BEFORE THE ARBITRATOR

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| In the Matter of the Arbitration of a Dispute Between | : | |
| SHEBOYGAN COUNTY | : | Case 221 No. 49779 MA-7510 |
| and | : | |
| LOCAL 2427 SHEBOYGAN COUNTY INSTITUTIONS, AFSCME, AFL-CIO | : | |

Appearances:

Ms. Louella Conway, Personnel Director, 615 North Sixth Street, Sheboygan, Wisconsin 53081, on behalf of the County.

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

## ARBITRATION AWARD

The above-captioned parties, hereinafter the County and the Union respectively, are signatories to a collective bargaining agreement providing for final and binding arbitration. Pursuant to said agreement, the parties requested the Wisconsin Employment Relations Commission to appoint a member of its staff to hear the instant dispute. The undersigned was designated by the Commission. Hearing was held on December 2 and 22, 1993, in Sheboygan, Wisconsin. No stenographic transcript was made. The parties completed their briefing schedule on March 16, 1994. Based upon the record herein and the arguments of the parties, the undersigned issues the following Award.

## ISSUE

At hearing, the parties stipulated to the issue as follows:

> Did the County violate the contract when it suspended Sherry Ruge on May 9, 1993, and terminated her on June 10, 1993? If so, what is the appropriate remedy?

## RELEVANT CONTRACT PROVISIONS

**ARTICLE 3**

**MANAGEMENT RIGHTS RESERVED**

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

the working 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 employee 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 direct its employees to perform such work wherever located subject only to the restrictions imposed by this Agreement and the Wisconsin Statutes. But in the event the Employer desires to subcontract any work which will result in the layoff of any county employees, said matter shall first be reviewed with the Union.

Unless otherwise herein provided, the Employer shall have the explicit right to determine the specific hours of employment and the length of work week and to make such changes in the details of employment of the various employees as it from time to time deems necessary for the effective operation of its institutions. The Union agrees at all times as far as it has within its powers to preserve and maintain the best care and all humanitarian consideration of the patients at said institutions and otherwise further the public interests of Sheboygan County.

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

FACTS

The grievant, Sherry Ruge, is a part-time Licensed Practical Nurse (L.P.N.) at Sunny Ridge Nursing Home, a Sheboygan County skilled geriatric nursing facility. She has been employed by the County since March 9, 1987. Ms. Ruge had received generally below average and/or unsatisfactory evaluations with one single exception. These appraisals continued to reflect the County's dissatisfaction with respect to her poor work performance, in particular her assessment skills, and her ability to follow through with directions given by the supervisor and to function within the Guideline and Standards of Practice for L.P.N.'s.

At the time of the two incidents before the Arbitrator, she worked on the day shift from 6:45 a.m. to 3:15 p.m. As an L.P.N., she is responsible for administering certain treatments to patients, passing medications, observing the patients for change in their physical health, and charting the status of patients.

On April 29, 1993, an audit of the medication room indicated that the controlled substance record showed two more Ritalin tablets in a supply bottle than should have been there had medication been given to the patient at the appropriate times based upon the medix record. This record, which was signed by Ruge, indicated that she had given the patient the requisite dosage. Ruge's supervisor, Renne Bourett, discovered that Ruge had initialed the medix indicating that she had given the resident in question the medications at 7:00 a.m. and 11:00 a.m. A count or tally of the Ritalin tablets as indicated on the controlled drug use record (Exhibit 14), however, showed that there were 6 tablets remaining in the dosage pack at 11:00 a.m. on April 28, 1993, and there were still 6 tablets remaining at 7:00 a.m. on April 30, 1993. It should be noted that a new page was started with regard to the April 30 entry, but there is no evidence of falsification of substitution of this very important medical record.

Ruge could not offer a reason or explanation for the discrepancies in the controlled drug use medical record sheets and the medix records of the patient. She claimed that she did give the medication in a timely and proper fashion. She maintained that she had signed a new page sheet with her count notation but she could not and did not produce the sheet that she claimed to have signed at the hearing.

