
In Re the Arbitration between:

BMS File No. 07-PA-0158

St. Louis County, Chris Jensen Health
And Rehabilitation Center,

Employer,

**GRIEVANCE ARBITRATION
OPINION AND AWARD**

and

AFSCME Council 5,

Union.

Suspension of Janis Nelson.

Pursuant to the terms of their Collective Bargaining Agreement, the parties have submitted the above captioned matter to arbitration.

The parties selected James A. Lundberg as their neutral Arbitrator from a list of Arbitrators maintained by the Minnesota Bureau of Mediation Services.

There are no procedural issues in dispute and the grievance is properly before the Arbitrator for a final and binding determination.

The grievant was disciplined on May 18, 2005.

The grievance was submitted May 23, 2005.

The hearing was conducted on August 14, 2007.

Briefs were posted on August 28, 2007.

APPEARANCES:

FOR THE EMPLOYER

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FOR THE UNION

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ISSUE:

Whether the Employer had just cause to suspend the grievant, Janis Nelson, for five (5) shifts? If not, what is the proper remedy?

FACTUAL BACKGROUND:

Grievant, Janis Nelson, has been employed by St. Louis County as a Registered Nurse for twenty seven (27) years. During her career, the grievant has worked in a number of different positions. Except for the discipline that is the subject of this grievance, Ms. Nelson has no disciplinary history and has a positive work record.

On March 27, 2005, Easter Sunday, Ms. Nelson was the General Duty Nurse Supervisor at the Chris Jensen Health and Rehabilitation Center of Duluth, Minnesota, which is operated by St. Louis County. The grievant was charged with the responsibility of overall supervision of the entire facility. It is clear from the testimony that grievant was working under extremely difficult and stressful conditions on March 27, 2005. The supervisory role that she was assigned included the tasks normally assigned to three Registered Nurses from Monday through Friday.

On March 25, 2005, Mr. John Doe¹ was admitted to Chris Jensen for Physical Therapy, following a traumatic brain injury. Mr. Doe, who was in his late 60s, had been injured in a fall. When he checked into the Nursing Home, Mr. Doe was able to get around with a walker. He was able to tell staff that he was nervous about his situation. He was alert but somewhat forgetful. Dr. Doe was a smoker but was given a nicotine patch. He was not supposed to smoke while using the nicotine patch, because the combined level of nicotine from the patch and from smoking cigarettes could have a negative impact upon his heart.

¹ There is no need to use the patient's real name in this award.

The Nursing Chart Note made at 10:30 PM on March 26, 2005 says that Mr. Doe experienced a seizure. The note also says that Mr. Doe went out to smoke with his brother-in-law between 8:45 PM and 9:30 PM.

The Nursing Chart Note made at 9:00 AM on March 27, 2005 says that Mr. Doe was sleeping very soundly. The note indicates that Mr. Doe's speech was slow, he was making inappropriate statements and his head was deviating to the right. At that time, Mr. Doe's daughter indicated concern for his condition. Mr. Doe's medications were held except for Dilantine.

The Nursing Chart Note made at 10:00 AM says that Mr. Doe's legs were mottled to his knees, he was experiencing tremors and head shaking and his left eye was deviating to the left.

The Nursing Chart Note from 10:30 AM says that Mr. Doe had difficulty swallowing his medications and there was no change in the mottling of his legs.

At Noon the Nursing Chart Note says that extreme diaphoresis was noted on his face and he was sleeping soundly.

The 12:30 PM the Nursing Chart Note says that Mr. Doe's hand grasp was present but may be a little weaker and his legs continued to be mottled but the mottling was lighter in color.

The Nursing Chart Note at 12:45 PM says that the Nurse Practitioner was contacted regarding the patient's seizure from the night before and his lethargy during the morning. Blood was drawn from Mr. Doe and sent to the lab, fifty five (55) minutes later.

The Nursing Chart Note at 1:30 PM says that Mr. Doe was unable to assist at his meal, he could not hold his head up and he had difficulty chewing his food. He was able to eat some pie and ice cream.

From 9:00 AM to 1:30 PM none of the notes that appear in the Nursing Chart are signed by the grievant.

At 2:45 PM the Nursing Chart Note made by the grievant says:

“Daughter came to the desk demanding that her father be sent to the hospital. Writer told her that there were protocols that needed to be followed and that I needed to call the Nurse Practitioner for an order to send him. She became very angry and said “I’ll call 911 myself” then called this nurse “very uncaring” and walked off towards her father’s room.

