#1798

IN THE MATTER OF ARBITRATION

BETWEEN

DISTRICT 1199 SEIU

AND

STATE OF OHIO/OHIO VETERANS HOME

Before: Robert G. Stein

Grievant(s): La Tonya Lacey
Case # 33-00-20031125-0145-02-11
Termination

Advocate(s) for the UNION:

Harry W. Procter, Organizer
DISTRICT 1199 SEIU
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Advocate(s) for the EMPLOYER:

Donna L. Green, OVH
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INTRODUCTION

This matter came on for hearing before the Arbitrator pursuant to the Collective Bargaining Agreement (herein "Agreement") between the State of Ohio/Ohio Veterans Home (herein "Employer" or "Home") and District 1199, SEIU (herein "Union"). The Agreement is effective from June 1, 2003 through May 31, 2006 and includes the conduct that is the subject of this grievance.

A hearing on this matter was held on September 20, 2004. The parties mutually agreed to the hearing date and location and were given a full opportunity to present both oral testimony and documentation supporting their respective positions. The parties each subsequently submitted post-hearing briefs in lieu of making closing arguments. There was a problem with electronic transfer of the Employer's closing argument due to Norton Anti-Virus software blocking transfer. In addition, an electronic copy of the Union's closing statement did not accompany its written closing. Efforts were then undertaken to receive both a written copy of the parties' closing statements and an electronic copy. This took additional weeks to accomplish. The case was officially closed November 5, 2004.

The parties have also agreed to the arbitration of this matter pursuant to Article 7: Grievance Procedure.

ISSUE

Was there just cause to terminate the grievant, La Tonya Lacey? If not, what shall the remedy be?

RELEVANT CONTRACT LANGUAGE
(As cited by the parties, listed for reference, see Agreement for language)

ARTICLES 1, 2, 5, 7, 8

BACKGROUND

The Grievant is La Tonya Lacey, RN ("Grievant", "Lacey"), a Registered Nurse. Her employer is the Ohio Veterans Home ("OVH", "Employer" "Home"). Lacey had been employed with OVH for approximately nine (9) years and was terminated on 11/24/03. She was terminated from her employment for violation of the following OVH standards: *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, N-08; Endangers life, safety or property of residents, staff, or public, failure to ensure proper security/safety/sanitary conditions.*

OVH is a certified nursing home for veterans, and Lacey was part of the direct care staff. The Grievant was initially employed by OVH on

January 31, 1994 as a Nurses' Aide, and during the subsequent years of her employment she attended school and earned her certification as a Registered Nurse. She was promoted to Registered Nurse on September 9, 2001.

The incident leading to the Grievant's termination from employment occurred on October 26, 2003. Lacey was RN/Clinical Coordinator on the afternoon shift, responsible for ten nursing units including Unit 3 South, the site of the incident, which is the subject of this dispute. At approximately 1810 hours (6:10 p.m.) a resident, Mr. V., age 93, was severely congested, prompting Nancy Ratliff, LPN, ("Ratcliff") who was providing immediate care, to request a suction machine to be sent to resident V's room. Ratcliff called the Grievant, who at the time was assisting two LPNs on Unit 3 North/ and stated she needed a suction machine due to the fact resident V's respirations were "gurgling" and he sounded congested. The Grievant called Nurse Manager, Lisa Rogers, at approximately 6: 25 p.m. and requested a suction machine for resident V. However, in this approximate 15 minute interim, resident V's condition got worse.

After attempting to provide care to resident V, who was in respiratory distress, Ratcliff asked Nurses' Aide, Delbert Stegall, STNA, ("Stegall") to assist her at approximately 6:15 p.m. At that time she was unable to obtain a blood pressure reading. Stegall was asked to assist

Ratcliff in providing oral care to resident V. According to Stegall, at approximately 6: 18 p.m., Ratcliff told him resident V, who had just thrown up, had a weak pulse. Ratcliff left resident V's room and according to the 10/26/04 statement of the Grievant, called her and told her to "get here right away." The Grievant stated the time of Ratcliff's second call was approximately 18:25 or 6: 25 p.m. Ratcliff's 10/26/03 statement contains one reference to time, 1800 hours. According to the medical record, the Grievant entered resident V's room at approximately 6: 25 p.m. Ratcliff and Stegall were both in V's room. The Grievant then asked Stegall the code status of V, and Ratcliff replied she thought he was "full code."

The Grievant then asked Stegall to get a re-breather mask and the crash cart. Ratcliff was unable to get a reading on resident V on the blood pressure machine beginning approximately 10 minutes prior to the Grievant entering resident V's room. After dispatching Stegall to get the re-breather mask and the crash cart, she attempted to take V's blood pressure manually and was unable to note any vital signs. Stegall then returned to V's room and the Grievant declared, "he's gone." None of the caregivers present prior to the Grievant declaring resident V had passed, i.e., Ratcliff, Stegall, or the Grievant, all of whom are CPR certified, attempted any CPR on resident V.

