BEFORE THE ARBITRATOR

In the Matter of the Arbitration of a Dispute Between	
SHEBOYGAN COUNTY INSTITUTIONS EMPLOYEES LOCAL 2427, AFSCME, AFL-CIO	Case 194 No. 48856 MA-7740
and	
SHEBOYGAN COUNTY	

Appearances:

Ms. Helen Isferding, Staff Representative, Wisconsin Council 40, AFSCME, AFL-CIO, 1207 Main Avenue, Sheboygan, Wisconsin 53083, for the Union.

Ms. Louella Conway, Personnel Director, Sheboygan County, Sheboygan County Courthouse, 615 North Sixth Street, Sheboygan, Wisconsin 53081, for the County.

ARBITRATION AWARD

Sheboygan County Institutions Employees Local 2427 ("the Union") and Sheboygan County ("the County") are parties to a collective bargaining agreement which provides for final and binding arbitration of disputes arising thereunder. The Union made a request, in which the County concurred, that the Wisconsin Employment Relations Commission appoint a member of its staff to hear and decide a grievance over the discharge of a member of the bargaining unit which the Union represents. The Commission designated Stuart Levitan as the impartial arbitrator. Hearing in the matter was held on May 4, 1993; it was not stenographically transcribed. The Union filed written arguments on June 21 and July 12; the County filed written argument on June 16, and, on July 28, waived its right to file a reply brief.

ISSUE

> Did the employer violate Article 3 of the collective bargaining agreement when it discharged Pam Grossheim on December 16, 1992? If so, what is the remedy?

RELEVANT CONTRACTUAL LANGUAGE

ARTICLE 3

MANAGEMENT RIGHTS RESERVED

> Unless otherwise herein provided, the management of the work and the direction of

the work forces, including the right to hire, promote, transfer, demote or suspend, or otherwise discharge for proper cause, and the right to relieve employees from duty because of lack of work or other legitimate reason is vested exclusively in the Employer. If any action taken by the Employer is proven not to be justified, the employe shall receive all wages and benefits due to him/her for such period of time involved in the matter.

Sheboygan County shall have the sole right to contract for any work it chooses and to direct its employes to perform such work wherever located subject only to the restrictions imposed by this Agreement and the Wisconsin Statutes.

. . .

In keeping with the above, the Employer may adopt reasonable rules and amend the rules from time to time, and the Employer and the Union will cooperate in the enforcement thereof.

. . .

OTHER RELEVANT LANGUAGE

PERSONNEL POLICIES -- ARTICLE IX SAFETY

Safety is essential to good resident care, employee welfare and morale, and to good public relations. With this in mind, Administration has established a comprehensive safety program integrated within all departments and all levels of activity. This program is formulated and administered by a committee appointed by administration. The function of this committee is to advise on the elimination of hazards, establish safe procedures and administer the authorized safety program. The committee may investigate and use reasonable means to make the work place safe. The full support of all employees is essential to the effectiveness of this safety program for the control of accidents.

BACKGROUND

The grievant, Pam Grossheim, was employed at the County's

Sunny Ridge Nursing Home from May 17, 1978 until her termination on December 16, 1992, for giving unassisted care to resident 3112.

On January 10, 1992, 1/ Karen Kuhfuss, R.N., Grossheim's supervisor, imposed a one-day suspension to Grossheim and a co-worker for transferring a resident without the use of a gait belt. As explained in the Statement of Incident, "Nursing care plan directives stated to use a gait belt with assistance of two for transfer. Facility gait belt procedures states a gait belt must be used for all pivot transfers and assisted ambulation to assure maximum safety for residents and employees." Under Action Taken, Kuhfuss wrote the grievant "will be issued a one day suspension on 1/15/92 for failure to follow safety procedures. Failure to correct will result in further disciplinary action including a 3 day suspension." It appears on the face of the document that the "future disciplinary action" originally was stated as a five day suspension; the number five is crossed out, and the number 3 is inserted.