The Nursing Chart Notes say that at 2:50 PM the grievant called the Nurse Practitioner and informed her that Mr. Doe’s family wanted him to be taken to the hospital. Mr. Doe’s daughter believed that Mr. Doe had experienced a stroke. The grievant wrote that Mr. Doe had no symptoms to indicate a stroke.

The note also indicates that the Nurse Practitioner would not give an order to send the patient to ER but the family had already called 911.

The Nursing Chart Note by the grievant says that an ambulance arrived at the Nursing Home at 3:15 PM per the family’s request. The Nurse Practitioner was contacted and the Nurse Practitioner said she would contact the ER physician.

Upon calling to provide the ER physician with information, the Nurse Practitioner was informed that Mr. Doe had experienced a heart attack and a stroke.

The Nurse Practitioner testified that the grievant had not fully informed her of all of Mr. Doe's symptoms and, if she been fully informed of Mr. Doe's symptoms, she would have directed that Mr. Doe be sent to the hospital.

The grievant testified to a number of uncharted observations of Mr. Doe on March 27, 2005. However, when Mr. Doe's daughter approached her at approximately 2:45 PM and requested that the grievant arrange for transportation to the hospital, the grievant did not make any attempt to examine the patient or to clarify what changes in Mr. Doe's condition may have been observed by his daughter. A Nursing Chart Note made out of sequence on March 28, 2005 by the LPN on duty says that the grievant saw Mr. Doe at 10:30 AM and was updated regarding Mr. Doe's condition at 11:40.² There is no record of any assessment of the patient by the grievant between 9:00 AM and 2:45 PM, when the patient's daughter asked the grievant to arrange for her father to be sent to the hospital.

The LPN who attended to Mr. Doe on March 27, 2005 talked to the Director of Nursing, Carol Mc Curley, on Monday March 28, 2005 about the events that took place on March 27, 2005. The LPN believed that the treatment of Mr. Doe had not been appropriate and she did not know whether it would have been appropriate for her to directly contact a Doctor to discuss her concerns.

A complaint was made to management by Mr. Doe's family about how the facility treated Mr. Doe on March 27, 2005. The grievant's interaction with Mr. Doe's daughter was a part of the complaint.

² From the photocopy of the record it is not clear, whether the communication was made at 11:40 or a few minutes later.

The situation was investigated by management. As part of the investigation, the grievant was asked about what happened. By letter dated May 5, 2005 the grievant was suspended for the duration of the investigation.

By letter dated May 18, 2005 the Director of Nursing, Carol Mc Curley, informed the grievant that she had a number of performance problems and deficiencies on March 27, 2005. A two month suspension was imposed on the grievant. Grievant was also notified that when she returned to work she would be required to go through training in a number of areas to ensure grievant was comfortable with Chris Jensen policies. Finally, she was advised that another RN Supervisor would be working along side her for her first shifts.

The Union grieved the discipline in accordance with the contractual requirements. The disciplinary order was reviewed by the St. Louis County Grievance Board on Friday August 11, 2005.

The St. Louis County grievance board made the following findings of fact:

1. Janis Nelson was continuously employed by St. Louis County since May 23, 1978, beginning as a Licensed Practical Nurse at Nopeming and most recently as a Registered Nurse Supervisor at Chris Jensen Health and Rehabilitation Unit.
2. On March 27, 2005, Easter Sunday, Ms. Nelson was working as a Registered Nurse (RN) Supervisor in charge of the facility. An RN supervisor performs a variety of tasks including conducting overall assessments of resident data collection by other staff members assessing individual residents as warranted, prioritizing resident care, directing

and assigning the work of other staff, and serving as the facility's representative to the resident and family members. As in most health care settings, RN Supervisors working weekend shifts are very busy, requiring them to prioritize issues and delegate tasks that can be assigned to others.

