Decision and Award in the Matter of Arbitration between:

Ohio Department of Rehabilitation & Correction
Chillicothe Correctional Institution

and

Service Employees International Union
District 1199

DRC- Case Number: 2018-02578-11

Grievant: Denise Dunn

Arbitrator: John F. Buettner

Hearing Date: June 5 and July 2, 2019
Date Briefs Received: October 12, 2019
Date Decision Issued: December 16, 2018

Representing the Management:

Don Overstreet	Labor Relations Officer 3, ODRC

Representing the Union:

Josh Norris	Executive Vice President, SEIU/District 1199

In Attendance for Management: June 5, 2019

Neil Glendening	LRO-2/CCI
Don Overstreet	LRO-3/DRC
Eric Eilerman	LRO-3/DAS/OCB
Rayma Jensen	QIC, Witness
Melissa Hughes	RN, Witness
Keisha Dobbie	RN, Witness
Gary Artrip	CNP
Roseanne Dove	MSN, FNP-C, Witness

In Attendance for the Union: June 5, 2019

Josh Norris	Executive Vice President
Amanda Schulte	Administrative Coordinator, Union Advocate
Denise Dunn	RN, Grievant

In Attendance for Management: July 2, 2019

Neil Glendening	LRO-2/CCI
Don Overstreet	LRO-3/DRC
Eric Eilerman	LRO-3/DAS/OCB
Sarah Scott	OCB
Melissa Hughes	RN
Rayma Jensen	QIC/CCI
David Conley	LCA

In Attendance for the Union: July 2, 2019

Josh Norris	Executive Vice President
Amanda Schulte	Administrative Coordinator, Union Advocate
Denise Dunn	RN, Grievant
Lovanna Gladman	
Angela Curtis	RN
John Hamm	RN

By mutual agreement the Hearing was convened on June 5, 2019, at 10:00 AM. The Hearing was held at the offices of the Chillicothe Correctional Institution, Chillicothe, Ohio. A second day of hearing was held on July 2, 2019, at the Terry Collins Re-Entry Center in Chillicothe, Ohio. John F. Buettner was jointly selected by the parties to

arbitrate this matter in accordance with Article 8, Section 7.07, of the Collective Bargaining Agreement (CBA), and was officially appointed to the case by the State Employment Relations Board.

The parties jointly stipulated to the statement of the issue, a series of background facts, and the admission of joint exhibits. The Parties also agreed to the following:

1. The testimony and admitted documentation provided by witnesses Shelly Viets, Rayma Jensen, Gary Artrip, John Hamm and Beverly Hardy in the Beverly Hardy Arbitration is part of the official records, and shall be given the weight the Arbitrator deemed appropriate when admitted, for each of the following arbitration cases:

    Beverly Hardy
    Denise Dunn
    Angela Clark

2. The testimony and admitted documentation provided by witness Denise Dunn during the Beverly Hardy Arbitration is part of the official record, and shall be given weight the Arbitrator deemed appropriate when admitted, for the Angela Clark Arbitration.
3. The testimony and admitted documentation provided by witness Angela Clark during the Beverly Hardy Arbitration is part of the official record, and shall be given weight the Arbitrator deemed appropriate when admitted, for the Denise Dunn Arbitration.
4. Denise Dunn will testify during the Arbitration of her own case in chief and Angela Clark will testify during the Arbitration of her case in chief.
5. This agreement does not prohibit witness testimony not previously provided.

The parties have also agreed to the arbitration of this matter. No issues of either procedural or jurisdictional arbitrability have been raised, and the matter is now properly before the arbitrator for a determination of the merits.

The Parties mutually agreed to have the awards for the three (3) falsification of medical records arbitrations issued at the same time.

The following were submitted as Joint Exhibits:

Joint Exhibit #1	SEIU District 1199 Contract (2015 to 2018)
Joint Exhibit #2	Grievance Snapshot DRC-2018-02578-3
Joint Exhibit #3	Position Description- Nurse1
Joint Exhibit #4	Notice of Disciplinary Action effective August 4, 2018
Joint Exhibit #5	Pre-Disciplinary Meeting Hearing Officer's Report dated July 11, 2018
Joint Exhibit #6	Just Cause Worksheet dated July 10, 2018
Joint Exhibit #7	Pre-Disciplinary Hearing Sign In Sheet dated July 11, 2018
Joint Exhibit #8	Additional documentation provide by Grievant and Union
Joint Exhibit #9	Pre-Disciplinary Meeting Notice dated July 5, 2018
Joint Exhibit #10	Acknowledgment of Pre-Disciplinary Meeting Notice dated July 6, 2018
Joint Exhibit #11	Blank DRC 1311 & DRC 1136 Forms
Joint Exhibit #12	Administrative Investigation Summary Report dated June 11, 2018
Joint Exhibit #13	Incident Report Dated April 26, 2018
Joint Exhibit #14	Denise Dunn Investigatory Interview Questions and Answer Document dated June 8, 2018 a. Denise Dunn Garrity Right Form dated June 8, 018 b. Denise Dunn Acknowledgement and Waiver to Right of Representation dated June 8, 2018 c. Denise Dunn Notice of Interview/Conference dated June 8, 2018

