



by discharging the grievant, Kelly M. Skelly. The last of post-hearing briefs was received by the arbitrator on September 17, 2009.

FACTS

The Employer operates a full-service hospital (the "Hospital") in Grand Rapids, a north-central Minnesota city. The Union is the collective bargaining representative of the Registered Nurses employed by the Employer. The grievant was hired by the Employer on April 25, 2005. She worked for the Employer as a Registered Nurse (sometimes hereafter, merely "Nurse") until she was discharged from her employment on March 10, 2009.

The grievant has been licensed by the State of Minnesota as a Registered Nurse since 1995. From then until 2005, she worked for the Deer River Healthcare Center, a hospital, first as a staff Nurse, then as a Charge Nurse, then as Outpatient Director and then as Director of Nursing.

The events that led to the grievant's discharge occurred on February 11, 2009. In the months preceding that date, the grievant's assignment was to work in the Hospital's Emergency Room (sometimes hereafter, merely "ER"\*) where patients come, often by ambulance, to receive emergency treatment. The ER is

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\* I note that the terms, "Emergency Room" and "Emergency Department," with their abbreviations, "ER" and "ED," were used in the testimony of witnesses and in documents as interchangeable. For consistency, I use "Emergency Room" or "ER" in this Decision.

usually staffed each day by a total of five Nurses -- two who work the day shift, from 7:00 a.m. till 7:00 p.m., two who work the night shift, from 7:00 p.m. till 7:00 a.m., and one who works the swing shift, from 3:00 p.m. till 11:00 p.m. The ER is also staffed at all times by an ER Physician and, usually by a Unit Coordinator -- a clerical position, responsible for telephone answering and non-medical record keeping.

Though the parties refer to this part of the Hospital as the "Emergency Room," its area is divided into several separate rooms -- a reception area where patients come first, a small room off the reception area referred to as the "triage room," where patients are evaluated by one of the Nurses to determine the acuity of their condition, and several small numbered rooms or "bays" where patients are diagnosed and receive treatment. These numbered rooms surround a large open area that accommodates the Nurses' station. There, the Nurses can record medical information in medical charts for each patient, and they can observe monitors that track electronically the vital signs of the patient in each room. Just off the Nurses' station is an alcove used by the ER Physician to dictate information for recording in his or her charts.

The events that led to the grievant's discharge occurred during the evening of February 11, 2009. At 7:00 p.m., the grievant and Randolph Sweet began their twelve-hour shifts as the night shift Nurses, joining the swing shift Nurse, Kelly Poquette, who had begun her shift at 3:00 p.m. Thomas J. Viren, an ER Physician, began his shift at 8:00 p.m. When the grievant

started her shift at 7:00 p.m., a Unit Coordinator was also working, but became ill and left just before 8:00 p.m. Of these personnel, Viren and the grievant testified at the hearing, but Sweet, Poquette and the Unit Coordinator did not.

Diane S. Grahek testified that she worked from 3:00 p.m. till 11:00 p.m. as the Hospital's House Supervisor. As she described that position, the House Supervisor has responsibilities throughout the Hospital during "off hours," i.e., during hours other than 7:00 a.m. through 3:00 p.m. Grahek is a Registered Nurse by training. Robin Argir, also a Registered Nurse, was the House Supervisor assigned to the next shift, the one that began at 11:00 p.m. on February 11 and ended eight hours later at 7:00 a.m. on February 12. Argir did not testify.

The Employer's primary witness was Pamela M. Boswell, Director of Nursing Services for the Intensive Care Unit ("ICU") and the Emergency Room. She was not present during the events that led to the grievant's discharge, but she conducted the Employer's investigation of those events.

The following is a summary of the evidence relating to the events that led to the grievant's discharge. The grievant testified that she was not feeling well when she came to work on the evening of February 11; she had diarrhea and felt nauseated. She had worked the twelve-hour shift the night before and did not sleep well between shifts. At the start of the February 11 shift, she and the other two Nurses, Sweet and Poquette, decided that the grievant would start the shift as the Triage Nurse -- the Nurse who, when the triage alarm buzzer is sounded, goes to

the triage room to evaluate entering patients for the acuity of their condition. The grievant testified that the ER was very busy that evening and that just before 8:00 p.m., the Unit Coordinator became ill and left. The grievant then assumed the duties of the Unit Coordinator and began answering incoming ER telephone calls. At about 8:10 p.m., the grievant asked Grahek to find a replacement for the Unit Coordinator.

At about 9:00 p.m., an ambulance Paramedic called by radio with the message that he would arrive at the ER in about ten minutes with an elderly, combative male patient. The grievant asked Sweet and Poquette if they could take this incoming patient, but they said they could not, and the grievant agreed to care for him. The grievant asked Grahek if she could triage other entering patients while the grievant cared for the new patient about to arrive by ambulance. Grahek said she would be busy transferring a patient whom Sweet was caring for from the ER to the ICU, but Sweet said that that patient was not ready for transfer. The grievant testified that Grahek then agreed to act as the Triage Nurse after the arrival of the new patient by ambulance.