On May 20, Kuhfuss imposed a five-day suspension to the grievant for transferring a patient with a Hoyer lift without the assistance of a co-worker. As explained in the Statement of Incident, the grievant stated she "did not use the call light in the resident's room to summon a co-worker to assist with the transfer because 'nobody would probably answered (sic) the light anyway.'" Under Action Taken, Kuhfuss wrote the grievant "will be issued a 5 day suspension ... for poor work performance related to failure to follow safety procedures. Failure to correct will result in further disciplinary action including termination."

On June 17, Kuhfuss issued to the grievant her Performance Appraisal. Of 11 categories, the grievant scored Outstanding in none; Above Average in four (productivity, interpersonal relationships, attendance and punctuality); Satisfactory in three (knowledge, communication and presentation); Some Deficiencies in four (quality, judgment, reliability and ability to work with others) and Unsatisfactory in none. As commentary, Kuhfuss added that the grievant "has had 2 serious violations in the safety procedures in past year. She must follow safety procedures /s exceptions and will be provided education material," and that the grievant has "made several extremely poor decisions jeopardizing resident safety." As Areas for Improvement, Kuhfuss wrote, "(1) Follow safety procedures. Refer all questions and concerns re: resident care directly to unit nurse or supervisor." As a Goal, Kuhfuss wrote, "(1) 100% compliance with facility policies & procedures with special emphasis on safety procedures."

On August 13, under the signature of Director of Nursing Susan McCabe, R.N., but in the same handwriting as the documents

1/ Unless otherwise stated, all dates are in 1992.

which Kuhfuss signed, the County terminated the grievant for allegedly transferring a patient without a gait belt, in violation of the stated procedure requiring a gait belt for all pivot transfers and assisted ambulation. The incident report noted that the grievant denied the allegation. On September 3, the County's Personnel Committee voted to offer the grievant reinstatement under the following provisions: She be reinstated September 21, with no back pay; she be placed in a different unit or wing; and that the agreement would be "considered a 'last chance' agreement meaning that any work safety violations will result in immediate termination." The grievant agreed to the terms of this settlement on September 18, adding the following statement for attachment to the settlement: "I ... am settling this grievance because I can not financially afford to continue in the grievance procedure. I am innocent of the Employer's charge of not using a gait belt on a patient."

Resident 3112, housed on ward 2-South, suffers from progressive dementia, and displays increasing aggression which is manifested in her grabbing and scratching at others. Her patient care sheet, posted on the back of her bathroom door, indicated she was disoriented and withdrawn; had garbled speech and wore glasses; required a wheelchair and a walker; needed complete assistance in her morning and oral cares and in dressing; required certain restraints, and did not wear disposable diapers. As of late July, the patient care sheet bore the notation, "II /c all cares", meaning, "two with all cares", or "two for all cares". Grossheim was transferred to Ward 2 - South upon her reinstatement on September 21.

On October 23, Grossheim submitted an Employee Incident Report detailing an injury she received when resident 3112 clawed her wrists while Grossheim, unassisted, was attempting to wash her back. Grossheim left entirely blank the line asking for witnesses, and checked "yes" as to whether she had followed safety rules. In her Supervisor's Report of Accident, Kuhfuss checked "no" as to whether the incident could have been prevented, adding, "resident behavior has been aggressive & unpredictable. Staff informed to do cares /c II." As to the box for corrective action, Kuhfuss checked, "Not needed."

Early in the morning shift of December 9, Grossheim was passing resident 3112's room when she noticed that the resident had been incontinent of urine, and was atop wet pad and bedsheets. With no assistance, Grossheim went to remove the wet materials. While so doing, resident 3112 grabbed her arm and scratched her, drawing blood. In her Employee Incident Report, Grossheim entered the symbol for the null set on the line asking for witnesses, and circled "Yes", as to whether she had been following safety rules. In her Supervisor's Report of Accident, Kuhfuss checked "No", as to whether the incident could have been prevented, adding, "However, Nursing care plan indicates cares are to be given by II

because of unpredictable behavior." As to Corrective action, Kuhfuss left blank the boxes Not needed/Needed/Taken, adding, "Pending investigation".

On December 16, the County fired Grossheim "due to not following safety procedures." Grossheim grieved, and the matter was brought to arbitration.