The Grievant was subsequently terminated for the violations stated above. At the time of her termination she had a written warning on her

personnel record for "Failure to notify a change of condition. It was issued on 10/23/03, three (3) days prior to the date of the incident leading to her discharge. It was the position of the Employer that without a "do not resuscitate" order ("DNRCC"), the Grievant should have attempted CPR during a full code. The Grievant filed a grievance stating her termination was not for just cause.

SUMMARY OF EMPLOYER'S POSITION

The Employer argues that the Grievant had the responsibility and the duty as RN/Clinical Care Coordinator to take corrective measures when she saw resident V in distress, but did not. She did not follow physician's orders, the Code Blue Policy, as well as the policies and procedures established by the Board of Nursing and OVH. The Employer's arguments are succinctly stated in its written closing as follows:

> The case presented on September 20, 2004 involves the removal of La Tonya Lacey, who was employed full-time at the Ohio Veterans Home (OVH) as a Nurse Aide On January 31, 1994. While employed at OVH the grievant went to school and became A Registered Nurse, she was promoted on September 9, 2001 as a RN until her termination, November 24, 2003, for OVH Corrective Action Standard(s) 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."
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> The Ohio Veterans Home is a certified nursing home and domiciliary entrusted to care for veterans who have served during armed conflicts. Our direct care staff, including the grievant, is responsible for the health and welfare of our veterans and is expected to follow the policies and procedures that are in place to provide quality care to these residents. In addition, direct care staff are trained prior to and following employment on Board of Nursing Rules/Laws Regulating the Practice of Nursing including the following: "A registered nurse shall maintain current knowledge of the duties, responsibilities, and accountabilities for safe nursing practice," "the registered nurse shall use acceptable standards of safe nursing care as a basis for any observation, advice, instruction, teaching, or evaluation and shall communicate

information which is consistent with acceptable standards of safe nursing care with respect to the nursing care (JT #4)." Management proved through documents and testimony that the grievant failed to abide by these standards.

On October 26, 2003 the grievant was the RN/Clinical Care Coordinator responsible on the 3 South Unit. At 1810 a resident on that unit was found to be congested by Nancy Ratliff, LPN. Ms. Ratliff notified the grievant of the resident's status, and also to request a suction machine. You heard the grievant testify that at this time the LPN did not say that it was an emergency situation. However, her employee statement (Union Exhibit 3), written on October 30, 2003 says otherwise. She states that at "1810 I was on 3N when Nancy Ratliff called and said she needed a suction machine d/t Mr. Vasko's lungs filling up." The fact that she says that his lungs were filling up was proof enough that it was a serious situation.

Delbert Stegall, NA, testified that he was called into the room to assist with the resident. You heard him tell you that he was sent out by the grievant to get a rebreather mask and the crash cart. At this time, the situation was now critical, but the resident was still breathing. Upon Mr. Stegall's return he testified that the resident had passed and no one had discussed CPR.

During the proceedings the union focused on a disparity of treatment between the grievant and the RN Manager on duty, Christine Pluckhorn. This case was not about Ms. Pluckhorn's actions it was about the grievant's actions.

Karen Connors, ADON, explained to you the difference between a 1199 Registered Nurse (RN) and a exempt Registered Nurse Manager. The 1199 RN delegates direct care of residents to nursing personnel based on the needs of the resident. The RN Manager on the other hand, supervises all direct care staff. Ms. Pluckhorn was not on the floor to make an assessment until the grievant was already on the phone with the family. The grievant took it upon herself to pronounce the resident dead and make the appropriate phone calls, before Ms. Pluckhorn was even on the unit.

The union failed to prove the disparate treatment.

The union also tried to show through Doctor Ramey's statement that he would have eliminated the whole process of resuscitation. The grievant acknowledged that this was over an hour later, that Doctor Ramey made that decision. Management also showed through Doctor Ramey's statements that his comments were based solely on the facts as presented by the grievant. We don't know what he would have said at 1825 if presented the same facts because grievant never called him before pronouncing him dead.

The policy at the Veterans Home (JT #3) explains in detail the actions that the grievant should have taken from the time she discovered the resident in distress. She did not call a "Code Blue" over the public address system, she did not call the rescue squad and she most certainly did not administer CPR. The grievant was well trained in CPR. As she told you, she is a CPR instructor.

Violation of the corrective action standard in question is a serious offense. The grievant is trained both in Nursing School and by OVH to be placed in a position of trust to care for our veterans. The grievant never denied the fact that she made a bad judgment call, however her bad judgment call may have caused Mr. John Vasko to lose his life, we will never know. The grievant's failure was not a judgment call it was a failure to follow basic standards of care.