Joint Exhibit #15	Roseanne Dove Investigatory Interview Questions and Answer Document dated May 22, 2018 a. Roseanne Dove Acknowledgement and Waiver to Right of Representation dated May 22, 2018 c. Roseanne Dove Notice of Interview/Conference dated May 22, 2018
Joint Exhibit # 16	Lori LeMaster Investigatory Interview Questions and Answer Document dated May 22, 2018 a. Lori LeMaster Acknowledgement and Waiver to Right of Representation dated May 22, 2018 c. Lori LeMaster Notice of Interview/Conference dated May 22, 2018
Joint Exhibit #17	eCW Progress Notes dated April 25, 2018
Joint Exhibit #18	DRC Policy 68-MED20 Emergency Services dated August 21, 2017
Joint Exhibit #19	68-MED-20 Post Tests Denise Dunn
Joint Exhibit #20	Lippincott Procedures-Triage Emergency Department
Joint Exhibit #21	Lippincott Procedures tests results Denise Dunn
Joint Exhibit #22	Administrative Investigation Summary Report dated March 26, 2018
Joint Exhibit #23	Incident Report dated January 23, 2018
Joint Exhibit #24	Additional Documentation
Joint Exhibit #25	Denise Dunn Investigatory Interview Questions and Answer Document dated February 12, 2018 a. Denise Dunn Acknowledgement and Waiver to Right of Representation dated February 12, 2018 b. Denise Dunn Notice of Interview/Conference dated February 12, 2018
Joint Exhibit #26	Julie Clark Investigatory Interview Questions and Answer Document dated February 28, 2018 a. Julie Clark Acknowledgement and Waiver to Right of Representation dated February 28, 2018 b. Julie Clark Notice of Interview/Conference dated February 28, 2018

Joint Exhibit #27	Misty Davis Investigatory Interview Questions and Answer Document dated March 15, 2018 a. Misty Davis Acknowledgement and Waiver to Right of Representation dated March 15, 2018 b. Misty Davis Notice of Interview/Conference dated March 15, 2018
Joint Exhibit #28	Beth Higginbotham Investigatory Interview Questions and Answer Document dated February 6, 2018 a. Beth Higginbotham Acknowledgement and Waiver to Right of Representation dated February 6, 2018 b. Beth Higginbotham Notice of Interview/Conference dated February 6, 2018
Joint Exhibit #29	Gary Artrip Investigatory Interview Questions and Answer Document dated February 6, 2018
Joint Exhibit #30	Missy Hughes Investigatory Interview Questions and Answer Document dated March 20, 2018
Joint Exhibit #31	Keisha Dobbie Investigatory Interview Questions and Answer Document dated March 2, 2018 a. Keisha Dobbie Notice of Interview/Conference dated March 22, 2018
Joint Exhibit #32	DRC Medical Protocol B-10 Medication Administration dated August 8, 2016
Joint Exhibit #33	DRC Policy 68-MED-21 Infirmary Care dated July 2, 2015
Joint Exhibit #34	Nursing Staff Minutes and Training Report dated August 17, 2017
Joint Exhibit #35	Lippincott Procedures – Oral Drug Administration
Joint Exhibit #36	Lippincott Procedures – Safe Medication Administration Practices
Joint Exhibit #37	DRC Medical Protocol B-10 Medication Administration Tests Denise Dunn
Joint Exhibit #38	Lippincott Tests Denise Dunn
Joint Exhibit #39	Administrative Investigation Summary Report dated June 22, 2018

Joint Exhibit #40 — Incident Report dated March 9, 2018

Joint Exhibit #41 — Denise Dunn Investigatory Interview Questions and Answer Document dated June 7, 2018
- a. Denise Dunn Garrity Right Form dated June 7, 2018
- b. Denise Dunn Acknowledgement and Waiver to Right of Representation dated June 7, 2018
- c. Denise Dunn Notice of Interview/Conference dated June 7, 2018

