ARBITRATION DECISION NO.:
447

UNION:
OCSEA, Local 11, AFSCME, AFL-CIO

EMPLOYER:
Department of Mental Health,
Pauline Warfield Lewis Center

DATE OF ARBITRATION:
May 11, 1992

DATE OF DECISION:
June 19, 1992

GRIEVANT:
Candes Brooks

OCB GRIEVANCE NO.:
23-13-(91-08-29)-0473-01-04

ARBITRATOR:
Mitchell B. Goldberg

FOR THE UNION:
Lenny Lewis

FOR THE EMPLOYER:
Malleri Johnson, Advocate
Shelly Ward, Second Chair

KEY WORDS:
Removal
Neglect of Duty Due to Illness
Patient Abuse

ARTICLES:
Article 24 - Discipline
§24.01-Standard
§24.02-Progressive
Discipline

FACTS:

The grievant was a licensed practical nurse at the Pauline Warfield Lewis Center, a state hospital for chronically mentally ill adults. She had approximately eleven years of service at the time of her removal. She was removed on August 23, 1991 for patient abuse.

On July 27, 1991, the grievant was the only attending nurse assigned to Unit A, which houses 25 or 26 patients. She notified management of the understaffing problem. The stress of the understaffing situation aggravated a pre-existing asthma condition and she had trouble breathing. She continued to suffer

breathing problems until she found it necessary to leave work to obtain her medication. She notified two nursing supervisors that she was leaving because she was ill. She did not mention that she was alone in the Unit. She failed to complete her charts, sign the drug/narcotic log book and to provide a fingerstick test to a diabetic patient who required it.

EMPLOYER'S POSITION:

The grievant committed patient abuse by leaving her station and failing to perform her required duties. Unit A was a locked ward and one of the patients was placed in seclusion with restraints and required constant attention. Many of these patients are a danger to themselves and others.

While the department is understaffed, the grievant should never have abandoned her station. The grievant could have paged a supervisor or called an emergency code which would have immediately brought staff to her unit allowing her to go home. Because the grievant did not take the simplest precautions available to her, she committed neglect and patient abuse by allowing the patients to be unattended.

UNION'S POSITION:

The acts of the grievant did not constitute a major offense of "gross neglect of duty" and/or "gross abuse" of patients as defined in Directive A-48 for which progressive discipline as set forth in Directive A-22 is not applicable. She was forced to leave her station because of illness. She attempted to notify the staffing office and finally notified a registered nurse.

If it is determined that the grievant neglected her duties, her conduct under the circumstances should be judged under the "minor offenses" standard which requires the issuance of progressive discipline. Removal or termination may not occur unless preliminary disciplinary action is taken in the form of reprimands or suspension.

ARBITRATOR'S OPINION:

The grievant cannot be disciplined for failing to update her log book, administering the finger test or failing to fill out her charts. In this understaffing crisis, she had to prioritize her work in order to tend to the patient's immediate needs.

The Employer failed to prove that the grievant was abusive or neglectful as defined by Directive A-48 which warrants immediate dismissal. She did not intentionally cause any physical harm to any patient or engage in reckless activity that caused harm to patients. An important factor in determining neglect is whether the person was reckless or acted without regard to the possible injurious consequences. The grievant understood the staffing difficulties, tried to contact the staffing office and ultimately informed a registered nurse on duty. This was an error in judgment, not an act of reckless neglect.

While the grievant's actions warrant some type of discipline, her actions do not amount to neglect for which removal from State service is warranted. The progressive discipline standards set forth in Directive A-22 should apply. The grievant was issued two other written reprimands for neglect of duty in her eleven years of service. Because these prior instances concerned similar acts, the grievant should be given a three day suspension.

AWARD:

The grievance is sustained in part and denied in part. The grievant shall be reinstated with full seniority and back pay.

