BEFORE THE ARBITRATOR

In the Matter of the Arbitration of a Dispute Between SHEBOYGAN FEDERATION OF NURSES & HEALTH PROFESSIONALS, LOCAL 5011, AFT, AFL-CIO and SHEBOYGAN COUNTY	Grievance of William H. Westphal regarding a one-day suspension Case 144 No. 46007 MA-6842

Appearances:

Ms. Carol A. Beckerleg, Field Representative, 7700 West Bluemound Road, Milwaukee, WI 53213, appearing on behalf of the Union.

Ms. Louella Conway, Personnel Director, Sheboygan County Courthouse, 615 North 6th Street, Sheboygan, WI 53081.

ARBITRATION AWARD

The Wisconsin Employment Relations Commission designated the undersigned Arbitrator to hear and determine a dispute concerning the above-noted grievance under the grievance arbitration provisions of the parties' 1990-91 collective bargaining agreement (herein Agreement).

The parties presented their evidence and preliminary arguments to the Arbitrator at a hearing held at the Sheboygan County Courthouse, Sheboygan, Wisconsin, on October 21, 1991. The hearing was not transcribed, but the parties agreed to permit the Arbitrator to make an audio cassette tape recording of the hearing exclusively for his own use in award preparation. Post-hearing briefing was completed on November 21, 1991, marking the close of the record.

STIPULATED ISSUES

At the hearing, the parties authorized the Arbitrator to decide the following issues:

1. Was the Grievant disciplined for just cause?

2. If not, what shall the remedy be?

BACKGROUND

The County operates three health care facilities, including Sunny Ridge, a skilled care facility for elderly residents. Grievant has been employed by the County as a Registered Nurse (RN) at Sunny Ridge since his initial hire on April 24, 1989.

On November 20, 1990, Grievant and a Nurse's Aide (NA) were assisting resident #2899 in that resident's infirmary room. Specifically, Grievant was attempting to examine a duoderm dressing which had been applied to the coccygeal region of the resident's lower back. By all accounts, the Director of Nursing (DON), Lu Ann Lonergan, knocked on the door, entered the room and observed Grievant and an NA assisting the resident to stand so that Grievant could check the dressing, left the room for about a minute, returned and observed the resident in the same situation with no gait belt in use or in the room. A few minutes later Lonergan called Grievant aside and told him he had violated the facility's gait belt policy and issued him a one day suspension without pay. The same penalty was imposed on the NA involved.

The suspension notice issued to Grievant specified the offense as follows:

> On 11-20-90 at 1010, Bill was assisting a Nursing Assistant in lifting Resident #2899 in the 3S Infirmary Room # 333. Bill did not have a gait belt on the resident.
>
> This 1-day suspension is given for nonuse of gait belt which is a safety violation. Further incidents of violation of safety rules will result in additional disciplinary action. . . .

As Lonergan described the incident in her testimony, the resident was standing in front of her wheelchair with her feet on the floor and with each of the employes holding one of her upper arms in such a way that the resident was hunched forward with her elbows in a raised position.

According to Grievant, the resident had been sitting in a wheelchair wearing a vest restraint. The wheelchair was in a locked position with foot rests up and the resident's feet flat on the floor. Grievant explained to the resident that he was going to check the dressing while the NA untied the restraint. During the course of the explanation, the resident became agitated, insisted that she could stand alone and didn't need any help, and began to raise herself out of the wheelchair, with both feet on the floor and with both hands on the wheelchair. Concluding that it would have been more dangerous to attempt to put a gait belt on the resident in these circumstances, Grievant chose instead to hold onto the resident's arm with one hand while the NA held onto the other arm. Grievant completed the examination of the dressing and, with the assistance of the NA, helped the resident sit back down in her wheelchair. According to Grievant, the resident was never held in a hunched forward position with elbows raised, and the resident raised herself out of the chair and was not lifted out of it by Grievant or the NA. Grievant testified

that, as was his custom, he had his gait belt on his rolling cart which he left outside the room involved. Grievant also testified that he did not routinely keep his gait belt available for immediate use by wearing it on his person, and that he had never been disciplined or cautioned about not doing so.