Joint Exhibit #42 — Denise Dunn Investigatory Interview Questions and Answer Document dated June 22, 2018
- a. Denise Dunn Garrity Right Form dated June 22, 2018
- b. Denise Dunn Acknowledgement and Waiver to Right of Representation dated June 22, 2018
- c. Denise Dunn Notice of Interview/Conference dated June 22, 2018

Joint Exhibit #43 — Rayma Jensen Investigatory Interview Questions and Answer Document dated June 4, 2018
- a. Rayma Jensen Acknowledgement and Waiver of Right to Representation dated June 4, 2018
- b. Rayma Jensen Notice of Interview/Conference dated June 4, 2018

Joint Exhibit #44 — Lisa Holdren Investigatory Interview Questions and Answer Document dated June 19, 2018
- a. Lisa Holdren Garrity Right Form dated June 19, 2018
- b. Lisa Holdren Acknowledgement and Waiver to Right of Representation dated June 19, 2018
- c. Lisa Holdren Notice of Interview/Conference dated June 19, 2018

Joint Exhibit #45 — Beverly Hardy Investigatory Interview Questions and Answer Document dated June 22, 2018
- a. Beverly Hardy Garrity Right Form dated June 22, 2018
- b. Beverly Hardy Acknowledgement and Waiver to Right of Representation dated June 22, 2018
- c. Beverly Hardy Notice of Interview/Conference dated June 22, 2018

Joint Exhibit #46	Angel Clark Investigatory Interview Questions and Answer Document dated May 17, 2018 a. Angel Clark Garrity Right Form dated May 17, 2018 b. Angel Clark Acknowledgement and Waiver to Right of Representation dated May 17, 2018 c. Angel Clark Notice of Interview/Conference dated May 17, 2018
Joint Exhibit #47	Emails and Staff Meeting Minutes
Joint Exhibit #48	Policy 68-MED-21 Infirmary Care Test Denise Dunn
Joint Exhibit #49	Read and sign Memo Infirmary Services 68-MED-21 dated November 20, 2014
Joint Exhibit #50	Read and sign Memo Infirmary Services 68-MED-21 dated April 21, 2014
Joint Exhibit #51	DCR Policy 68-MED-21 Infirmary Care date July 2, 2015
Joint Exhibit #52	Nursing Staff Minutes dated August 17, 2017
Joint Exhibit #53	DRC Medical Protocol B-4 Charting Directives dated May 1, 2007
Joint Exhibit #54	eCW Progress Notes dated March 6, 2018
Joint Exhibit #55	eCW Progress Notes dated March 7, 2018
Joint Exhibit #56	eCW Progress Notes dated March 10, 2018
Joint Exhibit #57	eCW Progress Notes dated March 11, 2018
Joint Exhibit #58	Denise Dunn Standards of Employee Conduct Certificate of Information Received dated May 23, 2016
Joint Exhibit #59	Denise Dunn Administrative Leave Notice dated May 30, 2018
Joint Exhibit #60	Video #11 dated March 6, 2018
Joint Exhibit #61	Video #13 dated March 7, 2018
Joint Exhibit #62	Video #19 dated March 10, 2018

Joint Exhibit #63	Video #20 dated March 11, 2018

The following were submitted as Management Exhibits:

Management Exhibit #1	Medication Administration Record
Management Exhibit #2	Dosage Directions: MethylPREDNIsolone
Management Exhibit #3	Guidelines for Assessment & Processing of Medical Emergencies
Management Exhibit #4	ODRD Standards of Employee Conduct
Management Exhibit #5	Video
Management Exhibit #6	Summary View of J. Ramey, 3/13/18
Management Exhibit #7	Summary View of R. Whaley, 3/13/18

The following were submitted as Union Exhibits:

Union Exhibit #1	Incident Reporting and Notification
Union Exhibit #2	Medication Administration Record
Union Exhibit #3	Infirmary Chart, 3/13/18

Background:

The Grievant, Denise Dun, was hired as a Registered Nurse (RN) for the Ohio Department of Rehabilitation and Corrections (DRC) at the Chillicothe Correctional Institution on April 30, 2007. On August 4, 2018, she was terminated for violating the following Standards of Employee Conduct Rules:

> Rule 7: Failure to follow post orders, administrative regulations, policies, or written or verbal directives.

Rule 22: Falsifying, altering, or removing any document or record.

Rule 41: Unauthorized actions or failure to act that could harm any individual under the supervision of the department.

During this time the Grievant became a Union Delegate and had no active discipline at the time of removal.

Issue:

Did Management/Employer violate Article 8, Discipline? If so, what shall the remedy be?