TEXT OF THE OPINION:

ARBITRATION

In the Matter of Arbitration
Between:

OHIO DEPARTMENT OF MENTAL

HEALTH, PAULINE WARFIELD
LEWIS CENTER,
Public Employer

and

OCSEA, LOCAL 11 AFSCME,
AFL-CIO,
Union

Case No.:
23-13-91-8-29-0473-01-04

Grievance of:
Candes Brooks

OPINION AND AWARD

This matter was heard on May 11, 1992 in Columbus, Ohio.

APPEARANCES

Arbitrator:
Mitchell B. Goldberg
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For the Union:
Lenny Lewis, OCSEA Advocate
Candes Brooks, Grievant
Barbara Burton, Steward

For the Employer:
Malleri Johnson, Advocate
Shelly Ward, 2nd Chair,
Labor Relations Specialist, OCB
George Nash,
Management Representative,
Ohio Dept. of Mental Health
Rita Surber, Personnel
Manager, Lewis Center
Dottie Gilbert,
Lewis Center Nurse
Martha F. Dunn, RN
Nurse Manager, Lewis Center
Marianne Russ, RN
Nurse Manager, Lewis Center
Lou Kitchen, Asst.
Chief of Operations OCB

I. INTRODUCTION AND BACKGROUND

The State of Ohio, Department of Mental Health, operates the Pauline Warfield Lewis Center located in Cincinnati, Ohio. The Lewis Center provides treatment and care for mentally ill patients with varying degrees of illness and care requirements. Certain patients require complete treatment and care. They are not able to leave the facility and they are required to be with staff at all times. Other patients require less treatment and care. Some are given grounds privileges with less supervision and others may actually leave the facility on weekends.

Employees at the Lewis Center, including licensed practical nurses ("LPN") are covered by a Collective Bargaining Agreement between the State of Ohio and the OCSEA, Local 11, AFSCME, AFL-CIO ("Union"). The Agreement contains provisions covering degrees of discipline and provides that any discipline issued, including suspensions, discharge or removal from service, shall only be for "just cause." The Agreement further contains a grievance procedure with multiple steps leading to arbitration in the event the grievances are not resolved during the process. The parties have stipulated that the grievance in this case has proceeded through the grievance process and is properly before this Arbitrator for decision.

This matter involves the grievance of Candes Brooks which was filed on August 29, 1991 as a result of her being discharged or removed from service in her employment position as a licensed practical nurse. On August 1, 1991, the Grievant was placed on an administrative leave pending the investigation into allegations that the Grievant had committed an act of patient abuse. The investigation proceeded and on August 20, 1991, pursuant to an order issued by the Director on August 16, 1991, the Grievant was removed from her position, effective August 23, 1991. The Grievant's Manager, on August 1, 1991 issued a request for disciplinary action to be taken against the Grievant based upon the Grievant's activity on July 27, 1991 during the morning shift. The Manager's investigation found that the Grievant left her duty station at approximately 7:25 a.m. without notifying her supervisor/manager. The Grievant notified the staffing office that she was leaving but she left 25 patients on the unit unattended, including 1 patient who was in seclusion under 3 point restraints (leather strap restraints to both legs and one arm).

The Grievant was also criticized for failing to complete her charts, failing to perform a fingerstick on a diabetic patient and failing to sign the drug or narcotic log or book.

The Grievant was issued a pre-disciplinary meeting notice dated August 2, 1991 as a result of said findings and the pre-disciplinary meeting was scheduled for August 8, 1991. A pre-disciplinary meeting procedure is set forth in the Collective Bargaining Agreement.