A few minutes later, the ambulance arrived with the new patient, and the grievant placed him in Room 903 at about 9:10 p.m. (Hereafter, I sometimes refer to this patient as the "Room 903 patient.") The grievant testified that he was confused and combative, pushing at those around him. As she helped Viren assess his condition, he had a high pulse rate and remained combative. At Viren's orders, she placed the patient on a heart

monitor and attached twelve EKG leads to his body. The EKG machine failed to print properly, and Sweet came to Room 903 and helped her adjust the EKG machine so that it would print.

The grievant testified that, after the Room 903 patient was given sedative medication intravenously, he settled down and began to sleep. She and Viren stayed in Room 903 with him until then -- about twenty to thirty minutes after his arrival. She thought the patient required "one-on-one" care until he settled down. The grievant testified that, during the twenty to thirty minutes she was with the Room 903 patient, the triage alarm buzzer sounded persistently with no one answering it. At about 9:40 p.m., when she thought it safe to leave the Room 903 patient, she went to the Nurses' station to begin charting, and as she did so, she saw Poquette going to the triage room to respond to the alarm.

At the Nurses' station, the grievant began to enter information about the Room 903 patient in his chart. While doing so, she could observe him through the open doorway to Room 903, and she could observe his vital signs on the monitor for that room. The grievant testified that, just after 9:40 p.m., as she was charting, Grahek came down a hallway into the ER and walked by the grievant and that, as Grahek walked by, the grievant said to her, "Diane, if you say you are going to triage and leave, you've got to let me know." According to the grievant, Grahek responded that she was very busy, and the grievant repeated what she had said -- that Grahek should let her know if she was going to leave the ER and not be available

to triage. The grievant testified that Grahek then left the area without answering. The grievant also testified that she "felt bad" because she had been abrupt during this conversation and had spoken to Grahek in a "raised voice," though the grievant denied that she had been yelling.

A few minutes later, Poquette returned to the Nurses' station from the triage room, and Grahek returned and passed by the grievant as she was charting at the Nurses' station. The grievant testified that she said to Grahek, "can we talk?" Grahek responded, "no, I don't have time; we can talk later."

The grievant testified that just after 10:00 p.m., she was at the Nurses' station with Poquette and Sweet and that Viren was in the ER Physician's alcove, dictating information for his charts. According to the grievant, Viren and the three Nurses had a discussion about what was apparently faulty equipment that caused the monitor for the Room 903 patient to show an erroneous pulse rate. The grievant testified that she then told Poquette about the Room 903 patient, describing his symptoms and giving her opinion about his condition; she said she would be interested in seeing his "lab work when it came back."

The grievant testified that, about five minutes after this discussion, Grahek returned to the Nurses' station and said to the grievant, "you don't have any right to speak to me in that tone," referring to the earlier exchange between them when, according to the grievant, she said to Grahek abruptly and in a raised voice, "Diane, if you say you are going to

triage and leave, you've got to let me know." The grievant began to respond to Grahek, but Viren came out of the dictation alcove and said, "that's enough; take it some place else," and Grahek left.

The grievant also testified as follows. After Grahek left the ER, she felt embarrassed about her behavior; she felt "very bad," and her stomach was upset. She told Poquette and Sweet, who were still at the Nurses' station, that she felt sick and was going home. She told them she was going to call Grahek and tell her. She called Grahek and said she was ill and was going home, and Grahek responded, "if you have to, go ahead." The grievant had finished her charting. The condition of the Room 903 patient had not changed; he was resting comfortably and was no longer in a "one-on-one" condition. Poquette and Sweet walked with her down to the break room and the rest room.

The grievant testified that Poquette and Sweet were fully aware that she was leaving and that she would no longer be there to care for the Room 903 patient. She assumed they knew they would be caring for him after she left. She thought that they had a detailed description of the patient's condition from her conversation with Poquette about ten or fifteen minutes earlier and that, if they had any questions, they would ask them of her as she was leaving. Neither of them asked any questions about the Room 903 patient after she said she was ill and going home, either at the Nurses' station or as the three of them walked to the break room. The grievant testified that, before she left, she went to the rest room, retrieved her purse from

her locker in the break room, put her coat on, punched out at 10:30 p.m. and drove home. The grievant testified that she found out later that the assessment of the patient's condition that she had given Poquette was correct. Within ten minutes after the grievant called Grahek to say she was leaving, Sweet called Argir, who was about to begin her shift, and told her that the grievant had left without reporting off with respect to the Room 903 patient.