Management's Position:

Management contends that they had just cause to terminate the Grievant for violating Rules 7, 22, and 41 of the Standards of Employee Conduct Rules. Each work rule violation allows for removal on the first offense. Three incidents were cited that led to the termination.

The Grievant was charged with falsely documenting safety checks which were conducted by other nurses and failing to document checks she conducted herself. The Union acknowledged this and Management confirmed this through video evidence on four occasions:

Video # 11 Dated March 6, 2018 at 1:25 pm
Video # 13 Dated March 7, 2018 at 1:19 pm
Video # 19 Dated March 10, 2018 at 7:12 am
Video # 20 Dated March 11, 2018 at 6:53 am

Management cited this as an example of falsification of a document which is a clear violation of Rule 22. The Grievant was aware of these rules as well as aware of ODRC Policy 68-MED-21, Protocol B-4 Charting Directives, and Ohio Administrative Code 4723-4-6 Standards of Nursing Practice Promoting Patient Safety which all address the issue.

The Union countered that this was a common practice, which Management “must have known”, and that Management engaged in the practice. The example the Union provided, which alleges that Rayma Jensen did a check that Beth Higginbotham documented, was proven false by video evidence (Video # 7). Additionally, Ms. Rayma Jensen, the Quality Insurance Coordinator (QIC), testified that neither she nor anyone else from Management was aware of this practice until an incident report was filed. The Union produced no witness who could testify that Management had any foreknowledge of the practice or that it was condoned.

Management also alleged that the Grievant failed to properly administer medication to a patient. A Medical Administration Record (MAR), also known as a Kardex, was written for a patient. Rayma Jensen testified that the Kardex was properly filled out by RN Melissa Hughes and verified by Nurse Keesha Dobbie as per Protocol B-10 Medication Administration (Joint Exhibit #3). This included placing the date, patient name, medication and dosage timing on the document. Both nurses testified they did not cross or scribble out any lines on the Kardex. The Grievant administered the medication according to a Kardex which had scribbled out information and new information added concerning the timing of the medication. Dunn administered one dose versus a graduated dosage. Management contended that either the Grievant modified the Kardex without initialing it, or she blindly followed a Kardex that should have been questioned for accuracy due to scribbled out parts. Either way, Management contended the Grievant improperly administered a medication that could have endangered a patient.

The last allegation is that the Grievant failed to timely notify the Advanced Level Provider (ALP) of a patient medical issue which is a violation of Rule 41. The Grievant and Nurse Lori LeMaster responded to a sick patient in D2 Unit. The Grievant immediately called the ALP, CNP Rosanne Dove, to ask if they should call an ambulance for the patient. Nurse Dunn could not provide any vitals or other health information on the patient so CPN Dove asked the Grievant to take the patient to the infirmary for evaluation, if he was stable. CNP Dove asked that an Electrocardiogram (EKG) be performed and that she be notified of the result. Over forty-five (45) minutes

went by without word from the Grievant. She testified that she performed and reviewed the EKG, which showed an abnormal reading. This result should have called for immediate medical action. When the ALP arrived to examine the patient, she immediately called an ambulance. Management alleged that the Grievant's lack of urgency in providing patient care constituted negligence.

Management contended that each of these violations could have jeopardized the health and well-being of the inmates in the Grievant's care. Taken collectively, Management felt that they had just cause for termination.

Union Position:

The Union contended the Employer did not establish just cause for termination of the Grievant, Denise Dunn. Further, clear and convincing proof to sustain the allegations was not presented.

Management alleged that the Grievant failed to follow policy before calling NP Rosanne Dove about a patient in cardiac distress. The incident occurred on April 25, 2018, when the Grievant was called to the dormitory about an inmate having chest pains. The Grievant immediately recognized the signs of a heart attack, placed oxygen on the inmate, then called CNP Rosanne Dove to ask if the inmate should be sent to the hospital. CNP Dove instructed the Grievant to bring the inmate to the Medical department, if he was stable, and to perform an EKG. The Grievant did as instructed.

Management alleges, however, that the Grievant violated Emergency Services Policy 68-MED-20 which states, "All components of the clinical emergency evaluation relevant to the inmate shall be documented and communicated to the institutional advanced level provider (ALP)." (Joint Exhibit 3, p. 72) CNP Dove was the ALP at the time. The Grievant recorded all the information relevant to the inmate on his medical chart and created an electronic appointment for CNP Dove to see the inmate. This allowed CNP Dove to access and read what was documented prior to seeing the patient. The

Grievant did not violate the policy; records show she followed all the proper documentation requirements.