Grievant also testified that his orientation did not include the information contained in the NA orientation manual, but rather only that contained in the RN/LPN orientation manual. Accordingly, he states that he was only aware of the Nursing Service Procedure (NSP) Manual language which calls for gait belts to be used (i.e., tied around the resident's waist and grasped by staff where it crosses the middle of the resident's back) for all pivot transfers and assisted ambulation and which makes no reference to an automatic one day suspension. Grievant further testified that he did not consider it to be a pivot transfer or a transfer of any kind to support a resident who has stood up and to assist that resident to sit back down in the same wheelchair.

Additional testimony and documentary evidence was adduced regarding whether Grievant and other RNs had been fairly put on notice of the gait belt policy as it was being applied to him in this case. Other evidence was presented concerning the degree of uniformity of Management's application of that policy. The evidence on those subjects is referred to in the summaries of the parties positions and in the discussion, below.

POSITION OF THE EMPLOYER

Management's legal responsibilities for providing safe and high quality patient care show beyond question that it has the right to establish and enforce its gait belt policy both as the policy is written in the NA orientation book and as the procedure for use of the gait belt is carried forward in the NSP Manual.

Grievant's failure to cause a gait belt to be used in connection with his and a Nurse's Aide's assistance of resident #2899 violated the facility's clearly written and uniformly applied gait belt policy and procedure. The policy and the gait belt procedure, by their terms, were applicable to the situation in question. Neither authorizes Grievant to use professional judgment about whether or not to follow their requirements. The policy as written in the NA orientation book includes both a statement, "Any time you touch a resident to assist them you must put the gait belt on the resident" and a further notification that "If you don't the discipline is a one day suspension without pay." The evidence establishes that Grievant acknowledged that he had reviewed those materials during his orientation as a new hire. The numerous one-day suspensions issued by Management for gait belt nonuse since 1987 might well also have provided Grievant additional notice of the disciplinary penalty he could expect for violating that policy. In any event, those suspensions show that Management has been consistent in the discipline imposed for such violations.

For those reasons the Arbitrator should conclude that Management had just cause for

imposing the one day suspension as it did in this case.

POSITION OF THE UNION

Management did not have just cause for imposing a one-day suspension or any discipline in the circumstances of this case.

The NSP Manual routinely used by RN and NA staff only makes reference to use of gait belt in relation to ambulating and transferring the patient. Grievant cannot fairly be said to have either been ambulating nor transferring the resident in question, making those policies inapplicable to the situation altogether.

In any event, the resident in this case was agitated, confused and resistant. When the resident began to stand on her own, Grievant made a reasonable professional judgment that it would have been more dangerous to attempt to put a gait belt on the already standing resident than to support the resident with her hand as he did. The patient suffered no harm as a consequence of the nonuse of a gait belt. Because RNs are expected to use independent professional judgment in their work, Management ought not be permitted to second-guess the reasonable, good faith professional judgment made by Grievant for the good of the resident in these circumstances.

Grievant and several other RNs testified that they were unaware of a policy calling for imposition of a one-day suspension for gait belt nonuse. The evidence shows that Grievant's orientation and that of at least some other RNs only included reading the RN/LPN orientation book, and not the NA orientation book. Since it was only the latter that contained a reference to a one day suspension for gait belt nonuse, Grievant had no notice that a one day suspension was applicable to a first gait belt violation.

Management cannot claim consistent application of one-day suspensions for gait belt violations because shortly after the instant case, staff at another County facility covered by the instant Agreement were notified that one-day suspensions would be imposed for gait belt violations after a preliminary period during which verbal "reminders" rather than one day suspensions would be issued for such violations.

Accordingly, the suspension should be removed from Grievant's record and the County should be ordered to make him whole for the loss he experienced because of it.