The grievant worked the next night shift, the one that began at 7:00 p.m on February 12 and ended at 7:00 a.m. on February 13. Toward the end of that shift, at about 6:45 a.m., Boswell asked to talk to her. The grievant testified that Boswell did not tell her she was conducting a disciplinary investigation. Boswell asked the grievant to describe what had happened on the evening of February 11. The grievant told Boswell that she did not mean to be disrespectful and angry toward Grahek and that she went home because she was ill. Boswell asked the grievant whether she "shook her finger" at Grahek during their discussion that night, and the grievant replied that she had not. Boswell also asked the grievant if she "gave report" with respect to the Room 903 patient before she left, and the grievant said she had not, but that Poquette and Sweet had enough information about the patient from their earlier discussions. The grievant testified that no one asked her again about the events of February 11 until she attended the meeting where she was given notice of her discharge, on March 10, 2009. On that day, Boswell told her there would be a

meeting about possible discipline and that she should have Union representation at the meeting. The grievant asked Boswell if she could know what the subject of the meeting was and Boswell refused to tell her. At the meeting, Boswell gave her a discharge notice, which is set out hereafter.

Grahek testified as follows. She has been a Registered Nurse for twenty-two years and has held several management positions at other hospitals. She had worked as a House Supervisor at the Employer's Hospital since December of 2008, and previously, for about three months in 2006.

Grahek worked as House Supervisor from 3:00 p.m. till 11:00 p.m. on February 11, 2009. The grievant had called her and had told her she was sick and was leaving. Grahek had not observed any symptoms of illness in the grievant that night, and the grievant had not complained of any to her. Grahek assumed that the grievant would "report off" to Poquette or Sweet before leaving. Grahek made calls to find a Nurse to replace the grievant in the ER, including a call to Boswell asking for her input about a replacement. Grahek testified that she heard later that Sweet had called Argir, the House Supervisor who began work on the 11:00 p.m. shift, to tell her that the grievant had not reported off before leaving. Argir assisted as an ER Nurse until about 1:30 a.m., when Grahek found a replacement for the grievant. Grahek prepared a "variance report" of the incident later that night and eventually furnished it to Boswell for her investigation of the incident.

Grahek's description of her interactions with the grievant is generally consistent with the testimony of the

grievant, except for the following differences. As Grahek described the first exchange between them, when the Room 903 patient was about to arrive, the grievant asked her, "Are you going to help?" Grahek responded that she would after transporting a patient to the ICU. According to Grahek, when she returned, the grievant said to her in an angry, disrespectful voice, "I thought you were triaging; I want you to triage." Grahek testified that she was a supervisor that night and that supervisors do not take on a Registered Nurse's role. She said to the grievant, "I have the whole house to take care of." Viren then came out of the dictating alcove and asked them both to calm down.

According to Grahek, at about 9:45 p.m., she came back through the ER on her way to a meeting of House Supervisors, and the grievant yelled to her, "we have to talk; we have to talk." Grahek responded that she had to go to the meeting. Grahek described the grievant's tone as "quite angry and demanding" that she talk to the grievant immediately. Grahek testified that she assumed that the grievant wanted to talk about their previous altercation. She also testified that she thought the grievant's behavior was inappropriate and that she was not supposed to be the fourth ER Nurse that night with her duties delegated to her by the grievant.

On cross-examination, Grahek testified that she did not recall saying, "you've got to do what you've got to do," when the grievant called to say she was ill and leaving. Grahek denied that she had agreed to triage, but, instead, had agreed to

assist with triage when the grievant asked for help. She is not trained in triage, but has assisted with triage in the past. She did not recall that the grievant asked her to find a replacement for the Unit Coordinator who left just before 8:00 p.m.

Boswell testified that she conducted the investigation that preceded the grievant's discharge. Her first knowledge of the incident came when Grahek called her just after 10:30 p.m., on February 11, as she was looking for a replacement for the grievant. The next morning, Boswell received Grahek's variance report, which Grahek wrote the previous evening in two installments. Below, I set out Grahek's Variance Report, noting that, though it shows that Grahek believed the grievant was caring for more than one patient when she left, all of the other evidence before me shows that she was caring only for one -- the Room 903 patient:

I was helping in the ER by transferring a patient to the ICU when [the grievant] yelled across "Are you going to triage." Kelly, I need to get this patient to the ICU. I returned to the ER to give a hand and [the grievant] stated "When I asked you to triage I want you to triage." I said I will give you a hand when I am finished with this task and I stated that I had the whole house to care for. [The grievant] got upset and her voice got angry & I said it was inappropriate to talk to me at the ER desk in this manner and that I needed to attend to other tasks which we could discuss this in the future. I went back to the Supervisor's office. She called on the phone and said to me that she was sick and she was leaving. She grabbed her purse and left did not report off to the patients she was caring for and left the building. Dr. Viren witnessed the interaction and that [Poquette and Sweet] had to pick up the patients that she walked out on. The ward clerk had gone home earlier.

