

In Re the Arbitration Between

**AFSCME Council 5, Union
and
Ramsey County, Employer**

BMS Case 10-PA-0024

**Carol Berg O'Toole
Arbitrator**

September 11, 2009

Representatives:

For the Employer:

Marcy Cordes, Labor Relations Manager

For the Union:

Tom Burke, Field Representative

Appearances:

For the Employer:

**Brandi Brown
Patricia Reller
Anne Erickson
Joleen Magee**

For the Union:

**Dawit Sebhatu
Jackie Cook
Michelle Escobar
Michele Fischer**

Preliminary Statement

The hearing in the above matter commenced at 9:38 AM on September 11, 2009, at the Ramsey County Parks and Recreation Administration Building at 2015 North Van Dyke Street, Maplewood, Minnesota. The parties involved are Ramsey County (Employer) and AFSCME, Council 5, representing, among others, nursing assistants (Union). The parties presented opening statements, oral testimony, oral argument and exhibits. Post hearing briefs were filed by both parties. The arbitrator closed the hearing on September 29, 2009.

Issue Presented

The parties agreed on the issues as follows: Was there just cause to discharge the Grievant? If no just cause exists, what is the appropriate remedy?

Contractual and Statutory Jurisdiction

The Union is the certified bargaining representative for the activity technicians, cooks, cook-trainees, custodial workers, laundry workers, food service workers, kitchen workers, nursing assistants 1 and 2, and storekeepers. The Employer and the Union are signatories to a collective bargaining agreement (Agreement) covering the period from January 1, 2009 to December 31, 2011, which provides in Article 15 that if the grievance is not settled in Step 3 of the grievance procedure, the parties will select an arbitrator to decide the grievance. The parties could not agree on a resolution through the grievance procedure; thus, the dispute is properly before the arbitrator.

Issue Presented

Whether there was just cause to discharge the Grievant? If no just cause exists, what is the appropriate remedy?

Employer's Position

The employer's position is that there is just cause to discharge the Grievant.

1. Jackie Cook (Grievant) was discharged from her position with the Ramsey County Care Center (Care Center) for a violation of County policies against abuse and maltreatment of residents who are classified as vulnerable adults under Minnesota Statutes 626.5572 and the Care Center policies. The Employer claims that the Grievant's actions on December 30, 2008, against Mr. K., a resident at the Care Center, constitute just cause for a discharge.
2. The actions constituting abuse and maltreatment include squeezing the hands of Mr. K., causing him pain and pushing him onto a bed.
3. On December 30, 2008, Brandi Brown (Brown), a Century College student nursing assistant performing her clinical experience, was assigned to shadow another Care Center nursing assistant, Dawit Sebbatu.
4. Brown was standing in the hallway outside of Mr. K's room, and, then, looked into his room and observed Grievant push Mr. K. down onto his bed and tell him to sit.
5. Brown stepped back into the hallway for a moment. When she looked back in she saw the Grievant hunched over Mr. K, squeezing his fingers and twisting his hand.
6. Brown heard Mr. K. say, "Ouch. Stop, that hurts."
7. Brown described Mr. K. as afraid.
8. Brown stepped out of the room for a second time and while in the hall, heard someone say in a deep voice, "Bastard." Brown heard nothing else.

9. Brown stated that she thought the Grievant did not know she was standing in the doorway.
10. Brown immediately reported the incident to the student supervisor and the Acting Director of Nursing, Joleen Magee (Magee). Brown stated she did so because she found the Grievant's actions disturbing. Brown said she was shaken, rattled, and concerned for Mr. K's safety.
11. The Employer places high credibility on Brown's account of the incident because her testimony is consistent with her contemporaneous written statement and with Magee's subsequent report of the incident to the Minnesota Department of Human Services
12. After she received Brown's report of the incident, Magee directed the Care Center's social worker to interview Mr. K., who supported Brown's oral and written report of the incident.
13. The Employer states that the Grievant's written reports of the incident challenged Brown's credibility. The Grievant erroneously thought that the student nursing assistant was her student nursing assistant and was motivated to report abuse by her anger at being criticized and corrected by the Grievant. The Employer points out that it is uncontroverted that Brown was not the Grievant's assigned nursing assistant, did not know Brown, and had no conversations with the Grievant prior to the incident. Brown reported the abuse because she was shocked by the Grievant's behavior and would not want her young child in day care to be treated that way.
14. The Employer points out that Brown had no motivation to tell on the Grievant than concern for the safety of the resident. The Employer points out that Brown had nothing to gain personally from reporting the incident.
15. The Employer states that the Grievant's statements were inconsistent. On one hand she stated that she grabbed Mr. K's hands because she wanted him to sit