Testimony

At hearing witnesses were sequestered, and testified on oath or affirmation. The following is a synopsis of their relevant testimony. Unless otherwise specified, all references to care are for Resident 3112.

Karen Kuhfuss, R.N., the grievant's supervisor, testified that the Patient Care Plan, posted in the patient's room behind the bathroom door, clearly states two caregivers are needed for all cares; that the patient involved has progressive dementia, and is often aggressive (scratching, grabbing); that at the time of the incident, there were three Registered Nurses and 10 Nurse's Aides on duty on this floor, establishing that adequate help was available; that two caregivers are not needed for wheeling the patient (which is not providing care) or feeding in dining room (a Registered Nurse is in close proximity); that this patient has waist restraints at all times; that day baths are given by one attendant, assisted by a specific nurse's aide; that she doesn't recall when this patient changed from day to night baths; that, "two with all cares" means whenever the resident is being cared for, whenever there is any involvement or closeness, and that "this chart says no Nurse's Aide is ever to provide any care by themselves."

Deborah Jones, Assistant Director of Nursing and Nursing Supervisor/Days, testified that it was decided to use two for all cares around the end of July 1992; this was relayed during morning reports; that anytime, anything involved with care giving is undertaken, you need two people; that she cannot recall if grievant was part of discussion on this patient; that there is some discretion on whether two caregivers are needed for transporting via wheelchair; that if an aide has a question, the aide should ask unit nurse.

Virginia Mueller, Staff Nurse, testified that a caregiver needs two for all hands-on care for the activities of daily living; that a caregiver would not need two to wheel in chair, but would need two to give new pillowcase; that any hands-on care needed two people; that she personally was the one who made notation of two for all cares in July 92; that caregivers are supposed to check care plan every day, every way; that as of July, there was not to be any solo bathing; that she does not know why resident 3112 moved to night baths in December.

Frank Ohm, Certified Nurse's Aide, testified that the care plan was posted on back of bathroom door; that this plan indicated two people were needed at all times during cares; that caregivers should always check care plan before care; that he doesn't know of anyone giving care with just one, and that he personally had been disciplined for failure to use proper restraints.

Sue Widder, Certified Nurse's Aide, testified that the care plan meant that anytime the patient was touched, moved or turned, it required two; that she was told about "two for all cares" around the end of July; that other aides "were aware of two for all cares -- it was common knowledge"; that aides are supposed to read care plans every morning, and that to her knowledge, there had always been two aides on days to help with baths.

Sue McCabe, R.N., Director of Nursing, testified that when the report of December incident was made, she was not aware of the October incident, the report of which was not in the grievant's personnel file; that had Kuhfuss raised the October incident with McCabe, McCabe would have terminated Grossheim for that incident; that she reviewed the personnel file, discussed with others before termination decision; that as of October, grievant was aware of last chance agreement; that even without it, next step would have been termination; that safety and care violations could lead to the State issuing citations and fines, but there was no need to report any of these events.

Deb Teghament, Nurse's Aide for two years, and the day bath aide on 2 - South, testified that resident 3112 was on the day bath list; with assistance of another aide, she would transfer her from wheelchair to bath, using safety belt; that the "other aide would leave and I would do her bath"; that afterwards, she would "call for assistance to move and transfer her"; that following Grossheim's termination, resident 3112 was transferred to the PM bath list, a shift where there are three bath aides; that she doesn't know when "two for all cares" was put on care plan; that if saw this on care plan, would have told nurse she couldn't take her; that she always tried to review care plan; that she did review care plan; that if the care plan said two for all cares, it would be a safety violation to give a bath unassisted; that she did bathe solo; that she would not have bathed solo if saw care plan; that she bathed her, solo, 12 times in 3 month period; that during bath, 3112 would be safety belted, with her arms and hands free; that she was not aware if any supervisors observed her giving solo baths.

Carolyn Mueller, LPN, union steward, testified that she had seen 3112 have her face washed and fed by unassisted aides; that when aides were told 3112 was "two people for everything, everything, everything, they acted stunned, they didn't understand"; that she doesn't recall when 3112 needed two for all

cares; that she has a loose interpretation of what that means, in that it was permissible to dress and transfer alone, and to wash her face after a meal.

