

AFSCME Council 5,
the Union,

-and-

State of Minnesota,
Department of Human Services,
the Employer.

ARBITRATION AWARD

Martin Discharge

BMS Case No. 07-PA-0900

Arbitrator: Barbara C. Holmes

Hearing Date: February 27, 2008

Date of Decision: March 27, 2008

Appearances:

For the Union: Bob Buckingham
AFSCME Council 5

For the Employer: Rebecca Wodziak
Department of Employee Relations
State of Minnesota

INTRODUCTION

AFSCME Council 5 (herein the Union), as the exclusive representative, brings this grievance challenging the discharge of its member Barbara Martin (herein the Grievant). The State of Minnesota (herein the Employer) contends that it had just cause to discharge the Grievant. An arbitration hearing was held at which both parties had a full opportunity to present evidence through the testimony of witnesses, the introduction of exhibits and the presentation of oral closing arguments.

ISSUE

Did the Employer have just cause to discharge the Grievant from employment? If not, what should be the remedy?

FACTUAL BACKGROUND

The Employer operates a facility at the Brainerd Regional Human Services Center that provides comprehensive residential mental health services to children and adolescents who have serious emotional disturbances. The Grievant is a Licensed Practical Nurse who provided care for patients at this facility since 1995 through her discharge in 2006.

On March 6, 2006, Patient A was admitted to the Employer's facility. As part of the admission process a Vulnerability and Risk Assessment Plan was completed for Patient A by her treatment team. This assessment identified Patient A as having a "propensity for risk and self-harm." Additionally, staff members used the following words to describe Patient A: "unpredictable," "gamey," "sometimes seemed okay, but would flip-flop," "wanted control," "wanted attention," "difficult because she had a borderline personality disorder," and "manipulative."

On April 10, 2006, Patient A found a pencil sharpener while outside the facility on a group walk. She later removed the blade from the sharpener and swallowed it. She was admitted to a local hospital for medical treatment. While at the hospital and under staff supervision she managed to surreptitiously remove two metal screws from the wall in her room and swallowed them. After appropriate medical treatment Patient A was discharged from the hospital on April 14, 2006.

Upon Patient A's readmission to the Employer's facility suicide precautions were implemented and she was placed on "one-on-one close observation" status. This status is defined in the Employer's policies as follows:

Staff member assigned must observe the patient in close proximity with immediate physical access and maintain continuous visual observation.

Under this type of observation a staff member sits at the door of the patient's room at all times, day and night, to observe her. When the patient is allowed to leave her room the staff member must maintain continuous visual observation and be close enough to the patient to have immediate physical access. If the staff member needs to take a break, another staff member assumes the observation of the patient. The staff member is

required to maintain an "Observation Record" that documents the patient's activities in fifteen-minute intervals. A treatment plan is also created for patients by the multi-disciplinary professional staff of the Employer. The Grievant was responsible for implementing the treatment plans of the patients to which she was assigned.

One of the items in Patient A's treatment plan prohibited her from having contact with other patients while she was in her room. It allowed her to leave her room and go into common areas of the unit for two hours a day specifically to play cards or watch a movie. Patient A was also placed on one-on-one close observation status.

On April 15, 2006, Staff Member 1 was assigned to conduct the one-on-one close observation of Patient A. Patient A was watching television, a permitted activity, and Staff Member 1 was standing behind the chair in which Patient A was sitting. Patient A surreptitiously removed the batteries from the television remote control she was operating, went to the drinking fountain, and swallowed the batteries. She then informed Staff Member 1 what she had done. Patient A was again taken to the hospital for medical treatment. On April 18, 2006, she was readmitted to the Employer's facility and again placed on one-on-one close observation status.

On April 24, 2006, the Grievant was working a shift that began at 3:00 p.m. and ended at 11:30 p.m. The Grievant was assigned to conduct the one-on-one close observation of Patient A. The Observation Record completed by the Grievant indicates that Patient A was in her room from 3:45 p.m. through 6:15 p.m., in the dayroom from 6:15 through 9:30 p.m., and in her room from 9:30 p.m. through the end of the Grievant's shift. The Observation Record also shows that the only time the Grievant was relieved from her duties was from 9:30 p.m. through 10:30 p.m. by Staff Member 2.