on the bed and because he was being combative. In her second written statement she says that she grabbed his hands and wanted him to both lie down and sit down, because he was unsteady on his feet. In her testimony at the hearing the Grievant said she was walking Mr. K. backwards towards his bed and wanted him to sit on the bed to take a nap.

16. The Employer states that Brown testified that she saw no combative behavior from Mr. K. and that the Grievant was standing in front of him trying to get him on the bed. Brown described him as afraid and confused rather than angry. Brown further stated that Mr. K did not appear unsteady or stumbling; in fact, the Grievant's actions of pushing Mr. K. backwards and squeezing his hands up against his chest, made Mr. K less steady on his feet.
17. The Employer contends that the "nap" rationale for Grievant's actions is inconsistent with Mr. K's plan of care, which nursing assistants are required to carry with them. Mr. K's plan of care required no nap at any time during the day.
18. The Employer states that Grievant's combative rationale for her actions lacks credibility. Magee testified that even when residents exhibit combative behavior it is never proper procedure for staff to physically restrain residents. Under the Care Center's policy, nursing assistants must do one of the following: a) leave the resident and redirect—provide care at a later time; b) push the call button for help from other staff; c) verbally call out for help from other staff. The Employer stated that Grievant did none of these. That, they maintain, proves Grievant is not credible in saying Mr. K. was combative.
19. Further evidence of Grievant's lack of credibility is in her written statements which both say she saw her own student helper standing in the doorway during the incident and that she actually spoke to her student explaining that she didn't want her help because Mr. K. was combative and she thought it would be unsafe

for the student helper. Brown contradicts these contentions in her testimony that she never spoke to the Grievant and that the Grievant did not see her.

20. The Employer points out that any resistance by Mr. K would not justify the Grievant's actions. The Care Center's Patient Bill of Rights, as well as policies addressing the care of vulnerable adults, clearly state that, unless medically restricted, Mr. K. has the right to choose activities, schedules, and health care, interact with members of his community and make choices about aspects of his life in the facility. The Grievant had no authority to require him to do something he didn't want to do and, in fact, violated the Care Center's policies in doing so.
21. The Employer argues that Care Center nursing assistants have a critical role because they are the primary providers of direct care to residents who are dependent people. They state that under Minnesota Statutes 625.5572, subd.,2(b) abuse is defined as "conduct which is not an accident or therapeutic...which produces or could reasonably be expected to produce physical pain or injury or emotional distress."
22. Magee testified that she followed state guidelines in making her assessment that the Grievant's actions constituted abuse.
23. The Employer argues that the Minnesota Department of Health (Department) actions whatever they might be do not exonerate the Grievant. The Employer can enforce a higher standard of care and treatment than used by the Department. Finally, the Employer points out that the Department is not directly responsible for the care and safety of the residents of the Care Center.
24. The Care Center is required to and has enacted a Resident Abuse Prohibition Plan which provides that abuse is pushing, physical restraint, threatening harm with verbal or nonverbal threats or gestures and failure to offer choice when the vulnerable adult is capable of making choices. The Employer argues that the Grievant squeezing Mr. K's hands and pushing him against his will onto the

bed, caused pain, created emotional distress and were not in accordance with the dignified and respectful treatment that residents are entitled to under the law and the Care Center's policy.

25. The Employer maintains that the Grievant received all of the pertinent policies during and after employee orientation and attended an annual training session on vulnerable adult requirements approximately one week prior to the incident with Mr. K. The Employer argues that the Grievant was on notice regarding the types of actions that constitute abuse of vulnerable adults under Care Center policies and that violation of such could lead to discharge.