Pam Grossheim testified that, regarding the October incident, "nobody ever said I broke safety rule"; that she does not remember ever being told about two for all cares for resident 3112, and was not aware of such requirement; that she "followed the care plan the way I interpreted it"; that she absolutely denies guilt of September incident; that for December incident, she wrote "giving AM cares" on incident report "for want of a better term," but in fact was not giving complete cares; that "changing a pad is not complete care"; that she went to change pad because, "I seen she was wet," and presumably had been so for some time. As to resident 3112, "I saw lots of solo care."

Mueller, recalled, testified that there never was a restrictive interpretation on "two for all cares"; that after the grievant was terminated, people asked if it really meant everything; that they were told yes; that "a couple of aides asked what it meant. I told them two with all cares means two with all cares. Cares is cares is cares"; that lying in urine or feces is "normal", not exigent, and requires only normal care; that she absolutely has affirmative recollection of placing "two for all cares" notation on patient care sheet by end of July 1992.

POSITIONS OF THE PARTIES

In support of its position that the grievance should be sustained, the Union asserts and avers as follows:

> The discharge of the grievant was done without cause. Both this aide and others have dealt with this patient alone without discipline. Because the care plan was unclear, the employer did not have just cause. The unclearness of the rule and the inconsistency of how it was interpreted by the grievant and other staff, plus the employer never correcting her on a previous occasion with the same circumstances, makes for an unjust discipline.
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> The grievant did remove a urine soaked pad from under the patient, but did not provide complete morning cares. What she did was a stop gap measure, a caring response to a helpless patient. The patient was calm. The grievant testified that her actions were consistent with past practice.
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> The care plan for this patient was vague and

confusing, and its interpretation in practice has varied. Certain functions have the notation "assists with two," while others do not. The plan states that the patient was not to wear disposable diapers, when in fact she did. The employer's own witnesses differed on the plan's interpretation: Karen Kuhfuss testified it meant "you can not even go into a room alone," while Deb Jones testified it related only to the activities of daily living.

The plan is further complicated by the fact that the orders are undated. The employer dates the reference to "two with all cares" to July or August; yet the grievant was not even on this floor at that time, but transferred there only on September 18 -- long after the plan was written and long after changes were announced to floor aides. The grievant of necessity learned about the practice from other aides, and they indicated that certain contacts were made without two aides in the room.

The bath aide testified she gave this patient baths unassisted except for help in transferring from wheelchair to tub. It was not until the grievant was terminated that the patient was changed to a night bath schedule on which all patients required two assists at all times.

Further, the grievant did the same thing in October with the same patient, and received no discipline. The grievant reported that she had been injured while caring for this patient, and that there were no witnesses; she indicated on the form that safety rules had been followed. Kuhfuss, the supervisor who later terminated her, signed the report, stating that the incident could not have been prevented. If the grievant had indeed broken a rule, why wasn't the report corrected, or why wasn't she fired then?

The full entry on Kuhfuss's report is very suspicious, in that the way she placed her answer to "please explain" is different from the way she placed all other answers, and makes it uncertain if it was written at the same time or later.

> If the grievant had indeed been warned that she should not attend to this patient alone or she would have been terminated, all she would have had to do is not report the December incident; but she voluntarily reported the incident.
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> Two sequestered witnesses both testified that staff was unaware of the alleged "two at all times" safety rule. Carolyn Mueller testified that such things as dressing, washing faces, pushing chairs and giving medication were done without two in attendance. And Virginia Miller, the employer's witness, testified that she was approached by aides questioning exactly what they could do for patients without two in attendance; if aides had to ask, then truly the rule was either not in existence or it was unclear.
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> Finally, the grievant has never accepted the discipline of September 18, 1992; she agreed to the settlement, which she challenged, because she could not afford to pursue justice.
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> Clearly the alleged rule, if it truly exists, has had its practice interpreted differently for others, and even once before to the grievant herself. The grievant's caring for the comfort of a difficult patient has unknowingly put her job in jeopardy. Under a just cause standard people should not get fired for a rule surrounded with such confusion, and mixture of interpretation.
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> Accordingly, the grievance should be sustained, and the grievant returned to her position and made whole.