Part 2 of 68-MED-20 states that all referrals to the emergency room of a hospital must be authorized by an institutional CNP following an on-site exam including vital signs. The Grievant followed proper procedure in calling CNP Dove. She did not relay any vitals to CNP Dove because Nurse LeMaster was taking them at the time, and the Grievant did not want to delay treatment of a patient in cardiac distress. CNP Dove did not ask for the vital signs but decided to send the inmate to the Medical department instead of the ER without that information. The Grievant again followed all the proper procedures in calling an APL. Vitals were taken and recorded so again no rule was violated.

Management further contended that the Grievant did not follow the Lippencott Emergency Training protocol (Joint Exhibit #3, p. 85). It states a nurse should first perform an “across-the-room visual assessment” and lists what to observe. Next is a Primary Assessment which includes administering oxygen. Then an assessment is done which includes vital signs. Under the same bullet with instructions to take vital signs, it states, “However, don’t delay emergency care to obtain these findings.” The Grievant followed each step exactly.

Management introduced Protocol B-8: Guidelines for Assessment Processing of Medical Emergencies at the hearing as further evidence of the Grievant’s alleged violations. This protocol however, explicitly states that, “the nurse taking the call shall obtain appropriate information to make an informed judgment about the response needed.” Since CPN Dove took the call, it was her responsibility obtain the information which the Grievant had duly taken and recorded. There was no just cause for terminating the Grievant for not verbally relaying the inmate’s vital signs.

Management further alleged in the Notice of Removal (Joint Exhibit #3) that the Grievant failed to notify CNP Dove in a timely manner when she had completed the patient transfer from the dorm to Medical. The Grievant did tell CNP Dove on the phone when she was headed to Medical. Also, no policy or procedure states that a nurse must

notify when a patient arrives at Medical or what would a “timely” period would be. Thus, no rule was violated.

Another allegation by Management was that the Grievant failed to follow the “right dose” and “right time” protocol when she administered medication to an inmate. The Grievant pulled the Kardex, a medication record filled out by a licensed nurse with and verified by another, from the box in the pill room. The Kardex stated “Medrol dose pack as directed.” (Union Exhibit #2) The Kardex had three (3) times a day written on it which were AM (morning, N (noon), and HS (hour of sleep). N and HS were scratched out indicating that the medication would be given one time and that would be in the morning. The medication package contained two different sets of instructions for first day use. One set of in instructions called for three times a day. The other set allowed for administration of all pills as a single dose. Since the Kardex showed a one-time administration of the drug, the Grievant gave all six pills as a single dose as indicated on the package. Hence, the medication was not improperly administered. The Grievant administered it as directed on the Kardex.

Management contended that the Grievant should have questioned a Kardex with scratch outs and implied that she made the changes. The Union stated that the instructions which were originally printed do not match the package instructions. The Kardex instructions called for four doses while the packages states that it may be given in two or three doses. The Union argued it was more likely that the original instructions were crossed out because the dosage was inaccurate.

The issue of “safety checks” was another issue in the termination of the Grievant. The Parties stipulated that the Grievant did, on two occasions, physically record the observation portion of a safety check for other nurses. On another occasion Dunn performed the safety check and another nurse recorded it. Management has alleged that this is falsification and in violation of Policy 68-MED-21. The Union contended that the policy does not require the same nurse who performs the safety check to enter the information into the computer. It only requires that, “A licensed nurse shall make rounds and document a safety check…” (Joint Exhibit #3) It does not say the same licensed nurse must do both parts. The Union stated that Management encouraged teamwork

and that the nurses were working together to comply with safety check requirements. It was common practice for one nurse to physically make the observation and then communicate this to a nurse at a computer who would enter the information. Several nurses testified that this was an acceptable practice, that managers knew about it, and engaged in it themselves. They did not know that entering safety check information would be considered falsification of a medical record.

Further, The Union contended that if this policy was as clear as Management purported it to be, there would have been no need to hold a meeting on or about March 18, 2018, to inform CCI nurses that the practice of documenting for one another was not acceptable. Further, on April 9, 2018, ODRC created a new policy, MED-69-OCH-06, that specifically defined "falsification" as documenting work performed by another person. The new policy was created after the alleged instances by which the Grievant was terminated.

The Union also contended that the Grievant received disparate treatment. Beth Higgenbotham's Incident report signed on March 19, 2018, and her Incident Report signed April 9, 2018, named other nurses who had presumably documented for each other. Only four (4) of them were interviewed. Eight (8) other nurses were presumably not investigated or disciplined.