Boswell's investigation included interviews with the grievant, Grahek, Sweet, Poquette, Viren, Argir and an ICU

Nurse, Wanda Baril. Boswell's notes of her interviews were presented in evidence. As counsel for the Union pointed out, the notes are admissible to show the information Boswell obtained in her investigation, but have no greater reliability than hearsay to support the truth or falsity of that information. Generally, Boswell's notes show that many of those who were interviewed were concerned about the grievant's loud and angry manner, not only during her interaction with Grahek on the evening of February 11, but at other times. Most of them also expressed an opinion that the grievant had not reported off with respect to the Room 903 patient, though some had no direct knowledge of the events and were giving opinions based on what they had heard from Sweet and Poquette.

After discussion with Robert J. Cocker, Vice President of Human Resources, and Tana Casper, Vice President of Patient Care Services, Boswell prepared a Notice of Disciplinary Action, dated March 10, 2009, which discharged the grievant (hereafter, the "Notice of Discharge"). In the following reproduction of the Notice of Discharge, for consistency, I refer to the individuals discussed, using the same manner of reference that I have used above, i.e., simply by using the last name of each individual or by using "the grievant" rather than her name:

The following information was obtained from [the grievant's] peers in ER, House Supervisors and the ER MD on duty February 11th during the 7p-7a shift.

We had received reports that there were several disruptive (voices raised and shaking of fingers) confrontations between [the grievant] and the House Supervisor on duty that ultimately led to [the grievant] calling the House Supervisor stating that she was leaving.

Summary of events for 7p-7a shift on 2-11-09

- Approximately [7:45 p.m.] the ER Unit Coordinator went home sick.
- [The grievant] contacted the House Supervisor for assistance.
- When the House Supervisor, Diane Grahek, arrived, [the grievant] informed her that [Poquette and Sweet] were overwhelmed and not able to take any more patients. [The grievant] gave [Grahek] the choice of triaging patients or taking a critical patient that had many needs. [Grahek] agreed to triage.
- [The grievant] assumed the care of the critical patient. [She] shared that while she was with the patient she could hear the triage buzzer going off repeatedly, and she wondered why it wasn't being answered. She left the patient's room to check on the situation and saw [Poquette] answering the triage light.
- [The grievant's] first encounter with [Grahek], described by peers and MD was loud and angry, was as follows: [the grievant] addressed [Grahek] from across the room, shaking her finger at her, stating, "When I tell you to triage, you need to triage." [Grahek] shared that she would when she was finished transferring a patient to ICU, she also shared she had to check on her other duties. [Grahek] shared with [the grievant] that it was inappropriate for her to talk to her in that manner at the ER desk. [Grahek] declined to have further discussion with [the grievant] at this time.
- After [Grahek] left the unit, [the grievant] shared with a peer, "Why do I always raise my voice?"
- When [Grahek] came back to the unit, [the grievant] again, in a loud voice, asked to talk to her about the situation. A peer unsuccessfully tried to intervene, asking that the conversation not be held at the desk. When voices continued to be raised, the ER MD intervened with the request that the conversation be taken elsewhere, stating that it was not appropriate to be held at the Nurse's station. [The grievant] stopped talking immediately, [Grahek] left the ER.
- [The grievant's] peers witnessed her making a call to [Grahek] and telling her that she was going home sick. [The grievant] then collected her lab jacket, set down her coffee cup in the lounge opened her locker and left.
- Later the MD asked where [the grievant] was, her peer informed him that she had gone home sick. At this point the MD gave report to the remaining staff regarding [the grievant's] patient.
- Misc. points shared by peers and MD:
  - [The grievant] was the aggressor and just wouldn't let it drop.
  - One of [the grievant's] peers shared "Never in my career have I seen anyone act like that. I was

shaken and nervous. It was a very traumatic event." Another peer shared, "I still have a sick feeling in my stomach when I think about it. I have never seen [the grievant] act like this, others report they have."

- It was also stated that [the grievant] communicated her dislike of [Grahek] to [Sweet] and the House Supervisor on the following night.
- During the investigation, [the grievant] shared with [Boswell] that she was very embarrassed that the MD had gotten involved in the situation.

After reviewing the findings the following concerns have been identified:

1. [The grievant] endangered the safety of the patient by abandoning the patient without reporting to the MD or her peers and ensuring the patient's needs would be met.
2. [The grievant] was insubordinate to the House Supervisor, with her intentionally defiant behavior, when [Grahek] had shared that she did not want to talk about the matter; [the grievant] continued to inappropriately press the issue.
3. [The grievant] created a disruptive work situation as evidenced by raised voice and shaking her finger at the House Supervisor.

Due to the seriousness of these findings we are terminating [the grievant's] employment at Grand Itasca Hospital immediately.

