedication of Youth Davis. Stephenson's unrebutted testimony established that the progress notes were clearly backdated in a deceitful attempt to cover up the grievant's mistake and bolster her excuse. The Union never adequately rebutted Stephenson's testimony and thus this Arbitrator, together with the grievant's stipulations, finds that the grievant violated the Employer's

policies and regulations by mismedicating Davis on February 5, 2000 and not properly reporting it.

2. The Grievant's Failure to Properly Call Off Work on February 16, 2000.

The grievant has also stipulated the grounds of her misconduct here. She admits in Joint Stipulation 10 that she "did not follow the correct call-off procedures/the call-off was late." This establishes a direct violation of the call-off policy.

Also, the grievant corroborated the Employer's position that she never provided any grounds for why she was reporting off. On cross-examination, the grievant admitted that she knew her significant other had been arrested for drunken driving, but that she did not submit any additional documentation to mitigate her failure to follow the call-off procedure because she was embarrassed by the nature of the emergency that led to her time off.

Hence, at the time the grievant reported off to work late, the Employer was faced with an employee who not only was reporting late but was refusing to provide any information of why she needed the time off. The Employer certainly had just cause to discipline the grievant on this basis.

3. The Mismedication and Mistaken Medication of February 18, 2000.

In its closing argument on behalf of the grievant, with respect to the mismedication issue on February 18, 2000, the Union concedes, "while this[mismedication] may be true, Nurse Dokter was not aware of this at the time." When she was asked on direct examination about the mismedication

of February 18, the grievant merely responded, "Well, I don't know." When pressed further by the Union, the grievant stated that her recollections about the incident were "rather vague." This Arbitrator does not view this evidence as probative to defend against the grievant's misconduct.

Also troubling, similar to the grievant's unrebutted backdating of the progress reports regarding the February 5 mismedication, was the grievant's unexplained decision to take home Davis' medication envelope containing confidential information during the time the grievant was aware that she was being investigated for her second incidence of mismedication on February 18.

The grievant admitted on cross-examination to taking the medication envelope home. She also admitted that the envelope contained the youth's name, the medication and the times and the last date of administration of the youth's medication. When asked why she took this information home, she merely stated that she "just brought it home, rather than throw it away."

Equally suspicious, was the undisputed fact that investigator Stephenson's copy of the envelope, made at the outset of his investigation, differed from the grievant's envelope in that the dosage of Buspar medications had been modified. No explanation for this discrepancy was ever provided.

This Arbitrator draws some significant negative inferences from the grievant's unexplained possession of a modified medication envelope that contained information relevant to the investigation of the grievant for mismedication of a patient. Similar to the unrebutted backdating of the February 5 progress reports, this Arbitrator draws negative inferences that the grievant knew she had violated a serious policy and was attempting

somehow to prepare to cover up her mistake. Hence, not only did the grievant commit an error, she was attempting to cover it up.

In addition, Jackie Martin, who the grievant relied on to defend her February 5 mismedication claim, verified in a written statement that she had found another youth's medication in the drawer with Davis' medication. Based on a count of the medication, Martin found that Zachary Davis was short of a count of one and one-half tabs and Jason Davis' medication was over by what had been passed out. Indeed, as it turned out, Martin discovered that Zachary Davis' Buspar, ten milligram pills, was in Jason Davis' pill drawer. Further investigation revealed that the grievant had signed off on a packing list of medications as accurate when in fact the medication had been miscounted. This Arbitrator thus finds cause to discipline the grievant for mismedicating Davis on February 18,2000[1]

4. The Improper Dispensing of Ritalin on February 27, 2000.

Once again, as admitted in the Union's Closing Argument, the grievant forgot to note dispensing Ritalin. She brushes this mistake off as routine and rationalizes her mistake because the "institution was busy, hectic and on this day the grievant was working alone." In her direct testimony, the grievant alleges that the normal practice was to get the Ritalin, administer it, take the Ritalin with her, and then later come back and sign the controlled substance record afterward. But even under the grievant's rendition of this practice, she admittedly failed to follow that

[1]The Union's preemption argument, based on the grievant's February 22, 2000 supervisory conference regarding her February 5 and 18 mismedications, is not well taken. The supervisory conference on its face is not discipline and does not prevent the Employer from disciplining her because of her mismedications on February 5 and 18.

procedure. The grievant clearly violated the Employer's rules and regulations about dispensing Ritalin.

Finally, this Arbitrator's separate findings of independent grounds of just cause for each of the grievant's rules and policy violations makes the Union's disparate treatment claims moot. In any event, no probative evidence exists on the record demonstrating that employees in a position similiar to the grievant under the same circumstances were not disciplined or terminated.

IX. The Award

The Union's grievance regarding the grievant's termination is denied. The Employer met its quantum of proof to demonstrate that the grievant was terminated for cause based on multiple and cumulative violations of the Employer's policies and procedures. In addition,compounding the grievant's violations of the Employer's rules and policies, persuasive evidence also exists that the grievant attempted to cover up her mistakes by modifying and confiscating relevant documents that could be used as evidence against her. The grievant's termination therefore stands.

July 30, 2001
Moreland Hills, Ohio

Dr. David M. Pincus