26. The Employer argues that other nursing assistants have been discharged for similar incidents.

Union's Position

1. The union argues that there is no just cause for discharge of Grievant, who has no previous record of discipline since she began work in 2000.
2. Mr. K. was a particularly difficult resident to care for with a diagnosis of Alzheimer's dementia anxiety, delusional disorder and psychosis with agitation and aggression.
3. The Union contends that Mr. K would attack staff members who were attempting to administer cares to him. The attacks included oral attacks, such as calling staff members "bastard", "son of a bitch" and physical attacks such as scratching and hitting.
4. A male co-worker of the Grievant, Dawit Sebhatu, (Sebhatu), would frequently assist Grievant when she was caring for Mr. K. so Mr. K would not harm Grievant.
5. On the morning of the incident at issue, both the Grievant and Sebhatu were caring for Mr. K in the bathroom located in the room that Mr. K shared with another resident. Sebhatu maintains that upon completing their work together in

the bathroom Sebhatu asked Grievant if she was all right with Mr. K. as it was his time for break. Sebhatu left the room.

6. After Sebhatu left the room, the Grievant continued to follow behind Mr. K as he returned to his bed. Mr. K. swung at the Grievant and since she was startled, she grabbed Mr. K's hands in hers to prevent him striking her. She attempted to steer Mr. K. into a sitting position on the bed which was directly behind Mr. K, approximately one foot away.
7. At this point, Brown, who was in her second day of practical experience and had never worked as a nursing assistant, stuck her head in the door of Mr. K's room. Brown knew neither the Grievant nor Mr. K. The Union argues that Brown's rendition of the event should be considered in light of her inexperience as well as her inability to recall whether the room contained one bed or two.
8. The Grievant testified that she was the person that said "Ouch. Stop, that hurts."
9. She said that because Mr. K was squeezing her hands and wouldn't let go even after he was seated on the bed. The Grievant also stated that it was Mr. K that called her a "bastard", a favorite expletive of his.
10. The Union argues that, despite the Employer's reports to the Department, the Department neither issued any penalties nor revoked Grievant's certification as a nursing assistant. In fact, the Department, after review, determined that no further action was necessary. This decision was explained in a letter before the Employer's termination took place. They further argue that the record is devoid of any evidence that the the Department was aware of any action taken or contemplated by the Employer. On the day following receipt of the Department's "no further action" letter, the Employer terminated the Grievant.
11. The Union argues that the statute and the Care Center's Abuse Prohibition Plan refer to "physical harm", physical pain", "injury" and "mental anguish", none of which occurred here. They further argue that the incidents the Employer cites

as similar evidencing consistent discipline, were not equivalent and unchallenged.

12. The Grievant now works as a certified nursing assistant at a nearby institution at a reduced rate of pay and no health benefits.

Discussion

At issue in this arbitration is the cause standard for discharge. Elkouri and Elkouri's *How Arbitration Works* (Ruben 2003) is illuminating in determining whether the Employer has met the "cause" standard for discipline and the requisite burden and quantum of proof

There is no question about whether the incident happened. What is at issue is who did what? The two individuals who were present were the Grievant and Brown both gave very different versions of what happened. Which version is to be believed?

It is without question that the job duties of a nursing assistant are among the most difficult of all jobs because of the nature of the work and the clients served. Employees at the Care Center deserve and have the gratitude and respect of all who know their work. The morning the incident occurred involved difficult and, in part, distasteful work. However, with that difficulty comes great responsibility.

Grievant's testimony, both in written form and orally was not as credible as Brown's. Brown had no motivation to lie. Brown could recognize abuse, even though she was not yet a certified nursing assistant. Her reaction was immediate and strong. Her oral and written account of the incident was consistent. Grievant had her job at stake, told a different story in her accounts and had a ready excuse for someone telling on her, even though the excuse disappeared with the uncovering of the identity of the reporter. The arbitrator finds that the Grievant abused Mr. K. and that Mr. K was the one who cried out in pain, not the Grievant.

Once the matter of who did what is determined, the question remaining is whether the punishment assessed by the Employer should be upheld or modified. To determine if a penalty is appropriate, a number of factors are typically considered: nature of the offense; due process; past record; length of service; knowledge of the rules; warning; equal treatment of other employees.