The Employer maintains a Policy, entitled, "Confidentiality and Courtesy," relevant parts of which are set out below:

Courtesy/Behavior. Employees are expected to show proper respect and consideration to patients, residents, co-workers, visitors, and physicians. Disrespect is considered to be misconduct. Our organization exists to care for people who are in need. Patients and residents should be treated with respect, compassion, courtesy, patience and good cheer. Patients, visitors and their families are often upset, disabled or in pain, and as a result may be inconsiderate. It is part of our job to reassure them and make their relationship with us a positive experience.

Courtesy and friendliness are also essential in dealing with other employees. We often work together at close quarters and in difficult jobs. Professional behavior is essential in making departments and this facility a pleasant place to work. . . .

The Employer also maintains a Policy, entitled, "'Hand-off' Communication - Transferring Patients." (The parties agree that the terms, "hand off" and "handing off," have the same meaning as the terms, "report off" and "reporting off" -- the terms used by the witnesses in this proceeding.) Some form of this policy has been in place at least since May of 1997; relevant excerpts from its most recent update, which was made in December of 2008, are set out below:

POLICY: Decisions to transfer a patient to another department, service, unit or facility are based on an assessment of the patient's status or needs. A change in the patient's condition, admission or discharge criteria, diagnostic or treatment orders may guide the transfer decision. It is the responsibility of the physician and hospital staff to ensure that patient services flow continuously and care is coordinated among practitioners when a transfer is needed. This is accomplished through the appropriate exchange of patient information and care needs. Communication between care sites must reflect this formal shift of responsibility.

PURPOSE: To ensure coordination of care for the patient who is transferred:

- To any patient area within the hospital.
- To any unit, treatment or clinical service.
- From one practitioner to another, and
- Outside the facility, as in discharge.
- For the purposes of this policy, a hand-off is defined as the provision of verbal and/or written information from one healthcare provider to another so that pertinent care, treatment or service needs as well as the patient's current condition and any recent or anticipated changes are accurately communicated.

RESPONSIBILITIES: Each patient care area and department is expected to communicate and arrange for any patient transfer to include:

- Appropriate actions taken to make transfer smooth,
- Communication of appropriate verbal and written information,
- Defining who takes responsibility for the patient during the transfer process,

- Completion of an initial assessment upon patient arrival from another facility or level of care, and
- Identifying what information is shared in documentation.
- Opportunity for questioning or clarification of patient information as necessary.

Situation

Process and Documentation

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| 4. Shift Reports | Template: worksheet (not part of Medical Record). Must include information about the patient's status, immediate needs, plan of care, and progression of the plan. |
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Boswell testified that several updates of this policy made during 2008 were intended to make the reporting off process more structured. She testified that a form, entitled "Nursing Documentation - Emergency Room," was implemented for use in the ER when Nurses report off from shift to shift. The one-page form has entry points for showing the Nurse to whom the end-of-shift Nurse is reporting off and for summarizing medical information from the patient's chart, with a space for the entry of "nurses notes."

Boswell testified that, when the grievant left the ER on February 11, she should have reported off either to Sweet or to Poquette specifically, so that the one who was to be responsible for the Room 903 patient could ask questions and so that there would be no ambiguity about that responsibility. In addition, Boswell testified that the grievant should have completed the Nursing Documentation form for that patient before leaving.

The Union presented the testimony of Debra M. Nyquist, a physician who is the Hospital's Chief of Critical Care Services. Nyquist testified as follows. She oversees the ICU and the ER "from the physician's side." Reporting off, Nurse to Nurse and

Physician to Physician, is important to the safety of patients so that there is no misunderstanding about who is responsible for a patient's care. During an ER shift, the care of a patient may be routinely passed from Nurse to Nurse, as the flow of work requires, without a formal, documented reporting off -- even for the care of a patient for whom a Nurse has "primary responsibility," as the grievant had for the Room 903 patient. When a patient is being transferred from the ER to another department, Nurses report off with documentation. At the end of a shift, a Nurse who has cared for a patient, but without primary responsibility, does "not necessarily" report off to another Nurse with respect to that patient. At the end of a shift, a Nurse with primary responsibility for a patient should report off to another Nurse, transferring responsibility. Nyquist testified that she would like to see the grievant returned to her employment.

Article 60 of the parties' labor agreement, which is entitled, "Discipline, Suspension And Discharge," is set out below:

The Employer shall not discipline, suspend or discharge any nurse without just cause and unless progressive discipline steps have been followed. The steps include a first warning, a second warning, unpaid suspension, and discharge. All warnings, suspensions and discharges shall be in writing and the Employer shall provide copies to the affected nurse, the affected nurse's personnel file, and the Association within seventy-two (72) hours of issuing the warning, suspension or discharge. The Employer may bypass one or more steps of progressive discipline in cases of gross misconduct or gross negligence. Written warnings which did not lead to a suspension shall become invalid as a basis for further discipline and shall be removed from the personnel file eighteen (18) months after they were issued.