3. On the morning of March 27, 2005, John Doe, a recently admitted resident, exhibited various symptoms indicating that his condition was deteriorating after having a seizure the prior evening. The Licensed Practical Nurse who was monitoring the resident reported the symptoms to Ms. Nelson, but **Ms. Nelson did not independently assess the resident's condition.**³ At 12.45 pm, Ms. Nelson contacted the Nurse Practitioner on duty at St. Mary's Duluth Clinic regarding the resident's seizure the night before and current symptoms, and laboratory tests were ordered. The residents family members expressed concern about his condition, and requested that the resident be transferred to the hospital for treatment. Ms. Nelson stated that she needed a Physician's order to send the resident to the hospital, and the family subsequently contacted 911 for an ambulance to transport the resident. The residents family complained that Ms. Nelson treated them and the resident poorly, and did not provide appropriate medical treatment.
4. Upon admittance to the hospital, the resident was found to have suffered a heart attack and a stroke. Due to the gravity of the resident's condition, the Nurse Practitioner was chastised by the Emergency Room

³ Arbitrator's emphasis.

doctor for not writing an order to admit the resident sooner, but responded that **she had not be adequately advised of resident's condition by the RN Supervisor.**⁴

5. Family members contacted the Nursing Home Director with their complaints about Ms. Nelson's treatment of them and the resident, intimating that they were contemplating legal action. The administrative staff of Chris Jensen conducted an investigation, and after interviewing the participants and investigating records of the incident, administered a two-month (ten work-shifts) disciplinary suspension to Ms. Nelson citing **failure to adequately assess the resident's condition, limited medical charting, failure to delegate or prioritize work efficiently, failure to provide the ambulance staff a full report of the resident's condition, and failure to represent the facility well to the resident's family.**⁵

The St. Louis County Grievance Board arrived at the following conclusion:

Based on the evidence and testimony presented, the Board found that the Grievant failed to properly assess the resident's condition despite documentation and information indicating serious symptoms. However, due to the hectic pace of the understaffed facility and the possible misinterpretation of Ms. Nelson's behavior by an emotionally strained family, the Board felt a ten-shift suspension was excessive.

⁴ Arbitrator's emphasis.

⁵ Arbitrator's emphasis.

The St. Louis County Grievance Board reduced the discipline from a ten-shift suspension to a five-shift suspension.

The decision of the St. Louis County Grievance Board was grieved and the matter brought to Arbitration.

SUMMARY OF EMPLOYER'S POSITION:

The Employer argues that it had just cause to discipline the grievant. The grievant has thirty (30) years of experience and knows her job responsibilities. There is no question whether grievant was informed of the duties she was to perform on March 27, 2005. Nevertheless, the grievant failed to carryout essential requirements of her job.

Of the 15 responsibilities designated as essential job functions in the RN Supervisor job description, the grievant failed to perform the following eight (8) in an acceptable manner:

1. Assesses patient's health and rehabilitative needs and implements individual nursing care plans. The grievant did not assess the Patient and did not review the Patient's chart until the end of her shift, despite the Patient being on the 24 hour report.
2. Assigns, directs and reviews the work of subordinate staff in the performance of daily nursing care activities on the unit. The grievant neither reviewed the LPN's assessment of the Patient nor agreed with the LPN's concern over the Patient's condition.
3. Maintains patient charts, treatment records and condition reports. The grievant did not review Patient's chart until the end of her shift despite Patient's presence on the 24 hour report. Grievant did not document all of her observations and

concerns regarding the Patient's condition. Grievant's most detailed records of her interactions with the Patient were notes later prepared for a communication made with her attorney. Attorney client privilege was waived.

4. Supervises admission, transfer and discharge procedures and confers with attending physician and Director of Nursing. The grievant did not effectuate, supervise or in any way monitor the Patient's transfer to the hospital.
5. Conducts individual patient assessment and emergency treatment on nursing care unit. Grievant did not conduct a complete exam of Patient, did not review the assessment of the LPN and she did not relate all of the symptoms and changes in condition to the Nurse Practitioner. Grievant made unfounded assumptions to explain Patient's condition.⁶
6. Provides personal counseling/information assistance to patients to promote their health and comfort on the unit and explains patient status and care programs to families. The grievant did not pro-actively notify Patient's family of Patient's change in condition.
7. Provides continuity of patient care, making rounds on all nursing units, checking charts, assisting in patient care and treatment on difficult or critical cases, and assessing emergencies and notifying physician on significant changes in patient's condition. The grievant did not assess the Patient despite the fact that he was on the 24 hour report. The grievant did not review Patient's chart until the end of her shift and did not review the LPN assessment. The grievant did not give complete and accurate information to the Nurse Practitioner.

⁶ The grievant fed the Patient chocolate without determining whether he could chew and what impact it may have on his blood sugar. Grievant wrongly assumed Patient was on some psycho-tropic substance or medication to explain deviation of his head and his shaking.