Staff Member 2 was working with the Grievant that evening and was assigned to work with the other two patients on the Unit. He testified that he observed the Grievant and Patient A working on an art project in the dayroom. He saw the Grievant go into the Nurse's Station Office and observed that Patient A was leaning against the doorjamb that faced into the office. He later stated that this "made him uncomfortable because they were not supposed to let Patient A near the Nurse's Station Office which contained a lot of small objects" and that "this particular [patient] was too close to the office."

That evening the Grievant also had the duty of dispensing medication to the three patients on the Unit. The medication records indicate that the Grievant gave one patient his medication at 7:40 p.m., another at 8:15 p.m., and Patient A at 9:40 p.m. The proper procedure to dispense medications was to take the patient to the medication office, have him or her stand outside the room at the “half-door,” obtain the medication in the medication office, dispense it to the patient, and document what was dispensed and the time it was dispensed. Staff Member 2 testified that the only time he took over the Grievant’s one-on-one close observation of Patient A was during the Grievant’s meal break.

Staff Member 3, the RN Charge Nurse at the facility for that evening, went to Patient A’s Unit while making her rounds. In an incident report she filed the next day she stated the following:

Walked onto C Unit and found [the Grievant] using the computer ... with [Patient A] standing at her side.

Staff Member 3 later stated that she was “shocked” to see that the Grievant brought [Patient A] into the Nurse’s Station Office “where she was exposed to paper clips and other objects she could swallow.”

Staff Member 4, a Registered Nurse, entered the Unit at approximately 9:00 p.m. In an incident report she completed the next day, she stated the following:

[Patient A] was down the hall. [Patient A] yelled to [me] – “I’m all alone – no one’s watching me.” The [Grievant] then came out of the office, saying, “I’m right here.”

Staff Member 4 testified that she was “shocked” to see Patient A standing alone out of the sight of the Grievant. She stated that she and the Grievant immediately went to Patient A’s location.

At some point during her shift the Grievant talked to the two other patients on the Unit while she was conducting her one-on-one close observation of Patient A. She stated that these conversations took place while she was sitting at the desk in front of the door to Patient A’s room.

During a staff meeting the following day Staff Member 3 reported the incident she had observed regarding Patient A. Staff Member 4 brought the incident she had

observed to the attention of her supervisor. Both staff members were advised to file an incident report. The Employer hired a professional investigator to conduct an investigation of the incident. The Grievant and Staff Members 2, 3, and 4 were interviewed as part of the investigation.

On May 12, 2006, the Grievant was discharged from employment for the following reasons set forth in her discharge letter:

This action is being taken because you did not comply with the ... Therapeutic Precautions Procedures or a patient's [treatment plan] when you were assigned to conduct a 1:1 close observation with the patient. Specifically, on April 24, 2006:

- You permitted a patient to have unauthorized contact with other patients.
- You permitted a patient to do activities not authorized in her [treatment plan].
- You left a 1:1 patient unsupervised.
- You permitted the patient who required 1:1 supervision to have access to two ... [offices] where prohibited and potentially dangerous objects were within the patient's reach.

The Union filed a grievance contesting the Grievant's discharge. A Step 3 hearing was held and the grievance was denied. The Union appealed the grievance to arbitration

POSITION OF THE PARTIES

Employer: The Employer argues that the Grievant's primary duty was to implement treatment plans of patients and that she failed to do so with respect to Patient A. The Employer contends that its only option was to discharge the Grievant because she failed to understand or admit that she placed Patient A in grave danger.

The Employer argues that the Union's claim of disparate treatment is without merit. It asserts that Staff Members 2, 3, and 4 intervened appropriately and filed incident reports regarding the Grievant's actions as required by law. The Employer also asserts that Staff Member 1 was not subject to an investigation or discipline when Patient A swallowed remote control batteries because there was no evidence that Staff Member 1 did anything improper.