The Union contended the Grievant was improperly terminated and that Management did not have just cause in doing so.

DISCUSSION:

In reviewing the issue, I have analyzed the testimony, videos, and all evidence put forth by both sides. The job of an Arbitrator, in a disciplinary case, is to evaluate the evidence and determine if "just cause" exists to support the action taken by Management. An Arbitrator generally must determine whether an employer has clearly proven that an employee has committed an act warranting discipline and that the penalty of discharge is appropriate under the circumstance. [*Hy-Vee Food Stores, Inc. and Int'l Brotherhood*

of Teamsters, Warehousemen, and Helpers of America, 102 LA 55 (Bergist 1994)]. Three (3) incidents were investigated by Management to determine if just cause existed for termination of the Grievant. Each incident must, therefore, be reviewed on its own merits.

As in all discipline/discharge cases, the Arbitrator evaluates Management's actions against the Seven Tests as written by Arbitrator Carroll Daugherty [Brand, N. & Biren, M. H. (Eds.) (2015). Chicago, IL: American Bar Association. Discipline and discharge in arbitration, third edition.] The questions an Arbitrator must consider:

1. Did the employer give notice?
2. Was the rule reasonably related to operations?
3. Was there an investigation prior to discipline?
4. Was the investigation fair?
5. Was there sufficiency of proof?
6. Were the rules applied in a nondiscriminatory way?
7. Was the penalty appropriate?

In the first incident, the Grievant was charged with improperly administering a medication called a Medrol Pack. The Kardex, which specifically states the directions for administration of a medication, was signed and confirmed by two nurses as required. When the Grievant pulled the Kardex while working from the pill room, the Kardex had lines scribbled out. The dosage was changed from three times a day—AM (morning), N (noon), and NT (night time)--to once a day. The Grievant followed the directions on the Kardex which crossed out the N and NT doses and left only the AM dose. She administered all six pills as directed on the modified Kardex and as indicated on the pack instructions.

The grievant did not improperly administer the Medrol pack. She followed the directions on the Kardex and on the medication pack itself which says:

> Unless otherwise directed by your physician, all six (6) tablets in the row labeled 1st day should be taken the day you receive your prescription, even though you may not receive it until late in the day. **All six (6) tablets may be taken immediately as a single dose,** (Emphasis added) or may be divided into two or three doses and taken at intervals between the time you receive the medication and your regular bedtime. (Management Exhibit #2)

The original instructions on the Kardex specified to take the tablets at AM (morning), N (noon), and NT (night time). This is contraindicated by one set of package directions directly under the 1st day pills which specifies: “Take 2 tablets before breakfast, I tablet after lunch and after supper, and 2 tablets at bedtime.” (Joint Exhibit #8) This direction calls for four (4) doses. The Medrol Pack can obviously be administered appropriately in several different ways. No attempt was made by either Party to get information from the prescribing doctor to know what the original intent was. The Physician’s Order (Joint Exhibit #8, p. 29) states, “Medrol dose pack per package directions”. Which package directions the physician intended were unclear.

It may be argued that the Grievant should have double checked the Kardex since it was altered. Management cited this as a violation of Protocol B-10 (Joint Exhibit #3, p.138). Applicable parts state:

> 5. The nurse should always question an incorrect, incomplete, or unclear medication order. The nurse should refuse to accept an order that is considered unsafe. The order in question will be immediately reported to the prescribing Advanced Level Provider (ALP), Chief Medical Officer (CMO), Psychiatric Nurse Supervisor, or designee for action.
>
> 6. Do not try to interpret illegible writing in medication orders. When orders are illegible, the nurse shall contact the ALP for direction and clarification.

The Grievant did not see the Kardex instructions as incorrect since they matched the package directions. They were not incomplete nor did she find them unclear. The notation was not illegible, and she was able to dispense the medication according to the Kardex and package directions. The Grievant had no reason to believe there was a

problem that needed to be brought before an ALP. No rule or protocol specifically states that scratch outs would invalidate a Kardex. Management also had no proof that the Grievant tampered with the Kardex as was suggested. Dunn followed the “right dose” and “right time” protocol, the instructions on the Kardex, and what is recommended on the medication instructions.

In the next incident, the Grievant allegedly failed to follow policy in dealing with a patient who was having cardiac distress. As cited on the Notice of Removal (Joint Exhibit #3, p.5): “On 4/25/2018 you failed to follow policy prior to notifying the ALP while in the unit then failed to notify the ALP timely once bringing the inmate to the Dispensary.”