8. Coordinates patient admission and discharge procedures, including maintenance of records and charts, counseling patients, notifying and/or briefing families and assisting unit staff in carrying out doctor's orders. Grievant refused to transfer the Patient to the hospital despite his family's request and she did not assist emergency personnel when they arrived at the nursing home.

The Employer arrived at the determination that grievant had made a number of serious mistakes on March 27, 2005, after conducting a thorough and fair investigation. The decision to suspend the grievant was made after considering the long service of the employee and the fact that she did not have prior discipline.

The Employer argues that it had just cause to impose a five shift suspension upon the grievant and asks that the discipline be upheld and the grievance denied.

SUMMARY OF UNION'S POSITION:

The Union argues that Ms. Nelson was singled out for discipline as a result of the complaints received from the family of Mr. Doe. The circumstances described by the family members and staff members involved with the March 27, 2005 incident demonstrate that a number of improprieties occurred and Ms. Nelson was not responsible for the problems that arose with Mr. Doe.

The Nursing Chart Notes demonstrate that Mr. Doe had a seizure long before Janis Nelson came on duty. The significant shift in Mr. Doe's condition occurred prior to Ms. Nelson's shift. The employer did not investigate anyone who cared for Mr. Doe on the prior shift. The medical records do not reflect any significant changes that should have or could have alerted the grievant to the fact that Mr. Doe needed to be sent to the hospital.

It is true that Ms. Nelson was very busy on March 27, 2005. She reasonably relied upon the notes and assessments made by the LPN who was caring for Mr. Doe. The LPN on duty at the time of the incident is experienced and grievant saw no reason why she should duplicate any assessment made by the LPN.

The conduct of the LPN who attended Mr. Doe was not reviewed by management, despite some improprieties. According to Nursing Home Rules, an RN must be involved with the decision to withhold medication. However, the LPN acting without prior authorization, withheld the Patient's medications for a time on March 27, 2005. The LPN was not disciplined for her misconduct.

The daughter who ultimately called 911 and asked that her father be transported to the hospital was not a good historian. She testified that she called 911 about twelve thirty (12:30) PM and the ambulance arrived within fifteen (15) minutes of her call. However, the records produced at hearing demonstrate that the ambulance arrived at three fifteen (3:15) PM. Furthermore, the daughter was not fully informed of the circumstances at the time she called 911. She had not been told of the changes in her father's condition on the prior shift and she had not been advised that the RN needed to obtain medical authorization before sending a Patient to the hospital. The grievant was the "highest ranking" person at the facility that morning and became the natural target of Mr. Doe's daughter's frustration.

In fact, much of the responsibility for the incident should reside with the Nurse Practitioner. At the hearing the Nurse Practitioner repeatedly testified that she was only as good as the information she received. She claims that Ms. Nelson failed to provide her with sufficient information to justify ordering a transfer. However, she could have given

the order based solely on the family's concerns. While the Nurse Practitioner claims that she was not fully informed, one of the four tests she ordered was a BNP to screen for heart attack. The inference that should be drawn is that the Nurse Practitioner knew the Patient had been smoking with a nicotine patch and feared he did have or may have had a heart attack. Finally, the Nurse Practitioner admitted that there was evidence that Mr. Doe's condition had actually been improving on the grievant's shift.

The grievant had made a "vulnerable adult" report in 2004. It is the Union's position that the Employer's focus on the grievant's conduct on March 27, 2005 may have been retaliation for her report, which resulted in a finding of abuse of a Patient who died.

The Employer did not have just cause to discipline the grievant. The grievant explained how her conduct was appropriate in light of the circumstances on March 27, 2005. She reasonably relied upon information she obtained from the LPN. She did check on the Patient but did not see any reason to make any duplicative assessments of his condition. The grievant did not record some of the events that occurred on March 27, 2005 but would have had to stay overtime to supplement the Nursing Chart. Finally, the decision whether to authorize the transportation of the Patient to the hospital was not hers to make. The Nurse Practitioner wanted to wait until she received test results before considering authorizing a hospital transport and the Nurse Practitioner was not willing to talk to family members.