The Employer also believes that the Grievant's testimony lacks credibility. In support of this claim the Employer points to the various inconsistencies with documentary evidence, other witness's testimony, and between different versions of facts provided by the Grievant.

Union: The Union faults the Employer's investigation because it does not address the fact that Staff Members 2, 3, and 4 failed to intervene in the situation as required by "mandatory reporting" laws. Furthermore, the Union believes that the Employer's failure to address its staff members' lack of intervention proves that the Grievant's actions were not so serious as to justify her discharge. The Union also notes that even though Staff Members 3 and 4 are Registered Nurses they did not voluntarily file an incident report regarding the Grievant's actions until directed to do so by their supervisor.

The Union also argues that the Grievant is being treated unfairly because Staff Member 1 was not disciplined when Patient A swallowed the remote control batteries during Staff Member 1's one-on-one close observation period.

The Union contends that Patient A was in sight of the Grievant at all times and that no harm was intended by the Grievant nor came to Patient A during Grievant's observation period. The Union argues that at their worst, the Grievant's actions call for a short suspension.

DISCUSSION AND OPINION

The Employer must have just cause to discipline the Grievant. The analysis to determine whether or not just cause exists typically involves two distinct steps. The first step is to determine whether the Employer has submitted sufficient proof that the employee actually engaged in the alleged misconduct or other behavior warranting discipline. If the alleged misconduct is established by a preponderance of the evidence, the next step is to determine whether the level of discipline imposed is appropriate, taking into account all of the relevant circumstances. *See Elkouri & Elkouri, HOW ARBITRATION WORKS 905 (5th ed. 1997).*

A. The Alleged Misconduct.

The Employer has alleged the following misconduct by the Grievant: 1) permitting Patient A to have unauthorized contact with other patients, 2) permitting Patient A to do activities not authorized in her treatment plan, 3) permitting Patient A to have access to two Unit offices where prohibited and potentially dangerous objects were within the patient's reach, and 4) leaving Patient A unsupervised while under a one-on-one close observation status.

1. Unauthorized contact with other patients. Patient A's treatment plan prohibited her from having any contact with other patients while she was confined to her room. In the Grievant's investigatory interview she stated that she had a conversation with the other two patients on the Unit while conducting Patient A's one-on-one close observation at the desk placed in front of Patient A's doorway. The Grievant stated that Patient A attempted to join in the discussion but that she told Patient A to sit quietly and not participate. When the Grievant was asked to explain why she had a conversation with the other patients while in Patient A's presence she stated, "One of the patients can be very difficult. I didn't want to turn them away so they would cause a scene. I felt it was better to just listen."

Technically, Patient A had "contact" with other patients in violation of her treatment plan. But neither Patient A nor the Grievant initiated the contact. Given the placement of the Grievant's desk - in the hallway at Patient A's doorway - it would be difficult to ignore other patients on the Unit if they initiated a conversation. I find that the Grievant did not violate Patient A's treatment plan in this instance.

2. Activities not authorized by Patient A's treatment plan. Patient A's treatment plan stated that she was allowed outside of her room for two hours a day to "play cards with staff 1 hour and movie 1 hour." The Grievant testified that Patient A got bored playing cards and the television wasn't working. She stated that she allowed Patient A to color pictures because she wanted to reward Patient A for good behavior. She stated that she and Patient A were looking on the computer to find images that Patient A wanted to print and color.

I find that the Grievant, by her own admission, violated Patient A's treatment plan by allowing her to take part in an activity not permitted by the treatment plan.

Additionally, the Observation Record indicates that Patient A was outside of her room for more than two hours, specifically, from 6:15 p.m. through 9:30 p.m.

3. Permitting Patient A to have access to potentially dangerous objects. When Staff Member 3 went onto the Unit to do her rounds she observed the Grievant in the Nurse's Station Office sitting down in front of the computer screen with Patient A standing behind her. Staff Member 3 testified that as soon as the Grievant saw her, the Grievant looked surprised and left the Nurse's Station Office taking Patient A with her. Staff Member 3 stated that she was "shocked" to see that the Grievant brought Patient A into the Nurse's Station Office "where she was exposed to paper clips and other objects she could swallow."