DISCUSSION

Grievant's signatures in April of 1989 on the two-page orientation checklist (Exhibit 7b) satisfies the Arbitrator that the gait belt policy as set forth in the NA orientation manual was among the materials he acknowledged reviewing during his orientation as a new hire. That Exhibit bears check marks corresponding to manual segments (including "gait belt") in an order consistent only with the NA manual and not with the RN/LPN orientation manual. Moreover, during the same April, 1989 time frame, Grievant signed a separate checklist of the orientation materials given only to new RNs/LPNs but not to new NAs. He also signed a form acknowledging that he had been issued, among other things, a gait belt. Accordingly, the Arbitrator finds that Grievant was oriented as follows:

> Gait Belts
>
> Each staff is given their own gait belt.
> Put your name on it in case it is misplaced.
> To assure maximum safety for residents, and staff during transfers and ambulation, and pivots.
> Gait belts must be used for all pivot transfers, and assisted ambulations.
> This includes to and from tub lift, to and from bed, to and from chair and vice versa, commodes, toilets, etc. Any time you touch a resident to assist them you must put the gait belt on the resident.
> If you don't the discipline is a one day suspension without pay.
> This goes into your personnel file.
> Demonstration in classroom and on unit.

With regard to the incident in question, the Arbitrator finds that Grievant was touching a patient to assist the patient out of and back into the same wheelchair. His failure to use a gait belt for that purpose violated the terms of the policy set forth above. The undisputed absence of a gait belt in the room casts doubt on the notions that the NA and Grievant had intended to utilize a gait belt during the examination of the dressing and that they would have done so but for the particular responses of resident involved. Moreover, the policy makes no exceptions for patients who resist or prefer not to have a gait belt utilized for their protection. While RNs no doubt make numerous professional judgments during their work days, the clear and longstanding policy of Sunny Ridge Management has been to require use of the gait belt by NAs as well as RNs, without exceptions being made for resisting residents. The Union presented no evidence of any instance in which Sunny Ridge Management has condoned RN failures to use a gait belt or condoned failure of any direct care staff to use a gait belt on a resisting resident.

The Union correctly points out that the "Gait Belt" procedure as set forth in the NSP Manual, which is much more readily available to nursing service personnel on their respective units than the books used to orient new employes, states,

DISCUSSION (cont'd)

> Gait belts must be used for all pivot transfers and assisted ambulation. This includes transfers to and from lift chairs, commodes, toilets, etc. Staff are to wear gait belts around waist when not in use.

However, the Arbitrator is satisfied that the language of that procedure applies to assisting a resident to get up out of and get back down into a stationary wheelchair, just as it would apply to assisting a fallen patient off the floor to a standing position, even though neither of those situations are specifically listed in the "This includes . . ." sentence. That procedure is clearly marked in the NSP Manual as applicable not only to NAs, but also to RNs and LPNs. Furthermore, upon consideration of Grievant's testimony and the record as a whole, the Arbitrator is not persuaded that Grievant's nonuse of the gait belt was based on a good faith belief that the gait belt requirement as written in the NSP Manual did not extend to the sort of assistance he provided to the resident in question.

Management issued to Grievant the same one-day suspension penalty for a gait belt policy violation in Grievant's case that its orientation materials, above, specify and that it imposed on the NA involved in this case and that it has imposed in the numerous other instances of gait belt nonuse violations occurring during the past several years. The fact that Management in another of the County's health care facilities saw fit to notify its employes that gait belt violations would be met with only reminders until after a specified date certain does not alter the evidence of Management's consistent pattern of one-day suspensions in response to gait belt policy nonuse at Sunny Ridge. The fact that all of those other instances involved NAs rather than RNs does not detract from the consistency of Management's application of the one-day suspension policy, above, because there is no evidence that Sunny Ridge Management has condoned gait belt violations by any other Sunny Ridge RN.

Management's legal obligations to provide safe, quality care to its residents constitutes a sufficient justification for Management's decision to establish the gait belt policy as written in the NA orientation manual and procedure as written in the NSP Manual and to uniformly impose a one-day suspension for the first violation.

For the foregoing reasons, the Arbitrator is satisfied that Management had just cause of imposing the one day suspension in this case.

DECISION AND AWARD

For the foregoing reasons and based on the record as a whole it is the DECISION AND AWARD of the undersigned Arbitrator on the STIPULATED ISSUES noted above that:

DISCUSSION (cont'd)

1. The Grievant was disciplined for just cause.

2. The subject grievance challenging the one day suspension issued to Grievant is denied. No consideration of a remedy is necessary or appropriate.

Dated at Shorewood, Wisconsin
this 7th day of May, 1992 by Marshall L. Gratz /s/
Marshall L. Gratz, Arbitrator