The Employer treated the grievant disparately. The responsibility for the problem that occurred on March 27, 2005 was a shared responsibility. The Nurse Practitioner was the only person who could have given an order authorizing the ambulance. The Nurse Practitioner was called twice on March 27, 2005 and given information about the

Patient's condition, but the Nurse Practitioner did not order an ambulance. The Nurse Practitioner was not disciplined. The LPN violated the Nursing Home protocol, when she held the Patient's medications. The LPN was not disciplined. Staff members on duty when Mr. Doe experienced a seizure, the change in condition, were not disciplined for failing to contact Mr. Doe's family nor were they disciplined for failing to properly assess and treat the Patient. In 2004 an investigation resulted in a determination of neglect of a Patient who died. The attending nurse received counseling and instruction. The grievant was treated differently than other employees under the same or similar circumstances. Grievant should not have been disciplined but it may have been appropriate to counsel her.

The Union asks that the discipline be reversed and the grievance upheld.

OPINION:

The Employer established by clear and convincing evidence that the grievant failed to perform her duties as Registered Nurse Supervisor at Chris Jensen Health and Rehabilitation Unit on March 27, 2005. The evidence adduced at Arbitration is consistent with the findings of fact made by the St. Louis County Grievance Board.

There is some argument that the grievant was new and unfamiliar with the role she was placed in at the Chris Jensen facility. The argument does not address a glaring problem with Ms. Nelson's conduct on March 27, 2005. The daughter of Mr. Doe went to the grievant with concerns about her father's condition. There is no evidence that the grievant had performed a recent and thorough assessment of Mr. Doe's condition. Nevertheless, Ms. Nelson did not go to Mr. Doe's room and perform an assessment. Even if Ms. Nelson thought that Mr. Doe's daughter was over reacting, Ms. Nelson had no

factual basis for her belief. Regardless of her claimed unfamiliarity with her supervisory position, the grievant made no reasonable claim that she was not required to assess the condition of a patient under her care nor was a reasonable explanation given for her failing to respond to Mr. Doe's daughter's request that her father be sent to the hospital by going to the patient and assessing the patient's condition. The grievant did not have a clear, complete and current picture of Mr. Doe's condition at the time she was approached by Mr. Doe's daughter. The grievant chose to inform the Nurse Practitioner about the patient's condition without the benefit of a current personal assessment. It is abundantly clear that the grievant could have and should have responded to Mr. Doe's daughter's by going to the Patient's room and performing an assessment of his condition.

The grievant's conduct must be evaluated in light of the environment wherein she worked. The Chris Jensen facility is a nursing facility. It is reasonable to infer that the greatest percentage of the population of the nursing home is elderly and in poor health. It is also reasonable to infer that nurses at the nursing home are familiar with and alert to rapid changes that may occur in a patient's condition. The special nature of the environment demands that a patient be assessed, when a family member notifies an RN that significant changes have occurred in a patient and the RN knows that the patient recently experienced a seizure and experienced a variety of symptoms that could be interpreted as signs of other serious developments.

The grievant's conduct on March 27, 2005 was not reasonable conduct for a Registered Nurse in light of all the facts and circumstances she encountered and the Employer had just cause to discipline the grievant.

The level of discipline was reduced from a ten (10) shift suspension to a five (5) shift suspension by the St. Louis County Grievance Board. The Board took into consideration the hectic pace of the facility and reduced the amount of discipline by fifty percent (50%). According to the original disciplinary notice, the grievant's long tenure without any prior discipline was taken into consideration by management. In this instance, the arguments that discipline was measured and proportional to the nature of the misconduct are convincing.

The argument that grievant was treated disparately is rejected because of the nature of Ms. Nelson's misconduct. The grievant's misconduct could have been remedied by simply responding to Mr. Doe's daughter's concerns by going to see the patient and performing an assessment. The grievant's conduct is simply not comparable to the conduct of employees on a prior shift, the conduct of the LPN on duty, the Nurse Practitioner or the misconduct of the employee involved in the 2004 abuse incident. Ms. Nelson knew she had not performed a current assessment on Mr. Doe at the time she was approached by Mr. Doe's daughter. The grievant could have and should have gone to Mr. Doe's room and performed an assessment so that she would be fully informed as to the patient's condition.

The Employer had just cause to discipline the grievant and the discipline of a five (5) shift suspension was reasonable under the circumstances. Hence, the grievance should be denied.

AWARD:

The Employer had just cause to suspend the grievant for five (5) shifts.

The grievance is hereby denied.

Dated: September 19, 2007

James A. Lundberg, Arbitrator