VOLUNTARY LABOR ARBITRATION TRIBUNAL

In the Matter of Arbitration	*	
Between	*	
	*	OPINION AND AWARD
OHIO CIVIL SERVICE	*	
EMPLOYEES ASSOCIATION	*	Anna DuVal Smith, Arbitrator
LOCAL 11, AFSCME, AFL/CIO	*	
	*	Case No. 33-00-20031203-1474-01-04
and	*	
	*	Nancy Ratliff, Grievant
OHIO VETERANS HOME	*	Removal
	*	

APPEARANCES

For the Ohio Civil Service Employees Association/AFSCME Local 11/AFL-CIO:

Robert Robinson, Staff Representative
Ohio Civil Service Employees Association/AFSCME Local 11/AFL-CIO

For the Ohio Veterans Home:

Donna Green, Labor Relations Officer
Ohio Veterans Home

Andrew Shuman, Labor Relations Specialist
Ohio Office of Collective Bargaining

I. HEARING

A hearing on this matter was held at 9:30 a.m. on September 30, 2004, at the Ohio Veterans Home in Sandusky, Ohio, before Anna DuVal Smith, Arbitrator, who was mutually selected by the parties pursuant to the procedures of their collective bargaining agreement. The parties stipulated the matter is properly before the Arbitrator and presented one issue on the merits, which is set forth below. They were given a full opportunity to present written evidence and documentation, to examine and cross-examine witnesses, who were sworn or affirmed and excluded, and to argue their respective positions. Testifying for the Ohio Veterans Home (the "Home") was Karen Connors, RN, Assistant Director of Nursing. Testifying for the Ohio Civil Service Employees Association/AFSCME Local 11/AFL-CIO (the "Union") were Chapter President Vanessa Brown, Union Steward William Kessler, LPN and the Grievant, Nancy Ratliff, LPN. Also in attendance was Chief Steward Carolyn Smith. Joint Exhibits 1-15 were entered into evidence. The oral hearing was concluded at 12:00 noon on September 30, 2004. Written closing statements were timely filed and exchanged by the Arbitrator on October 14, 2004, whereupon the record was closed. This Opinion and Award is based solely on the record as described herein.

II. FACTUAL BACKGROUND

The Ohio Veterans Home is a State of Ohio certified nursing home and domiciliary for the care of veterans who have served during armed conflicts. Among its Licensed Practical Nurses (LPNs) represented by OCSEA/AFSCME Local 11 at the time of the incident giving rise to the grievance was Nancy Ratliff, who was hired on August 27, 2001, and who had no prior discipline on her record at the time of her removal.

Regulations governing the practice of nursing in Ohio include the following pertinent provisions:

> **4723-4-04 Standards Relating to Competent Practice as a Licensed Practical Nurse**
>
> (B) A licensed practical nurse shall maintain current knowledge of the duties, responsibilities, and accountabilities for safe nursing practice.
> (E) A licensed practical nurse shall, in a timely manner:

(2) Clarify any order or direction for a client when the licensed practical nurse believes or should have reason to believe the order or direction is:

(a) Inaccurate;
(b) Not properly authorized;
(c) Not current or valid;
(d) Harmful, or potentially harmful to a client; or
(e) Contraindicated by other documented information.

(F) When clarifying an order or direction, the licensed practical nurse shall, in a timely manner:

(1) Consult with an appropriate licensed practitioner;

(2) Notify the prescribing practitioner when the licensed nurse makes the decision not to follow the direction or administer the medication or treatment as prescribed;

(3) Document that the practitioner was notified of the decision not to follow the direction or administer the medication or treatment, including the reason for not doing so; and

(4) Take any other action needed to assure the safety of the client.

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

(K) A licensed nurse shall not:

(1) Engage in behavior that causes or may cause physical, verbal, mental, or emotional abuse to a client;

(2) Engage in behavior toward a client that may reasonably be interpreted as physical, verbal, mental, or emotional abuse. (Joint Ex. 4)

On November 24, 2003, following an investigation and predisciplinary hearing, the Grievant's employment was terminated for violating the Ohio Veterans Home Corrective Action Standard RA-04, "Failure to Act on or Report Client Neglect – Including but not limited to: Failure to act in any manner which results in potential or actual harm to a resident," and N-08, "Endangers life, safety or property of residents, staff or public; failure to ensure proper security/safety/sanitary conditions" in that she failed to initiate CPR and/or rescue breathing on a "full code" resident of the Home who died during the incident. A grievance was timely filed protesting this action and subsequently fully processed to arbitration where it presently resides for final and binding decision on the stipulated issue of: *Was there just cause to terminate the Grievant, Nancy Ratliff? If not, what shall the remedy be?*