Nature of the Offense

In the Care Center Employee Handbook, "Serious misconduct can result in immediate discharge." Among the transgressions listed are the following: "Verbally threatening, abusing, coercing or physically abusing or, in any way, mistreating a resident, visitor, volunteer or coworker." The Care Center Employee Handbook delineates the required respect towards residents. Employees are to talk to the resident first and appropriately explain what is being done and why, and then, ask permission. If the resident refuses, the employee should ask if care may be done later and when would be a good time. Patricia Reller (Reller) testified that when confronted with a refusal by a resident and possible harm to the employee, the employee should call for help either with the call button or orally or step away,

In the Resident Abuse Prohibition Plan, the types of abuse and neglect are defined and delineated. Maltreatment is defined as abuse, neglect, and exploitation. Abuse is the willful infliction of any injury, unreasonable confinement, intimidation or punishment with resulting physical harm or pain or mental anguish. Physical abuse is further defined as the use of physical force that may result in bodily injury, physical pain, or impairment, including pushing and confinement. Physical restraint is any manual method or physical or mechanical device that he or she cannot remove easily and that restricts freedom of movement or normal access to his/her body. Emotional and psychological abuse includes failure to offer a choice when the individual is capable of making a choice.

The Combined Federal and State Residents' Bill of Rights of the Care Center includes caring for residents in a way that promotes maintenance or enhancement of quality of life, including treating residents with dignity and respect in full recognition of the resident's individuality. Under this document, a resident has the right to self-determination and participation including the right to choose activities, schedules, and health care, and making choices about aspects of his or her own life in the Care Center that are significant to the resident.

The offense as described by Brown, clearly constitutes serious misconduct against Mr. K: "push[ing]"; "squeezing his fingers"; "twisting his hand". Brown characterized the Grievant as "hurting" him and stated that the resident said, "Ouch. Stop, that hurts." Those actions violate the Care Center Employee Handbook, the Resident Abuse Prevention Plan and the Care Center's combined federal and state residents' Bill of Rights.

In addition to the pushing, squeezing and twisting, the Grievant's efforts to get Mr. K. to sit or lay down on his bed, demonstrates a failure to offer a choice, a restriction of freedom, and a lack of respect towards Mr. K., when there was no plan for him to take a nap or be in bed. McGee testified as to the lack of such provision in Mr. K.'s care plan and stated that if it were routine and warranted, it would be noted in the care plan.

Such misconduct is so serious and at the heart of care for vulnerable adults that it requires summary discharge as opposed to corrective discipline.

Due Process

Discharge by management has been reversed where the action was found to violate the basic notions of fairness or due process. Inherent in the notion of fairness and due process is the requirement that the employee be given the opportunity to present her side of the story before being discharged. The Grievant was asked to write her side of the story and did so, not once, but twice.

In addition, the Agreement provides in Article 15.9 that, "if the Employer feels there is just cause for discharge, the employee shall be notified , in writing, that the employee is to be discharged and shall be furnished with the reason(s) therefore and the effective date of discharge ." The Agreement also provides that the employee may request further explanation and is entitled union representation. No procedure failure was raised by the Grievant or her Union. Due process has been afforded the Grievant.

Past Record

It is uncontroverted that Grievant has no record of prior discipline during her employment with the Care Center. That is noted and was considered. If the misconduct had been of a less serious nature, the past record would have resulted in a reduction of the penalty.

Length of Service

Similarly, the Grievant's length of service with the Employer is long. She has been employed since 2000. Employees with such experience and service are prized by employers. Once again, if the misconduct were less serious, the Grievant's loyal and long service with the Care Center would mitigate in favor of a reduction. That is not the case here.

Knowledge of the Rules

Similarly, the Grievant's training on the Care Center Employee Handbook, the Resident Abuse Prohibition Plan, and The Combined Federal and State Residents' Bill of Rights is uncontroverted. An annual retraining was attended by the Grievant only days before the incident in question. This arbitrator finds the training as described in the hearing constitutes knowledge of the rules.

Warning

No warning was given the Grievant and none was required with this degree of seriousness of misconduct. The Care Center's Employee Handbook provides for

immediate dismissal for serious misconduct. The Grievant was given a copy of this handbook when she started employment and was trained on this annually.

Equal Treatment of Other Employees

The Employer presented evidence of three other discharges which, although not identical, were similar. All three involved abuse of residents and at least one appears to be the first violation by an employee. The Union offered no instances of abuse that were treated more leniently. The Employer appears to treat abuse very seriously and is even-handedly strict.

Award

The grievance is denied.

Carol Berg O'Toole

October 16, 2009