Management referred to two (2) parts of Policy 68-MED-20. In Part 1b, it states: “All components of the clinical emergency evaluation relevant to the inmate complaint shall be documented and communicated to the institutional advanced level provider (ALP).” (Joint Exhibit #3, p. 72) The Grievant did, indeed, record all of the relevant information concerning the inmate’s complaint on his medical chart. This is evidenced in Joint Exhibit 3, pages 61 to 63. She also created an electronic appointment for CNP Dove, the ALP at the time, to see the inmate. By creating the appointment, it allowed CNP Dove to access the inmate’s medical chart upon which all relevant information had been recorded. The Grievant did not verbally relay that information to CNP Dove when she initially contacted her via phone. Another nurse was taking the patient’s vital signs at the time while the Grievant placed the phone call due to the expediency of the situation.

A second part of Policy 68-MED-20 that Management sited in the allegations against the Grievant states that, “All referrals to the emergency department of the local hospital must be authorized by an institutional CNP or dentist following an on-site examination, which shall include vital signs, during normal work hours or by telephone order after hours.” (Joint Exhibit #3, p.73) The Grievant followed proper procedure and contacted CNP Dove since policy dictates that only a CNP can authorize sending a patient to the ER. Vitals were taken as mentioned above, just not by the Grievant. CNP Dove latter admitted that if another nurse was taking the vital signs, the Grievant did not have to also take vitals. Therefore, no violation of this policy is evident. The biggest error seems

to be that CNP Dove did not ask for the vital signs before making her decision as to where to move the inmate.

Another document (Joint Exhibit #3) outlines Emergency Department procedures. This document was not considered when Management decided to terminate the Grievant and the Union objected to its use. The outlined procedures, however, strengthen the Union's position. These procedures first call for an "across-the-room visual assessment" of the patient which the Grievant did. She saw obvious signs of cardiac distress. Then a primary assessment is to be done which includes checks for circulation, airway, breathing, disability and exposure. Noticing breathing difficulties, the Grievant administered oxygen to the inmate as per the policy. A secondary assessment then follows where vital signs are taken. This was completed by Nurse LeMaster. Under the Secondary Assessment, it does state, "Obtain the patient's vital signs, screen for and assess the patient's pain using facility-defined criteria consistent with the patient's age, condition, and ability to understand. However, do not delay emergency care to obtain these findings." (Joint Exhibit #3, p. 88) The Grievant followed all of the proper procedures. Further, part of this protocol says, "…the nurse taking the call shall obtain appropriate information to make an informed judgment about the response needed." The nurse taking the call was CNP Dove. She did not "obtain" the information which could have been done by simply asking the Grievant.

The other issue involved in this incident was that Grievant "…failed to notify the ALP timely once bringing the inmate to the Dispensary." (Joint Exhibit #3, p. 5) No policy or procedure was submitted that defined a rule whereby the Grievant was mandated to call the CNP upon arrival at the infirmary or what exactly a "timely" period would be. The Grievant had just spoken to CNP Dove to say that she was headed to the infirmary since the patient was stable. CNP Dove could have logically estimated an arrival time. The Grievant cannot be found in violation of a policy that doesn't exist.

Management did contend that in this incident the Grievant violated the standards of Employee Conduct, Work Rule-7 (Management Exhibit 4, p. 16) which states, "…failure to follow post orders, administrative regulations, policies, or written or verbal directives." This Arbitrator does not find any violation therein. Further, Management cited that Dunn

violated Work Rule-41(Management Exhibit 4, p. 20) which states, “Unauthorized actions or a failure to act that could harm any individual under the supervision of the department.” This Arbitrator finds that the Grievant did not perform unauthorized actions nor did she fail to act in providing appropriate care to the inmate in question.

The next issue involved the Grievant documenting safety checks that another nurse had performed and performing safety checks that other nurses documented. The Union and Management both stipulated to the fact that these events occurred and video evidence was shown to confirm it.

Video #11 (Joint Exhibit #60), March 6, 2018, 1:25 pm

Video #13 (Joint Exhibit #61), March 7, 2018, 1:19 pm

Video #19 (Joint Exhibit #62), March 10, 2018, 7:12 pm

Video #20 (Joint Exhibit #63), March 11, 2018, 6:53 am

The issue then becomes what the penalty should be for said infractions. The Union stated that Management knew about this practice and that it was accepted so no penalty should be levied. There was no evidence presented from any of the witnesses, Union or Management, to corroborate that Management knew about the practice or participated in it. The Union further alleged as proof of Management’s prior knowledge that they created a new policy addressing the issue after the fact. The new policy, MED-69-OCH-06, clearly delineates that staff cannot log into other’s accounts or document work performed by another. It states that these represent falsification of documents. This effort by Management codified regulations in an effort to clarify and prevent these types of incidents from happening again. It was not an admission of fault.