The incident giving rise to the grievance occurred on October 26, 2003, while the Grievant was Charge Nurse on 3 South for the 3 p.m. shift. She took a report from the nurse going off shift about a "full code" resident, JV. A "full code" resident in cardiac and/or respiratory arrest is to receive cardiopulmonary resuscitation ("CPR") and emergency transport to an acute care hospital, the procedures of which are set forth in the Home's Procedure 40-Nrsg-91. When the Grievant assumed the care of this resident at 1500 hours he had vital signs of 100.2 rectal temperature, pulse rate of 103, respiratory rate of 36 and blood pressure of 166/85,

and was resting comfortably without any complaints. The LPN going off duty said his respiratory rate had dropped to 28, but that he was quiet and comfortable. When the Grievant entered his room 1½ hours later to attend him, nothing was cause for alarm. Another hour and a half later, at 1800 hours, when she returned to perform a treatment, she noticed signs of congestion which she was unable to relieve with her attempts to get the resident to cough. She called for her RN, LaTonya Lacey, to bring a suction machine and began looking for one herself, then went on to her next treatment without taking the patient's vital signs. When she returned to JV's room at approximately ten or fifteen minutes later, his facial color was yellow and he had had an emesis. She called Nurse Aide Delbert Stegall to come and clean it up, then got a "nurse on a stick" to check his vital signs. She also called her RN again to come "right away." The vitals check (right side) read "CO5" (meaning "no pulse"), according to her written statement, but Stegall's statement has it that she said there was a pulse, but a weak one. RN Lacey arrived. Stegall was sent for a mask and the crash cart. RN Lacey used a manual BP cuff and stethoscope and to try getting JV's vital signs on his left side, but got none. As Stegall came through the door, Lacey said, "He passed away." It is undisputed that neither Lacey nor the Grievant performed CPR. Time of death was 18:25.

Meanwhile, RN Manager Lisa Rogers had received a page from RN Lacey earlier in the evening saying a suction machine was needed for JV and that she was with a resident who had fallen. Rogers said she would get one, which she did, handing it off to RN Manager Christine Pluckhorn to take to 3 South. When Pluckhorn arrived on the unit at 1840 hours and gave the machine to the Grievant, the Grievant said it was too late because JV was gone. Nurse Pluckhorn contacted Assistant Director of Nursing Karen Connors, who initiated an investigation. As a result of this investigation, RN Lacey and LPN Ratliff were terminated. RN Manager Christine Pluckhorn, who supervises all direct care staff on her shift, was not.

III. DISCUSSION

The Union raises several defenses, none of which, individually or collectively, are persuasive. At the heart of its case is an image of the Grievant as inexperienced, uninformed, poorly trained, inadequately equipped, and fearful of discipline. Beginning with the absence of a suction machine, while having one in JV's room may have prevented what ultimately occurred, even when the aide brought the crash cart (which had a suction machine on it), neither the RN nor the Grievant did as required by the resident's "full code" status. As for her training, the Grievant does not claim she does not know what to do with a full code patient, only that she did not know that she should have intervened when the RN failed to administer CPR or rescue breathing.[1] The facts that the Grievant had never before been in such a situation, that the Home revised its training after the incident, and that a far more experienced LPN has not read the entire Ohio Board of Nursing Rules does not excuse the Grievant. A licensed practical nurse accepting and maintaining employment in the profession has to be presumed to be informed on the duties and responsibilities of her profession. Otherwise, the license is meaningless. The Grievant's 2½ years of service is no excuse for failing to clarify with the RN that the resident was full code and then take other action if the RN was non-responsive. The insubordination defense also fails because there was no evidence of an order from legitimate authority other than the doctor's orders, which were "full code." But even if the RN had countermanded that order, and the Grievant wilfully disobeyed after clarificaiton, the Grievant had protection in 4723-4-04(F).

The Union also argues disparate treatment in that RN Manager Pluckhorn was not discharged. Nurse Pluckhorn arrived on the scene some fifteen minutes after the incident without have been informed of any urgency to her errand. This cannot be compared with the Grievant's

[1]At the arbitration hearing, the Grievant for the very first time, claimed she did not know the resident was "full code." This is too little, too late. It was the Grievant's responsibility to know the physician's orders on her patients. Moreover, the Grievant had ample opportunity to raise the claim from the beginning when she was first questioned by RN Manager Pluckhorn. Not having done so sooner than arbitration undermines the Grievant's credibility.

situation of actually being present when the resident was going down and intervention might have done some good.

Finally, notwithstanding the facts that since her termination, the Grievant has held other employment as an LPN and the Ohio Board of Nursing had not, by the time of the arbitration hearing, pulled her license, termination is not beyond the bounds of reason under these circumstances.

IV. AWARD

The grievance is denied in its entirety. The Grievant was terminated for just cause.

Anna DuVal Smith, Ph.D.
Arbitrator

Cuyahoga County, Ohio
December 20, 2004

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