Mr. Arbitrator, management cannot tolerate the actions of the grievant on this

day. The grievant had a responsibility as the RN/Clinical Care Coordinator to take the correct measures to ensure the basic standards of care are provided to the resident, and she did not. Not only that, but Management has grave concerns about the example she set for other direct care staff. Her behavior basically said that it was ok not to follow physician's orders, the Code Blue Policy, and all the training she received in nursing school. It was the grievant who told Ms. Ratliff that he was a full code resident. With that knowledge there is no excuse why the grievant didn't perform CPR. When asked by you, the Arbitrator, why she didn't do CPR the grievant responded by basically saying "I just didn't think it was necessary". It is not the grievant's responsibility to pronounce a resident deceased; it is the grievant's responsibility to follow the physician's orders layed out in the resident's chart (JT #5). She has a duty to follow the policies and procedures (JT#3) established by OVH and the Board of Nursing (JT #4) so that she does not have to make these type of end of life decisions on her own.

The union made mention that they felt that what happened was not a terminable offense, the union also felt that there was no progressive discipline in order to remove the grievant. Some violations are so serious that termination is the only appropriate penalty. The death of resident by itself should be a terminable offense, with no need for progression.

The action to terminate the grievant was commensurate with the offense and for just cause. Mr. Arbitrator, we respectfully urge you to deny this grievant in its entirety.

SUMMARY OF UNION'S POSITION

The Union stipulates to the fact that the Grievant did not administer CPR, but argues that punishment of the Grievant was excessive and was meted out in a disparate manner. The Union points out that Nursing Supervisor Pluckhorn received a reprimand, and Nursing Supervisor Rodgers and Nurses' Aide Stegall were exonerated. The Union also asserts Dr. Ramey, the attending physician, stated he was "not surprised by the outcome" that suggests resident V, at age 93 and in poor health, was not expected to live, argues the Union.

The Union contends that Grievant Lacey was part of a health care team that included supervisors. It argues that all members of the team bore responsibility for what happened on October 26, 2003 regarding

resident V. The Union asserts the Grievant was treated more harshly than others. The Union believes the Grievant's discharge is not supported by the facts and seeks her reinstatement with back pay and benefits.

DISCUSSION

Generally, in an employee termination case, an arbitrator must determine whether an employer has proved clearly and convincingly that a discharged employee has committed an act warranting discipline, and that the penalty of discharge is appropriate under the circumstances. *Hy-Vee Food Stores, Inc. and Local 147, Int'l Bhd. of Teamsters, Chauffeurs, Warehousemen, and Helpers of America*, 102 Lab. Arb. 555 (1994). Most arbitrators will not substitute their own judgment for that of an employer unless the penalty imposed is deemed excessive given any mitigating circumstances. *Verizon Wireless and CWA, Local 2336*, 117 Lab. Arb. 589 (2002). However, any judgment rendered must be based upon the Collective Bargaining Agreement, relevant convincing evidence and testimony, and any applicable law.

In large part the parties concur with the essential facts of this case. Moreover, the Grievant admits that she made a mistake in judgment and should have administered CPR to resident V. It is also a matter of record that the Grievant had just received a written warning for an error related to patient care.

The Union argues that the statement of the attending physician, Dr. John F. Ramsey, suggests that the patient was not expected to live. A careful reading of Dr. Ramsey's statement taken on 10/31/04 states in pertinent part:

> *"...had I been contacted prior to pt. expiring or during CPR I would have stopped the Code...I had just been involved with this patient and I was aware that pt. did not want to survive by artificial means. I told RN overall I was not concerned with the overall medical outcome but I did not know the consequences of not following the proper nursing procedures."*

I find this statement to be significant given the fact that Dr. Ramsey is the Assistant Medical Director, had recently visited this patient, and is in a position to make this assessment. While there is no question that the evidence and testimony, particularly from the Grievant herself, demonstrate she made an error in judgment, the consequences are mitigated by Dr. Ramsey's expert opinion.

I do not concur with the Union's contention that RN Manager Christine Pluckhorn was responsible to provide direct care. The facts indicate she was not in any position to administer timely emergency care. In addition, it is also clear that Nursing Assistant Stegall is at the bottom of the authority ladder and must take his direction from LPNs and RNs. LPN Ratlcliff was the nurse on the scene for most of the critical period of resident V's emergency, and Stegall had to take direction from her until the Grievant arrived.