Management deemed the instances of nurses signing safety checks for one another as “falsification” of records, a violation of Rule 22. The nurses were still performing safety checks on patients so care was not compromised, but they failed to sign their own names. Policy 68-MED-21 (f) (Joint Exhibit #33) states a licensed nurse shall make rounds and document a safety check. The Union argued that it does not require that the same nurse do both the check and the documentation. Conversely, it does not state that

one nurse can sign for another. The question then begs to be asked as to why the Grievant and other nurses did not sign their own names to the safety checks they completed. Further exploration of Policy 68-MED-21 (f) shows that part (i) states, "Safety checks shall include visualizing the patient and briefly documenting behavior and general condition." If a nurse has not actually seen the patient, it would seem improper to document such on a safety check. Nurses are taught to document only what they personally see, hear, do and teach. This is reflected in DRC's nursing policies, specifically 68-MED-21 Infirmary Services (Joint Exhibit #33) and Protocol B-4 Charting Directives (Joint Exhibit #53).

Mitigating circumstances are a factor to be considered in falsification cases. Penalties may be reduced in instances where the conduct is found "not to be deliberate, willful, or intended to deceive." [Drazin, A. L., Editor (2001). *Discipline and Discharge in Arbitration, 2001 Supplement.* Chicago, IL, American Bar Association.] By that standard, the Grievant did consciously falsify safety checks in that her signature misrepresented who actually did the checks. While it was falsification, it appeared that no malice or subterfuge was intended. Patients were not put at risk since they were being monitored. It seemed the Grievant and other involved nurses were striving to follow the mandate of completing safety checks which had been an issue in the past.

Management provided evidence that the Grievant was aware of the policies that were in place. DRC Protocol B-4 Charting Directives (Joint Exhibit #53) states that one should, "Never falsify or obliterate any entry on an inmate's medical record." The Grievant signed that she had read the Standards of Employee Conduct Certificate of Information on May 1, 2016 (Joint Exhibit #58). This policy specifically states, "Failure to comply with the Standards of Employee Conduct shall result in discipline, up to and including removal." Thus the Grievant was aware of the penalties that could result from her actions.

According to Article 8-Discipline, Section 8.02-Progressive Discipline, progressive discipline includes:

A. Written reprimand

B. A fine in an amount not to exceed five (5) days pay

C. Suspensions

D. Removal

Management did, on or about March 18, 2018, hold a meeting instructing CCI nurses to stop the practice of documenting safety checks for one another. This was in essence a reprimand. Management's witnesses testified that after the meeting no further instances regarding safety checks were discovered. If the goal of discipline is to provide corrective feedback and to positively change behavior, that goal was met. Nurses who were documenting safety checks they did not perform were disciplined. Section 8.02 states, "The application of these steps is contingent upon the type and occurrence of various disciplinary offenses." This does allow Management to skip steps in the process. Termination, however, seems unwarranted since the issue was remediated.

AWARD:

At the hearing, all Parties were afforded the right to call, examine, and cross-examine witnesses, present relevant documentary evidence, and argue their respective positions. The Parties filed post hearing briefs which this Arbitrator carefully considered. Accordingly, based upon the entire record including the post hearing briefs, and observation of the credibility of the witnesses, I make the following finding:

On the charge of failure to properly administer medication to a patient, there is not conclusive evidence to support the allegation.

On the charge of failure to timely notify ALP of a medical issue, there is not conclusive evidence to support the allegation.

On the charge of falsifying records by signing safety checks for one another, there was sufficient evidence to support Management's allegations, but mitigating circumstances as outlined above do not seem sufficient to sustain the termination.

Thus, the grievance is sustained in part and denied in part. The termination is modified to a thirty (30) day suspension. The Grievant will be returned to her position, assignment, and schedule at CCI effective fourteen (14) days from the date of the Award. Her seniority will be restored. Lost wages will be paid less interim earnings from any sources of employment.

This concludes the arbitration.

Respectfully submitted this 16th day of December, 2019,

John F. Buettner, Arbitrator

CERTIFICATE OF SERVICE

The undersigned hereby certifies that one (1) copy each of the Arbitration report was delivered via email on the 16th day of December, 2019, to

Neil Glendening, LRO-2/CCI

Don Overstreet, LRO-3/DRC

Josh Norris, Union Advocate/Executive Vice President

and

Amanda Schulte, Union 2nd Chair

Jack Buettner

Jack Buettner