The Director, Michael F. Hogan, issued an order of removal to the Grievant, dated August 16, 1991, on the grounds that the Grievant's activities on July 27 constituted "neglect of duty and/or patient abuse" on the basis of the above findings. The Order found that the Grievant violated Section 124.34 of the Ohio .Revised Code. This section of the Ohio Civil Service Law permits removal or discharge on the basis of "incompetency, inefficiency...neglect of duty, violation of such section or the rules of the Director of Administrative Services or the Commission, or any other failure of good behavior, or any other acts of misfeasance, malfeasance, or nonfeasance in office." The Director also found that the Grievant violated Institutional Directives A-22 and A-48. Directive A-22 establishes the rules of conduct and disciplinary action. It defines minor offenses and major offenses and further provides for a progressive discipline program. The directive also provides for notice of investigation, notice of a pre-disciplinary conference and the conducting of a pre-disciplinary conference. The directive sets forth in great detail the standards of discipline, suggested guidelines for the issuance of discipline and detailed procedures for due process relative to the issuance of discipline.

Directive A-48 substantively defines the terms "abuse" and "neglect" and establishes policies to prevent abuse and neglect of patients. The policy provides guidelines for preventive and corrective measures and establishes policies and procedures regarding the reporting of incidents to the proper authorities.

The grievance was considered at length at a Step III hearing, after which the Employer determined that it had acted properly in removing the Grievant from service. The Grievant thereafter appealed and proceeded to arbitration.

II. ISSUE

The issue for determination in this Arbitration is whether or not the Grievant was discharged or removed for just cause under the terms of the Collective Bargaining Agreement. If not, the Arbitrator shall determine the appropriate remedy.

III. FACTS

The parties have stipulated the following facts: (1) the Grievant was a licensed practical nurse at the Pauline Warfield Lewis Center; (2) the Grievant had approximately 11 years of service at the time of her removal; and, (3) the Grievant was assigned to Unit A at the Lewis Center on the first shift on July 27, 1991.

There is some dispute as to whether or not there were 25 patients present in Unit A on July 27 or 26 patients. It is undisputed that 1 patient was under restraints and in seclusion. Nevertheless, the following events transpired. The Grievant reported to work at approximately 6:20 a.m. Her department was seriously understaffed as defined and required by State directives and policies. There was only one other employee other than the Grievant assigned to Unit A. This co-worker, Ms. Sneid, reported for work at 6:26 a.m. but left at 7:00 a.m. because of illness. This resulted in the Grievant being alone in the Unit with 25 or 26 patients. The Grievant notified Jerome Redden, a registered nurse ("RN") on the third shift, that the unit was understaffed and that she was the only staff person present. The Grievant stated to Mr. Redden that 1 patient was in seclusion and according to Mr. Redden, the Grievant "seemed very upset." Mr. Redden stated that he would make her complaint known to the staffing personnel and the day shift nurse managers. According to Mr. Redden, he notified the three persons in the staffing office including two registered nurses and advised them of the problem. Mr. Redden cannot recall the specific person with whom he spoke but he believed he made the problem aware to everyone in the office. Mr. Redden further stated that to his knowledge the problem was not resolved at the time he went off duty from the third shift and before the Grievant left her station.

The Grievant's health and personal problems were undisputed in the record. She was under considerable stress as the result of caring for her ill mother who was hospitalized. The stress and anxiety of the understaffing situation on July 27 caused the Grievant to have difficulties with her breathing. The Grievant had a pre-existing asthma condition and the anxiety and stress caused her condition to become aggravated. The Grievant had medication for her asthma but she inadvertently failed to bring her medication with her to work. She continued to suffer until she found it necessary to leave work to obtain her medication and to otherwise obtain medical assistance for her asthma. The Grievant proceeded to leave her duty station and at approximately 7:30 a.m. she notified her two nursing supervisors that she was leaving because she was ill. The Grievant incorrectly marked her time card, stating that she left at 7:00 a.m. when in fact it was closer to 7:30 a.m. She did not tell any of the supervisors in the office that she was leaving her unit unattended. There is no question that the Grievant failed to complete her charts, failed to sign the drug/narcotic log book and failed to provide a fingerstick to a diabetic patient who required it.