The Employer shall provide notice to a nurse of investigatory or disciplinary meetings and a nurse may request MNA representation for that meeting as a condition to participation in the meeting.

Cocker testified that, though Boswell did the investigation of the events of February 11 and wrote the Notice of Discharge, he and Casper, with Boswell's consultation, made the decision about the level of discipline to administer. I summarize Cocker's testimony as follows. He considered the grievant's conduct to be gross misconduct for which discharge was appropriate, notwithstanding the first two sentences of Article 60 of the labor agreement, which require "progressive discipline" with steps that include a first warning, a second warning and an unpaid suspension, leading to discharge. Cocker noted that the fourth sentence of Article 60 permits the Employer to "bypass one or more steps of progressive discipline in cases of gross misconduct or gross negligence." He thought that the grievant's behavior toward Grahek was discourteous, in violation of the Employer's policy requiring courteous behavior toward co-employees, but he conceded that such conduct was not gross misconduct justifying discharge without progressive discipline.

Cocker testified, however, that he thought that when the grievant left the hospital she did so without reporting off and that her doing so endangered the safety of her patient. He considered her actions to be "patient abandonment" within the definition of that term as given on the website of the Minnesota Board of Nursing, the agency of the State of Minnesota that licenses Registered Nurses. The Employer presented in evidence a printout of a page from that website, parts of which are set out below:

The Nurse Practice Act does not define "patient abandonment," nor is it a specific ground for disciplinary action. Therefore, the behavior which may be considered by an employer as patient abandonment must be interpreted from, rather than defined by, the law. . .

Generally, the Board identifies that patient abandonment results when a nurse has accepted responsibility for assignment within the scheduled work shift, but the nurse does not fulfill that responsibility or transfer it to another qualified person. This failure to fulfill a nursing responsibility may result in unsafe nursing care. Failure to practice with reasonable skill and safety is a ground for disciplinary action by the Board. . .

The minimum standard of care to which the Board holds a nurse accountable requires the nurse to fulfill a patient care assignment or transfer responsibility for that care to another qualified person once a nurse has accepted an assignment. . .

The Board will review situations in which a nurse accepts an assignment and fails to fulfill the assignment or appropriately transfer the assignment. The primary concern for the Board is whether the actions of the nurse compromised patient safety. The following examples may illustrate these points:

1. Facility policy requires a nurse who will be absent from a shift to report the absence two hours before the start of the shift. The nurse calls the facility one hour before the start of her shift and reports she is ill and unable to work. Another nurse is required to work a "double" shift but the usual nurse-patient ratios are achieved.

In this example, the nurse's conduct may be a violation of facility policy and therefore subject to action by the employer. This conduct would not likely be subject to action by the Board. The nurse had not yet accepted a patient care assignment. Even if the Board viewed acceptance of a weekly work schedule as acceptance of a patient care assignment, the nurse made reasonable arrangements to transfer the assignment to another qualified individual and patient safety was not compromised.

2. The nurse is assigned to see a home-bound client on a daily basis. The nurse's responsibilities for this client include preparing insulin for administration by the client's son. The nurse failed to visit the client for a week and fails to request that another nurse visit the client. The client's son takes the client to the emergency department where the client is diagnosed with hyperglycemia and dehydration.

In this example the nurse did not transfer the assignment of care to another nurse and patient safety was compromised. In addition to possible action by the employer, this conduct should be reported to the Board for possible disciplinary action. . . .

Cocker testified that, when deciding on the level of discipline to impose, he and Casper were aware 1) that the grievant had not been disciplined before her discharge, 2) that she had received a non-disciplinary coaching relating to sick leave usage in the summer of 2008 and 3) that a performance review done by Boswell, also in the summer of 2008, criticized her for her discourteous manner toward co-employees when she was under stress. Nevertheless, Cocker testified that he thought that the grievant had left the Hospital without reporting off to Sweet or Poquette and that he considered her conduct to be "patient abandonment," as described on the Board of Nursing website. He thought her conduct was similar to that discussed in the second example from the Board of Nursing website, as set out above.

#### DECISION

Just Cause and Progressive Discipline. In the following discussion, I give a fair summary of substantive "just cause" as defined in American labor law. The essence of the employment bargain between an employer and an employee (or a union representing an employee) is that the employer agrees to provide the employee with pay and other benefits in exchange for the agreement of the employee to provide labor in furtherance of the employer's enterprise. When the employer and the employee (or a representing union) have also agreed that the employer may not terminate the employment bargain except for "just cause," they

intend that discharge will not occur unless the employee fails to abide by his or her bargain to provide labor in a manner that furthers the employer's enterprise.