In support of its position that the grievance should be denied, the County asserts and avers as follows:

> The County has the legal obligation to care for its residents; the arbitrator should take judicial notice of the legal setting in which this employment takes place. Wisconsin statutes require that, to maintain its license, a facility must comply with the service to residents requirement, the administrative requirement, and the compliance

with law requirement. The law also grants every nursing home resident specific rights, including the right to receive adequate and appropriate care within the capacity of the facility. Residents have the right to sue to ensure delivery of this adequate and appropriate care.

In order to insure a safe environment for the resident the employer established a care plan which provided for "II c/all cares," which, in the testimony of all witnesses, means that two people are necessary when giving any care to this resident. Nursing supervisor Mueller testified that any time care was given to this resident, any time this resident was touched, two people were needed. This statement was corroborated by both Mr. Olm and Ms. Widder.

The grievant testified she was not aware of the care plan. All other witnesses indicated that the plan was on the back of the bathroom door and that any time an aide gives cares the aide is to check the care plan.

The grievant had been counselled as far back as June, 1992 to "refer all questions and concerns re: resident care directly to unit nurse or supervisor. "But in her own testimony, she stated her interpretation of two with all cares did not include "all cares" but only certain things. This certainly was not the interpretation of the supervisor or other aides who testified. The union witness who testified that "two with all cares" did not include all cares openly admitted that she had not reviewed the care plan for months. Virginia Mueller, R.N., testified that she never made exceptions, and that two people were required for everything.

The care plan had been in place since July, 1992. When the grievant was reinstated in September, 1992, she was responsible for checking the care plan to familiarize herself with the residents under her care. The grievant testified she was not aware of the care plan, a very questionable statement in light of the fact that all other witnesses testified the plan was placed on the back of the bathroom door.

The employer has a safety policy, which is of the utmost importance. As stated, "the full support of all employes is essential" to that policy. This includes following all procedures in place, including the care plan.

The grievant had been counselled on numerous occasions regarding the importance of safety rules. She had had two serious violations of safety procedures, plus commentary in her evaluation. That evaluation states an area for improvement as follows: "Follow safety procedures; 100% compliance with facility policies and procedures with special emphasis on safety procedures."

The grievant signed this evaluation document, and was thus certainly aware that she needed to address this problem. Yet only two (2) months later she was disciplined for failure to use a gait belt. It was then that she was given a last chance agreement.

In addition, the grievant was counseled on October 23, 1992, when Ms. Kuhfuss investigated her report of being clawed by this resident. As noted in the exhibit, Kuhfuss noted that "staff informed to do cares with two." The grievant was on staff at the time. Further, the grievant should have taken extra care to follow the care plan after being clawed in October and advised to use two for all cares. Yet she placed herself in the same situation on December 8 when she was again scratched by this resident.

The grievant was disciplined on January 10 and May 20, 1992, for violations of safety rules. She was terminated on August 13, 1992, again for violations of safety rules. She was re-instated on a last chance agreement in September, 1992. The last chance agreement provided that any work safety violation would result in immediate termination. Notwithstanding her reasons for agreeing to the last chance agreement, the grievant did so agree to its terms.

The employer has a responsibility to insure the safety of the residents and the employes. In this case the care plan indicated "two for all cares." Testimony clearly shows that the

staff knew this resident required two people because of her behavior. The care plan was initiated to protect both the resident and the employe from injury.

On December 12, the grievant was alone with the resident, a violation of the care plan, and because she was alone, was injured, a violation of the safety rules due to the failure to follow the care plan. Further, the last chance agreement specified that immediate termination would result for any violation of the safety rules.

The employer acted appropriately when it terminated the grievant. There is no violation of the labor agreement.

In its reply brief, the Union posits further as follows:

There was no testimony on the record that Kuhfuss "counseled" the grievant. The note on the relevant exhibit states that "staff" was informed to do cares with two people; it does not say that the grievant was individually counseled. Kuhfuss was cross-examined and could not remember anything she said to anybody. The part of the form that contains this notation is not given to employes.