IV. POSITION OF THE EMPLOYER

The Employer argues that the Grievant committed an act of patient abuse or neglect of duty by leaving her station unattended and by failing to perform her required duties. The Lewis Center is a residential hospital that serves patients who are diagnosed with severe mental illness. The facility operates 24 hours a day, 7 days a week and provides care to those who have been determined to be unable to properly care for themselves. Many patients are in need of intensive psychological therapy and many of the patients are a danger to themselves or others. Unit A was a locked ward and one of the patients was placed in seclusion with restraints and required constant attention.

The Employer recognizes that the Department was understaffed. The supervisors had become aware that the Grievant was alone on Unit A for a short period of time but they were working to correct the problem by obtaining staff from other areas. She left her station before help arrived, thereby leaving all of her patients unattended including the patient who was in seclusion. Additional staff had arrived by 7:30 a.m.

Notwithstanding the fact that the Grievant became ill, she should have never abandoned her unit without

notifying her supervisors. There are emergency procedures which were available to the Grievant but she did not avail herself of those options. These procedures included the paging of the supervisor or the calling of an emergency code which would have immediately brought other staff to the unit. The fact that the Grievant did not take the simplest precaution available to her constituted a serious act of neglect and further amounted to patient abuse under the particular circumstances where patients with severe problems including 1 in seclusion and under restraints was left without any attention. The nursing supervisors did not become aware that Unit A was unattended until after the Grievant left her station. When the supervisor arrived in Unit A when making rounds, one of the patients advised her that there was no staff in attendance.

V. POSITION OF THE UNION

The charge of patient abuse is unwarranted from the record. The Employer did not produce any report of patient abuse completed by the Chief of Security or any report which arose out of any campus police investigation when there is an incident of patient abuse as required by Directive A-48. Further, the Grievant was not immediately suspended from service as the result of this incident as required by Directive A-48.

The Employer violated its own policies as set forth in Directive A-22. The acts of the Grievant did not constitute a major offense of "gross neglect of duty" and/or "gross abuse" of patients as defined in Directive A-48 for which progressive discipline as set forth in Directive A-22 is not applicable. The Grievant did not intentionally neglect her duties or abuse patients. She was forced to leave her station because of illness. She attempted to notify the staffing office by telephone but her calls were not answered and instead she received tape recordings. She notified Mr. Redden which was all that could be required of her under the circumstances.

Even if it is determined that the Grievant neglected her duties, her conduct under the circumstances should be judged under the "minor offenses" standard which requires the issuance of progressive discipline. The Grievant's past record includes only two written reprimands or charges of neglect of duty over an 11 year career. Progressive discipline concepts should apply as set forth in many arbitration authorities. There is no evidence that the Grievant could not appreciate and correct her actions or otherwise be rehabilitated by the use of corrective discipline. Removal or termination may not occur unless preliminary disciplinary action is taken in the form of a written reprimand or suspension.

VI. DISCUSSION

The neglect of duty charges against the Grievant for failing to properly complete her charts, failing to complete a fingerstick on a diabetic patient and failing to execute her narcotic/drug log book are not sustainable on the basis of the record presented in this case. The evidence is clear that even with two employees assigned to Unit A on the first shift on July 27, the Unit was understaffed when measured against existing policies and guidelines. The situation worsened when Ms. Sneid left work because of a migraine headache. No reasonable person could expect the Grievant to perform all of the necessary duties and responsibilities relative to caring for the patients under these severe circumstances. The Grievant was required to use her judgment and determine priorities with respect to her duties. She decided that charting and the execution of her drug log book could be performed later as was done on other occasions when there were staffing shortages. She intended to start the fingerstick at about 7:45 a.m. after she first attended to all of the patients. Ms. Sneid was in the process of waking the patients up. According to the Grievant, it was important to attend to the patients when they were waking and to pass out cigarettes to the patients who demanded them. Her intent was to perform all of her necessary duties but she was required to prioritize them under the existing circumstances of being short handed with staff. The Employer has not proven a case of neglect of duties for the failure on the part of the Grievant to perform these tasks within the time allotted under the circumstances.