The following two-part test of "just cause," derives from that intention:

An employer has just cause to discharge an employee whose conduct -- either misconduct or a failure of work performance -- has a significant adverse effect upon the enterprise of the employer, if the employer cannot change the conduct complained of by a reasonable effort to train or correct with lesser discipline.

Under this two-part test, an employer must establish 1) that the conduct complained of has a serious adverse effect on the employer's operations and 2) that the employer has attempted to prevent repetition of the conduct by training and corrective discipline, thus seeking to eliminate any future adverse effect from the conduct before taking the final step of discharge.

Nevertheless, some conduct is so obviously prohibited that neither a rule nor a warning against it is needed to inform the employee of the prohibition. Thus, no rule or previous warning is required to inform an employee that he or she may be discharged for theft, for fraud or for attacking a supervisor. Because such conduct violates an implied prohibition, an employee may be discharged for it, regardless whether an express rule has been issued prohibiting the conduct.

The application of the first part of this test requires a determination whether particular conduct is significantly adverse to the enterprise. Some conduct may create such a threat to the enterprise that discharge should be immediate and

need not be preceded by an attempt to change the conduct by training or progressive discipline, as required under the second part of the test. Such serious misconduct may be so adverse to an employer that the employer should not be required to risk its repetition. For example, an employer should not be required to use training and corrective lesser discipline in an effort to eliminate the chance of repetition for most thefts, for drug use in circumstances that threaten the safety of others or for insubordination so extreme that it undermines the employer's ability to manage its operations.

Some misconduct or poor performance is only a slight hindrance to good operations. For example, a single instance of tardiness will not have a significant adverse effect on the operations of most employers. Conduct, however, that is only slightly adverse when it is infrequent, may have a significant adverse effect on operations if it occurs often. Thus, tardiness and absence that become chronic will usually cause a serious disruption to operations, and, if progressive discipline does not eliminate such poor attendance, it will accumulate in its adverse effect and constitute just cause for discharge.

Similarly, an isolated instance of poor work performance will not, in most circumstances, have a significant adverse effect on an employer, but poor performance that persists even after a reasonable effort to correct it will undermine the essence of the employment relationship -- that, in exchange for wages and benefits, the employee will provide the employer with satisfactory work in furtherance of the enterprise.

In the present case, the primary issue presented is whether the Employer violated Article 60 of the parties' labor agreement. The first sentence of Article 60 requires that the Employer have just cause for the discharge of an employee and that the Employer use progressive discipline before discharge. The fourth sentence, however, provides that the Employer "may bypass one or more steps of progressive discipline in cases of gross misconduct . . . ." Thus, these two sentences expressly state what is implicit in the simple requirement that appears in most labor agreements -- that an employer must have just cause to discharge an employee.

The Employer argues that the grievant's conduct toward Grahek on the evening of February 11 violated its policy requiring courtesy in relations with co-employees. The Employer concedes, however, that the grievant's behavior toward Grahek was not "gross misconduct" that would justify bypassing the article's progressive discipline requirement.

Nevertheless, the Employer argues that, when the grievant left the Hospital in mid-shift that evening, she failed in her duty to report off by properly transferring the care of the Room 903 patient specifically either to Sweet in particular or to Poquette in particular. The Employer argues that the grievant's departure without a such a specific transfer of care endangered the safety of the patient because she left without resolving any ambiguity about who was responsible for the patient's care.

The Employer argues that this failure to report off properly was "patient abandonment" within the definition of that

term as given by the Board of Nursing and that, as such, the grievant's failure to report off was clearly "gross misconduct" within the meaning of Article 60. Therefore, the Employer urges that the discharge of the grievant without prior progressive discipline did not violate Article 60.

The Union makes the following primary argument. The grievant's conduct was neither "patient abandonment" nor a failure to report off. When the grievant left, she made a reasonable assumption that Sweet and Poquette, as the only two Nurses in the ER, would decide which of them would care for the Room 903 patient -- just as such decisions about patient care are routinely made by ER Nurses. That assumption was reasonable because it was based on her knowledge 1) that Sweet and Poquette were aware that she was leaving, 2) that they knew her only patient was the Room 903 patient, 3) that they knew the condition of the Room 903 patient from her discussion with Poquette minutes before she left and from Sweet's earlier presence in Room 903, and 4) that they had access to a written record of the patient's condition in his chart, which she had just updated.

The Union argues that, under these circumstances, when Sweet and Poquette asked the grievant no questions to supplement their knowledge about the patient's condition as they escorted her down the hall to the break room, it was reasonable for her to conclude that they thought they had sufficient information about the Room 903 patient to provide him safe care and that, therefore, it was reasonable for her to conclude that she had complied with reporting off requirements.