The employer's own witness, Virginia Mueller, testified that, after the grievant's termination, other staff asked for clarification on what two for all cares meant, so they wouldn't get into trouble.

The October incident relays the actions of the grievant as "washing the patient's back," a little different than just pulling a wet pad out.

All witnesses did not testify that two with all cares meant the same thing, as stated in the employer's brief. The grievant herself washed the patient's back in October with no assistance and no discipline. The bath aide gave the patient baths unassisted until after the termination. Carolyn Mueller had to reeducate staff to make sure they understood that two with all cares meant nothing was done for the patient in room alone.

> The employer's citation of a treatise's discussion of last chance arrangements in the context of drug and alcohol abuse is misleading. The agreement does not deny the grievant the opportunity to have the arbitrator decide if she did violate a safety rule.
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> When the employer's witnesses vary in their interpretation, to an array of staff doing things such as bathing, pushing, washing, it is clear that the directions regarding this patient were not straightened out until after the firing. The grievant should not be fired for such inconsistency and unclarity of how to care for this patient.
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> Accordingly, the grievance should be sustained.

DISCUSSION

Typically, a grievance over discipline generally presents two questions: Did the grievant commit the act upon which the employer has based the discipline? And, did the act justify the level of discipline which the employer has imposed?

Here, there is no dispute as to the first question. By her own declaration, the grievant did provide a certain amount of care to resident 3112 on the morning of December 9, 1992, with no other care-givers present. She committed the act of which she has been accused.

But did that act justify her termination? Here, there is support for both sides of the question.

The Union cites the venerable "seven tests of just cause" as enunciated by Arbitrator Carroll Daugherty, and argues that the employer has failed one or more of those tests. Without adopting the Daugherty system in its entirety, I do believe that its general concepts are inherent in the understanding of "just cause," particularly as relates to notice, equal treatment and penalty. Absent evidence to the contrary, I believe a reference to "proper cause," as is in this collective bargaining agreement, is tantamount to "just cause." There has been no such evidence. Nor has there been any evidence or argument by the County to suggest that the "last chance" agreement somehow superseded the "proper cause" provision of the bargaining agreement.

It is well-settled that, to establish proper or just cause for discipline, it is necessary for the employer to establish that it gave the grievant adequate foreknowledge of the possible or

probable consequences of her actions; that it applied its rules equally to all employes, and that the penalty imposed was reasonable in light of the offense committed and the grievant's overall record.

The issue of notice is a paramount principle in establishing due process. "The issue of notice is deeply ingrained in our judicial philosophy and is a fundamental part of due process. The idea is that no person should be put in jeopardy of having an adverse action taken against him without prior notice of the proscribed acts." Texas City Refining, Inc., 83 LA 923, 925 (King, 1984). The employer "has a responsibility to inform employes not only of the rules but also of the implications of the effects of failure to obey a rule." Stauffer Chemical Co., 83 LA 332 (Blum, 1984). "One of the most fundamental considerations of all is whether or not an employe is under clear notice that the behavior which was expected (or not acceptable) would lead to a certain type of penalty." Canteen Corp., 86 LA 378, 383 (Hilgert, 1986).

Here, there is no question that the employer has properly established the importance of safety rules. In any employment context, worker safety should be of vital concern to the employer; whether out of financial, programmatic or personal considerations, employers have a legitimate right to demand that their employes perform their duties in a safe manner. In the context of patient care, that concern rightfully becomes even more pronounced, especially in light of the many statutory requirements and obligations which the County has noted. 2/

But there is a question as to whether the employer has properly established precisely what the safety rule was regarding resident 3112. That is, what did the employes know, and when did they know it, regarding the concept of "two with all cares" for

2/ The existence and precise nature of the "safety rules" is not completely clear. The County cites as the framework for its enforcement of safety violations a passage from its handbook on Personnel Policies. That policy refers to "a comprehensive safety program" integrated throughout the facility, a program "formulated and administered" by a committee appointed by the administration. The committee is to "advise on the elimination of hazards, establish safe procedures and administer the authorized safety program", and may also "investigate and use reasonable means to make the workplace safe." The policy notes that the "full support of all employees is essential to the effectiveness of this safety program for the control of accidents." There is nothing in the record to relate the accident of December 9 to the kind of "safety" issues implicated by the Personnel Policies. While the County suggests that there is an inherent relationship between the resident care plan and the safety program, evidence to that effect would have been helpful.

this resident? Put another way, should the grievant reasonably have known that her actions on December 9 contravened the safety rules regarding this resident, and thus subjected her to discharge?