Staff Member 2 also testified that he saw the Grievant in the Nurse's Station Office working on the computer with Patient A standing behind her. He stated that this "made him uncomfortable because they were not supposed to let Patient A near the Nurse's Station Office which contained a lot of small objects" and that "this particular [patient] was too close to the office."

During the Grievant's investigatory interview she was asked twice to discuss all of the activities Patient A engaged in outside of her room on that evening. Both times she stated that Patient A played cards for one hour and then helped the Grievant use masking tape to hang pictures on the Unit walls. When the investigator confronted her with Staff Member 3's report of the Grievant being in the Nurse's Station Office with Patient A, the Grievant started to cry. She then admitted that she was looking up images on the computer to print out for Patient A to color. She acknowledged that there were numerous objects in the Nurse's Station Office and the office where the printer was located that Patient A could have swallowed. However, during the investigation and at the hearing the Grievant insisted that she could see Patient A peripherally at all times

I find that the Grievant allowed Patient A to have access to potentially dangerous objects by allowing Patient A into the Nurse's Station Office. I also find that during the nine minutes that the Grievant was at the computer she was unable to have continuous visual observation of Patient A. Both incidents constitute a violation of Patient A's treatment plan.

4. Leaving Patient A unsupervised. Patient A's treatment plan placed her on a "one-on-one close observation" status. The Employer's Patient Care Procedure Number 6283, entitled "Therapeutic Precautions," sets forth the following pertinent language:

Observation procedures are therapeutic precautions that may be used when clinically indicated for patients who present a threat of suicide, self-injurious behaviors ...

To secure the safety of patients ...

Close One-to-One Observation: Staff member assigned must observe the patient in close proximity with immediate physical access and maintain continuous visual observation. ...

Documentation in the therapeutic precautions observation record is required every 15 minutes ...

All transfers of staff assignment (for example, ... for staff breaks) shall be recorded in the progress notes ...

Staff Member 4 testified that when she came onto the Unit Patient A was standing by herself in the hall next to her room. According to Staff Member 4, Patient A "yelled" to her "I'm all alone – no one's watching me" and then the Grievant came out of the medication office saying, "I'm right here." Staff Member 4 said that she was "shocked" and reported the incident the next morning when she came to work.

During the investigation the Grievant initially stated that she took Patient A with her to the medication office while she distributed medications to the other patients and insisted that she was able to closely observe Patient A during that time. When pressed as to her ability to remain in continuous visual contact while dispensing medications she then stated that she asked Staff Member 2 to watch Patient A while she did this. Staff Member 2 stated that he was asked to watch Patient A only when the Grievant took her meal break. At the hearing the Grievant denied leaving Patient A alone.

I find that the testimony of Staff Members 2 and 4 is more credible than the Grievant's testimony. A tour of the Unit was taken during the arbitration hearing. Patient A's room was the third room down a hallway. Before entering the hallway the medication office was off to the left. A person in or near the medication office could not see down the hallway to any patient's room. Staff Member 4 saw Patient A in the hallway

and saw the Grievant come out of the medication office. Also, the statement by Patient A -“I’m all alone – no one’s watching me”- leaves little doubt that she was not being supervised. I find that the Grievant was not in “close proximity with immediate physical access” to Patient A and could not “maintain continuous visual observation” of Patient A as required by her treatment plan.

I also find that the Grievant violated Patient A’s treatment plan when she dispensed medication to the other two patients. The Grievant could not maintain continuous visual contact nor have immediate physical access to Patient A while in the medication room retrieving the medication and documenting who received medication.

B. The Appropriate Sanction.

Because the Grievant has been found guilty of misconduct for her failure to follow Patient A’s treatment plan, the appropriate sanction for her misconduct must be determined. In most cases of misconduct progressive discipline is applied. However, in cases of extremely serious offenses immediate discharge may be justified without the necessity of corrective discipline. I find this to be such a case.