I make the following rulings. The evidence shows that the grievant did not fully comply with the Employer's reporting off requirements. She should have stayed until Sweet and Poquette had decided which of them would take over the care of the Room 903 patient, and, when she knew which Nurse would succeed her, she should have discussed the patient's condition with that Nurse, so that she could provide whatever additional information the Nurse wanted. In addition, she should have completed the one-page Nursing Documentation form used to designate the particular Nurse taking over that care. For the following reasons, however, I rule that the grievant's conduct was not gross misconduct that justified the Employer in bypassing all steps of progressive discipline.

I understand that failure to report off and patient abandonment are not exactly synonymous, though both concepts describe a deficiency in the process of transferring the care of a patient. Indeed, Cocker's testimony made the analogy between the two concepts in his characterization of the grievant's conduct as patient abandonment. I agree that the two concepts are similar -- sufficiently so to make the following analysis useful.

The page from the Board of Nursing website that describes patient abandonment (which I have set out above) states that patient abandonment has not occurred if a nurse makes "reasonable arrangements to transfer the assignment" of a patient's care "to another qualified individual and patient safety was not compromised." This statement appears in the

Board's discussion of its first example, in which the Board states that calling in sick an hour before the start of a nurse's shift would not be considered patient abandonment by the Board -- even though an employer may decide to impose discipline for a possible work-rule violation.

The discussion on the Board of Nursing website shows that the decision whether patient abandonment has occurred requires a judgment whether, in the circumstances of the case at issue, a nurse has made reasonable arrangements for the transfer of care. As I interpret the discussion, the Board is indicating that the circumstances of each case must be considered in deciding if, and to what degree, a transfer of care is reasonable.

in the present case, the grievant concluded that, in the circumstances, she had made reasonable arrangements for the transfer of care of the Room 903 patient to Sweet and Poquette and that they would accomplish that transfer by deciding which of them would take over his care. As I have found above, she did not fully comply with the Employer's reporting off requirements, but she thought she had made reasonable arrangements for transferring his care in such a way that his safety would not be compromised -- as, in the event, it was not.

Cocker testified that he thought the grievant's conduct was similar to the conduct described in the second example from the Board's website, in which a nurse accepts an assignment to make daily visits to a patient to prepare insulin for injection by the patient's son, but then fails to make the visits for a

week and fails to request that another nurse make the visits, with the result that the patient required emergency treatment for hyperglycemia and dehydration. The Board's discussion of this example states that, because the nurse did not transfer care to another nurse and patient safety was compromised, this conduct should be reported to the Board for possible disciplinary action.

I reach the following conclusion. Clearly, the grievant's conduct was far less egregious than the conduct of the nurse in the Board's second example. The grievant's conduct was based upon her misjudgment about the degree to which strict compliance with reporting off requirements was necessary in the circumstances. Her conduct, based on a misjudgment, was the proper subject of corrective discipline, but it was not gross misconduct -- the kind so serious that, without her discharge, the Employer's operations would be subject to substantial risk by its repetition.

Accordingly, the award reinstates the grievant to her employment without loss of seniority. The discipline is reduced to a five-day suspension for her discourteous conduct toward Grahek and a thirty-day suspension for her failure to fully comply with reporting off requirements.

I note that the Union has also argued that the Employer did not comply with the last paragraph of Article 60, which I repeat:

The Employer shall provide notice to a nurse of investigatory or disciplinary meetings and a nurse may request MNA representation for that meeting as a condition to participation in the meeting.

The Union argues that Boswell's one interview of the grievant on the morning of February 13 was an "investigatory or disciplinary" meeting that triggered the requirement that Boswell notify the grievant of its disciplinary purpose, thus allowing the grievant to request Union representation. The Union also argues that, if the grievant had been given such notice, a Union representative could have requested a more thorough investigation, with responses from the grievant to the allegations made by witnesses Boswell interviewed after her interview of the grievant.

The Employer argues that, even without an express notice by Boswell to the grievant, the purpose of the February 13 meeting should have been apparent to the grievant and that, therefore, there was a de facto compliance with the notice provision.

I make the following ruling. Boswell should have informed the grievant that her February 13 interview had a potential disciplinary purpose. It appears, however, that any adverse effect on the grievant from the lack of notice was obviated by the full evidentiary hearing she received before me, with the resulting reinstatement and adjustment in discipline that results from the award.

#### AWARD

The grievance is sustained in part. The Employer shall reinstate the grievant, reducing her discipline to a thirty-five calendar day suspension without pay. The Employer shall restore the grievant's seniority in full and provide her with back pay

and benefits except for the following amounts. The Employer's obligation to provide the grievant with back pay and benefits shall be reduced by what she would have earned from the Employer during the period of suspension, assuming that it began on the date she was discharged, March 10, 2009. In addition, the Employer's obligation to provide her with back pay and benefits shall be reduced by what the grievant earned or should have earned in compliance with her duty to mitigate damages.

I retain jurisdiction to resolve any disputes the parties may have concerning the amount of back pay and benefits.

November 16, 2009

  
Thomas P. Gallagher, Arbitrator