The critical issue for determination in this case is whether or not the Employer has established a case of "abuse" or "neglect" based upon the admitted failure on the part of the Grievant to disclose to her supervisors that she was leaving her unit unattended and otherwise failing to use the emergency options available to her

to alert her supervisors that she was leaving the unit. The term "abuse" is defined in Directive A-48 as:

"Knowingly causing physical harm or recklessly causing physical harm to a person by physical contact with the person or by inappropriate use of a physical or chemical restraint, medication, or isolation of the person, or any act which constitutes sexual activity, as defined under the Ohio Revised Code. In addition, insulting or coarse language or gestures directed toward a resident which subjects the resident to humiliation, degradation or psychological damage as clinically determined; or depriving a resident of real or personal property by fraudulent or illegal means.

The term "neglect" means: recklessly failing to provide a person with any treatment, care, goods, or service that is necessary to maintain the health or safety of the person when the failure results in the physical harm to the person."

The evidence and record in this case fails to establish that the Grievant committed any act of abuse as defined by Directive A48. She did not intentionally cause any physical harm to any patient and she did not engage in any reckless conduct which actually caused physical harm to a patient.

The real question in this case is whether or not the Grievant committed an act of neglect by recklessly neglecting her patients when she left her station. The Grievant cannot be blamed for becoming distraught and upset as a result of her asthma condition and discipline is not warranted as a result of her failure to explain to her supervisors that her unit was without any staff when she left the premises. Presumably, at that point in time, the Grievant's illness had so overwhelmed her, that she could not engage in rational conduct. The Grievant's error, however, related to her conduct at an earlier point in time. When the Grievant contacted Mr. Redden about the problem of understaffing in her unit, she was upset, but her emotions were still under control. This is the time when she should have alerted her supervisors of the problem. She attempted to call the staffing office on the telephone, but received no answer and instead, received recorded messages. Nevertheless, she was able to contact Mr. Redden to explain her concerns. Because of the seriousness of the situation, the Grievant should have exercised her emergency options in order to alert her supervisors. The Grievant used poor judgment under the circumstances by not alerting her supervisors to the problem. The issue is whether or not this error in judgment constitutes recklessness under the circumstances because recklessness is a requirement in order to determine whether or not the Grievant committed an act of neglect. The term "recklessness" is defined by Black's Law Dictionary, Fourth Edition, as "rashness; heedlessness; wanton conduct. The state of mind accompanying an act, which either pays no regard to its probably or possibly injurious consequences, or which, though farseeing such consequences, persists in spite of such knowledge." It is conduct amounting to something more than mere negligence.

The Grievant was mindful of the problem at hand - the absence of any staff on the unit other than her. She attended to the problem by attempting to contact the staffing office and by ultimately contacting Mr. Redden. This was an error in judgment and not an act of recklessness.

The Grievant's actions, at this point in time, warranted some type of discipline for her negligence, but the Grievant did not engage in reckless conduct amounting to neglect as a major offense for which termination or removal from service was warranted. The progressive discipline standards should have applied and the Grievant's long employment history and past record should have been taken into consideration relative to any discipline for her negligence. The Grievant was issued a written reprimand on December 21, 1990 for neglect of duty relative to following through with a doctor's order for a patient; and, she was issued a written reprimand on April 7, 1991 relative to the accountability for medications administered to patients. Because these prior instances concerned similar acts of neglect or negligence concerning patient care, a suspension of three (3) days is warranted.

VII. AWARD

The grievance is sustained in part and denied in part. The discipline issued to the Grievant shall be reduced to a three (3) day suspension. The Grievant shall be reinstated to her former position with full

seniority, applicable back pay and benefits, less any interim earnings for governmental payments received by the Grievant. Jurisdiction is hereby reserved to resolve any and all issues of back pay, seniority and benefits which are to be issued to the Grievant or computed as a result of this Decision and Award.

Mitchell B. Goldberg

June 19, 1992
Date

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