Patient A was a highly vulnerable adolescent with life-threatening self-abusive tendencies entrusted into the care of the Employer. The Grievant was aware of Patient A’s treatment plan, knew that it had been developed by a multi-disciplinary professional staff, understood that it was her job to implement the plan on a daily basis, and understood what was required of her when conducting a one-on-one close observation of a patient. She also was aware of Patient A’s recent self-abusive history. Nevertheless, on a single night the Grievant chose to ignore Patient A’s treatment plan in several different ways – 1) she chose to allow the Patient to remain outside of her room for over three hours instead of two, 2) she chose to allow Patient A to do an activity not allowed by the plan (coloring), 3) she chose to leave the Grievant alone and out of sight causing Patient A to express concern (“I’m all alone – no one’s watching me”), 4) she chose to distribute medication to other patients during Patient A’ one-on-one close observation, and 5) she chose to allow Patient A into the Nurse’s Station Office where many potentially dangerous objects were available to Patient A and where the Grievant was not in continuous visual contact with Patient A. When taken all together, I find this to be very serious misconduct.

If the Grievant had acknowledged her mistakes she might have been given another chance to prove her trustworthiness. But her continued refusal to accept that her actions placed Patient A in grave danger is troubling. When asked during the investigation about letting Patient A into the Nurse's Station Office where many small objects that Patient A could swallow were accessible, the Grievant stated, "She (Patient A) wouldn't do that. We were doing something for her. Coloring was something she wanted to do. ... We were only in there for a few minutes at the most. I was watching her. I know she wouldn't have done that to me. ... I felt confident she wouldn't do that to me." The Grievant's overconfidence in this regard is alarming. During her testimony at the hearing the Grievant stated that she was rewarding Patient A for her behavior. She also continued to justify her misconduct and insist that Patient A was not in any sort of jeopardy because of the Grievant's actions. Because of the Grievant's serious misconduct coupled with her refusal to admit her mistakes, I find that the Employer's termination of the Grievant's employment was appropriate.

The Union argues that the Grievant has been subject to disparate treatment for her misconduct. It points to the fact that Patient A swallowed remote control batteries during Staff Member 1's one-on-one close observation of Patient A, yet Staff Member 1 was not subject to an investigation or discipline. I find that there is no disparate treatment of the Grievant for the simple reason that there was no evidence that Staff Member 1 was not following Patient A's treatment plan nor conducting the one-on-one close observation improperly.

The Union points out that state law and the Employer's policies require staff members to immediately intervene if they observe or discover any maltreatment of a minor. The Union argues that the failure of Staff Members 2, 3, or 4 to immediately intervene proves that the Grievant's actions were not that serious. I disagree.

First of all, when Staff Member 3 entered the Unit and found the Grievant in the Nurse's Office Station on the computer with Patient A standing behind the Grievant, the Grievant left the computer and Nurse's Station Office and took Patient A with her, thereby putting an end to the risky situation. Similarly, when Staff Member 4 came onto the Unit, saw Patient A standing alone and heard Patient A say "I'm all alone – no one's watching me," she and the Grievant immediately went to Patient A's location. Patient A

was no longer at risk. Staff Member 2 admitted that he did not intervene but stated that at the time of the occurrence he had only been employed for 3 months. He stated that he may have reacted differently now because he had gained more experience. Finally, the Grievant was disciplined for the totality of the various occurrences of misconduct.

The Union also points out that staff members are required to report any maltreatment of a minor within 24 hours of its observation or discovery. The Union again argues that the Grievant's misconduct was not that serious because Staff Members 3 and 4 did not file an incident report until instructed to by their supervisors the next day. Again, I disagree. Staff Member 3 voluntarily reported the incident she had observed the following day during a staff meeting. Staff Member 4 voluntarily reported the incident to her supervisor the following day.

CONCLUSION

The Employer has proven by a preponderance of the evidence that the Grievant's actions placed Patient A in grave danger. Because the Grievant fails to understand that she cannot substitute her judgment for the professionally developed treatment plan of a suicidal self-abusive patient, she cannot be returned to her employment.

AWARD

The grievance is denied.

DATED: 3/27/2008

Barbara C. Holmes
Arbitrator