At the outset, I find convincing and credible the testimony of staff nurse Mueller regarding her notation on the patient care sheet, and determine that, as of the end of July, that document did indicate "two with all cares". Making that determination, however, does not end the inquiry, but merely refocuses the question on what Grossheim reasonably knew "two with all cares" meant.

The County asserts that "in the testimony of ALL witnesses," the phrase means "that two people are necessary when giving any care to this resident." (emphasis in original). I am not sure this is necessarily true.

In fact, an implied rebuttal of the County's assertion came from a County witness, staff nurse Mueller herself. She testified that after Grossheim's termination, "people asked what it meant. They said, 'everything?' I said yes. A couple of aides asked what it meant. I told them, 'two with cares means two with cares.'" As the Union correctly suggests, the fact that staff asked for clarification (following Grossheim's termination), indicates that there was something less than universal and detailed understanding of the "two with all cares" notation. While in itself not fatal to the County's case, this does weaken its assertion that "two with all cares" was universally known and understood.

That assertion is further weakened by the testimony of nurse's aide Teghament, regarding her practice of bathing resident 3112. Teghament testified that, as the day bath aide on 2-South, she bathed resident 3112 approximately twelve times over the three-month period that ended just after Grossheim's termination. According to Teghament, she would have the assistance of another aide for transporting and transferring resident 3112 into and out of the bath, but that no other aide was present during the actual bathing, which Teghament did alone, while the resident was safety-belted with her arms and hands free. The use of a nurse's aide to assist in this regard is further corroborated by the documentary evidence.

Parts of Teghament's testimony were confusing and somewhat lacking in credibility, particularly her statements that she reviewed resident 3112's care plan, but did not see the "two with all cares" notation, and that she would not have given resident 3112 baths as she did had she known about that precaution.

The central and critical assertions of Teghament's testimony, however, are clear -- that during the exact time that supervisors were purportedly making clear to staff the importance of two for all cares for resident 3112, this resident was on a regimen which routinely required being bathed by a single care-giver; and that this practice ended almost immediately after Grossheim's

termination when resident 3112 was transferred to the more heavily-staffed night bath shift. The County did not rebut, nor even respond to this testimony.

Absent testimony to the contrary, I must assume that the County, consistent with its rights to manage and direct the work force, and to provide for the overall operation of the facility was aware both that resident 3112 was assigned to the day bath roster, and that day baths were given by a single care-giver. This conclusion further weakens the County's assertion that "two with all cares" for this patient was universally understood and rigorously enforced.

Further damage to the County's case comes from consideration of the incident of October 23, when Grossheim first gave unassisted care to resident 3112, was injured, and suffered no disciplinary consequences. By leaving the line on her Incident Report for witnesses entirely blank, Grossheim indicated that she had given resident 3112 care unassisted; she also checked the "yes" box indicating she had followed safety rules. In her Supervisor's Report, Kuhfuss indicated the incident could not have been prevented, and that corrective action was not needed. She also wrote "resident behavior has been aggressive and unpredictable," and "Staff informed to do cares" with two.

The County describes this last notation as indicating that Grossheim was "counseled." While the extent of this "counselling" is ambiguous, the basic facts of this incident are clear -- Grossheim reported to Kuhfuss that she had been injured giving unassisted care to resident 3112, an occurrence Kuhfuss determined did not justify corrective action. That was on October 23, after the "last-chance" reinstatement. When Grossheim reported a similar incident on December 9, she was fired.

Director of Nursing McCabe testified that, had Kuhfuss raised the October incident with her, she would have fired Grossheim at that time. That may well be so. But that is not what happened. What happened --- according to the record at hearing --- is that the County, aware that Grossheim gave unassisted care to resident 3112, made no response and took no action to give Grossheim an understanding that her actions were so improper as to merit her termination. Absent exigent circumstances or a clear explanation by the employer, an employe who is not disciplined for an action one day cannot reasonably be expected to know that a similar action seven weeks later will result in discharge. On the record here, I do not find such exigent circumstances or clear explanation.