However, a careful review of the facts also demonstrates that LPN Ratcliff has considerable culpability in this matter. LPN Ratcliff is the nurse assigned to 3 South Unit, and more importantly she was with resident V during the critical 15-minute period from 6: 10 p.m. to 6:25 p.m. She is also CPR certified, and why she did not administer CPR is unknown. Joint Exhibit 5 clearly demonstrates that LPNs sign medical orders, and it is assumed that Ratcliff was fully aware of the FULL CODE designation on the medical orders for resident V. Ratcliff is presumably aware of the fact that suction machines are located on crash carts. Presumably, she had not directed Stegall to get the crash cart at 6: 15 p.m. when resident V's pulse was weak and she had determined he was a "full code." According to Stegall it took him approximately one minute to get the cart and bring it to resident V's room (See Stegall's 10/31/03 statement).

Ratcliff's statement taken on 10/26/04 generates more questions than answers about her conduct in this incident. Unlike the other statements of other involved witnesses, and even the statement of Nursing Assistant Stegall, it is remarkably devoid of dates and details. It is not something one would expect from a professional nurse, and it raises suspicions. It is also clear the Grievant had to rely upon Ratcliff to convey the condition of resident V to her. At 6: 25 p.m. the facts indicate Ratcliff was very direct in her communication to the Grievant, telling her to come right away. However, prior to 6: 25 p.m. it is unclear what she conveyed

to the Grievant and with what sense of urgency she conveyed it. It is also unclear as to whether corrective action was taken against Ratcliff. The Union's argument regarding disparate treatment has persuasive value absent evidence that the Employer treated LPN Ratcliff in the same fashion it treated the Grievant.

There is no question that what happened regarding resident V is a serious matter and it must be effectively addressed with the utmost clarity by OVH. It is also clear the Grievant violated the rules cited by the Employer and admitted she made an error in judgment. A "full code" order requires CPR. However, it is not clear from the evidence whether resident V had already stopped breathing when Lacey entered the room. When LPN Ratcliff called the grievant and told her to come right away, resident V's color was already yellow (Ratcliff's statement of 10/26/03). We know there was no blood pressure reading, and no other vital signs were discernible upon Lacey's examination of resident V. Management has sufficient evidence to address this issue with corrective action, but the question arises as to whether this incident and the Grievant's conduct justify termination.

In determining an appropriate level of discipline under a just cause standard all factors must be considered. Was the degree of discipline issued related to the seriousness of the offense? The mitigating factor of Dr. Ramsey's affirmative statement that had he been contacted he

would have prevented CPR from going forward is very significant in this case. Dr. Ramsey without equivocation states he would have prevented CPR from going forward. Given the seriousness of this situation, this is not an incident in which the Grievant's actions should be viewed in isolation.

The Grievant acted upon what she was told by Ratcliff over the telephone, and the sense of urgency that was initially conveyed to her via telephone is not clear. Moreover, LPN Ratcliff not administering CPR earlier is puzzling, and to what extent it may have placed resident V in a more viable state when the Grievant arrived at approximately 6:25 p.m. is unknown. Ratcliff's credibility is this matter must be questioned given her sketchy account of her own actions.

Just days prior to the circumstances surrounding resident V's death the Grievant received a written warning, and this must be taken into consideration in reviewing the Grievant's termination. The Employer's own disciplinary grid provides a range of discipline from written to removal for violation of Standards N-08, and a suspension to discharge for violation RA-04. Negligence in health care where matters of life and death are being dealt with takes on a significance that may not be applicable to other professions. Furthermore, in cases involving elderly and infirmed patients, one must keep in mind the frailty of these human beings.

I find the Grievant's actions in light of the above-discussed mitigating factors, warrant progressive discipline in accordance with

Article 8 of the Agreement. The Grievant's relatively long record of service with OVH, her prior written warning, her admission of misjudgment and wrongdoing, and the display of remorse for her inaction were also considered in making this determination. However, it must be emphasized that the firm opinion of Dr. Ramsey in this case was a significant factor in the issuance of this award. It is also noted that although the Grievant had been employed in the care of patients with OVH since 1994, she had only been an RN with OVH for just over two years when the incident occurred. Nursing is a responsible and complex profession with a steep learning curve. An RN with two years of experience has much to learn in order to hone her skills and improve her judgment.

AWARD

The grievance is sustained in part.

The Grievant shall have her termination reduced to a time served suspension, and she shall be placed on a last chance agreement. Any substantiated work performance infractions directly involving patient care that occur within a year from the date of this Award shall result in the Grievant's termination of employment without recourse to the grievance procedure, except to establish the fact that the Grievant committed the infraction. During the last chance period, the Employer shall have the latitude to assign the Grievant to duty and shift it determines is most appropriate. After this period the Grievant's contractual rights of assignment and bidding shall be restored.

The Grievant shall receive no back pay, but shall have her seniority bridged, and benefits restored from the date of her termination.

It is also suggested that the circumstances of this case be reviewed by OVH's ethics committee as a way to obtain future guidance to staff in matters of this nature.

Respectfully submitted to the parties this 20th day of December, 2004.

Robert G. Stein, Arbitrator