In the context of this case, I cannot overstate the importance of the October 23rd incident. I also want to make sure, to the extent I can, that the parties do not draw an unintended conclusion from my treatment of this incident.

Without commenting on whether the County would have had proper cause to discipline/terminate Grossheim for the October

23rd incident, I am not holding it against the County that it did not do so. An employer who shows forbearance and does not exact the harshest penalty possible should not, in my view, necessarily be prevented from imposing such penalty for subsequent offenses.

What I am holding against the County is that it failed to make clear to Grossheim that her action of October 23 was an offense, and a dischargeable one at that. It is not the County's failure to punish that makes October 23 crucial; it is the County's failure to inform.

As noted, the December 9 incident was the fourth so-called "safety violation" which the County accused Grossheim of in an 11-month period. This last incident, however, is significantly and substantially distinct from the others. In January and August, the charge was not using a gait belt; in May it was failure to use a Hoyer lift. That is, the prior incidents involved an apparatus, mechanical or otherwise, used to lift, restrain, transfer or transport a resident --- a degree of physical impact on the resident simply not present in the December incident. The fact that the December 9 and October 23 incidents were significantly closer in degree and kind to one another (washing the back, removing the pad) than either were to the earlier incidents involving the gait belt and the Hoyer lift makes the County's response to the October incident even more important. There may be circumstances in which the removal of a urine-soaked pad poses as great a safety threat as the improper use of a gait belt or Hoyer lift; but those circumstances are not found in this record.

Finally, I must consider the grievant's own actions. Whether in the wild or in the workplace, the dominant drive for all living things is self-preservation. People generally don't knowingly do things that will result in their demise. Workers generally don't knowingly do things that will result in their being fired. It is even more unusual for workers to commit a dischargeable offense, and then voluntarily turn themselves in.

Consistent with the need for notice, the County's case requires a determination that Grossheim shared in the universal understanding of the rigorous application of "two with all cares" for resident 3112, and that she was aware that the penalty for violating this directive would be discharge. Yet, Grossheim herself reported both the October and December incidents. The logic of the County's case requires me to find that Grossheim thus knowingly reported a dischargeable offense, effectively signing her own termination notice. It is hard to make such a finding.

Given the County's emphasis on its legal responsibility to "attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident," and its citation to a resident's right to sue to receive adequate and appropriate care, a word is due on the specifics of the December incident. Grossheim's unchallenged testimony was that the care she was providing consisted of removing and replacing a urine-soaked pad and bedding. Staff nurse Mueller testified that it is "normal"

for patients to lie in their own urine or feces, and that such a condition justifies only normal, not expedited care, and that

Grossheim should have gotten one of the three nurses or nine other aides on duty at that time before attending to resident 3112. While I have no training or expertise in the administration of nursing homes, I find it hard to reconcile the County's legal responsibilities with the notion that it is "normal" for residents to lie in their urine and feces.

Based on the totality of the circumstances and the evidence, it is not clear that the Employer has established, by a preponderance of the evidence, that Grossheim had adequate reason to know the probable or possible consequences of her actions would be her termination. Such knowledge, or the reasonable expectation of such knowledge, is a necessary element of "proper cause".

Accordingly, on the basis of the collective bargaining agreement, the record evidence, and the arguments of the parties, it is my

AWARD

1. That the grievance is sustained;

2. That the County lacked proper cause for the discharge of Grievant Pam Grossheim.

3. That as remedy the County shall, forthwith upon receipt of a copy of this Award, offer Pam Grossheim reinstatement to her position or a substantially equivalent position with her full seniority, and shall make the grievant whole, for any loss of wages and/or benefits, by payment to the grievant of a sum of money equal to such losses less interim earnings, if any; and shall correct its records accordingly.

Dated at Madison, Wisconsin this 12th day of October, 1993.

By Stuart Levitan /s/
Stuart Levitan, Arbitrator