On that same day, April 29, another patient had fallen and bumped his head. Bourett instructed Ruge to call the patient's physician and advise him of the fall. Ruge indicated that she would do so. The next day Bourett discovered that no entry had been made on the patient's chart indicating that the physician had been notified. When confronted with this omission, Ruge indicated that she had tried to call the physician one time but that the line was busy. The fall occurred at 2:30 p.m., approximately forty-five minutes before the end of the shift and fifteen minutes before the report time when L.P.N.'s from the outgoing shift conveyed all noteworthy information to the L.P.N. on the incoming shift.

According to Ruge, she told the L.P.N. coming onto the next shift, Pat Durfee, about the patient's fall and how far she had progressed regarding notification of the patient's family and doctor. Durfee agreed to contact the doctor. Ruge claims that she put the information regarding the "busy signal" into the nurses' notes for that day, but she was unable to produce the

nurses' notes to substantiate this claim either. Durfee never did contact the doctor regarding the fall. Only after Bourett noticed the next day that Ruge had failed to chart her attempt to notify the physician did Ruge make a late entry on the patient's chart. She did make this late entry before she had knowledge that she would be disciplined over the matter.

Based upon these two incidents, Ruge received a five-day suspension which is at issue in the instant dispute. This suspension was also used as progressive discipline to justify Ruge's termination in June of 1993.

The events which led to her termination are as follows: One month later on June 2, 1993, complaints were received from three different patients to the effect that they had not received their medications all day on the shift on which Ruge worked. One patient is alleged to have complained about not having received her inhaler on two separate occasions. Another allegedly did not receive her treatment cream, while yet another allegedly did not receive all four doses of eye drops on that date.

The Union argues that these allegations are hearsay because no patient appeared to testify nor did they give any written evidence in their own handwriting. Ruge contends that she administered all of the required medication, including the cream treatment, and that the patient's medication records (Exhibit 19) contain her initials to evidence that she did provide the medications. To buttress her testimony, Ruge maintained that two of the patients have, as a part of their normal routines, a habit of hanging around the nursing stations until they receive their medications before going to other activities or meals. The N.A.'s do not take them to these other activities until they receive their medication. Ruge also testified that at least one of these patients had a reputation for getting staff into trouble, playing one employe against one another.

Another incident allegedly occurred on the same day regarding another patient who had cataract surgery on June 1. He was scheduled to see the eye surgeon on the afternoon of June 2. In the morning of June 2, he fell and bumped his head. He was being evaluated by the staff neurologically during the morning of June 2. Ruge, while calling his family physician, did not call the eye surgeon to report the fall and head bumping, nor did she include this information on the Physician Information Form which she prepared. This form was to accompany the patient to the eye appointment. (Exhibit 12).

Insofar as this second allegation is concerned, Ruge maintained that she knew the patient's eye doctor was being notified of the call because she heard the L.P.N. who relieved her calling him. While Ruge admits she did not record the fall, she was aware that contact with the doctor had been made before the

end of her shift. Because the patient had left at 2:40 p.m., this information was not received too late by the eye surgeon. It was just not written on the eye doctor's sheet. Ruge also points out that she did call the patient's physician when he fell in the morning and started the appropriate neurological checks on the patient.

In addition to the patient referred to above, yet still another patient fell during the day shift on that same day, June 2. While the patient did not complain of pain initially at the time of the fall; by 2:30 p.m. she was complaining to the Nursing Assistants (N.A.'s) about pain and being unable to bear weight. Ruge initially assessed the patient at the time of the fall. The N.A.'s informed Ruge when the patient began to complain of pain. She then came to the patient's room and stood in the doorway. She observed the patient and then returned to her nursing station. The County contends that she failed to reassess the patient properly at that time and to convey the status of the patient to any supervisor or the L.P.N. incoming on to the next shift. According to Bourett, Ruge did not notify any R.N., her supervisor, or physician regarding the patient's status. The patient was found to have a pelvic fracture that evening after the L.P.N. relieving Ruge performed the proper assessments and had the patient transported to the hospital for X-rays.

With regard to the patient who fractured her pelvis, Ruge maintains that she did reassess the patient upon her complaints of pain. According to Ruge, she went to the patient's room when the N.A.'s called her. She observed the patient and could see that she was not bearing weight. Ruge maintains that she reported this to the incoming L.P.N., Mary Ann Lammers, saying the patient was complaining of right leg pain.

The final incident is alleged to have occurred on June 7, 1993. Bourett told Ruge that she wanted to check the FAXes to be sent to several doctors regarding certain patients before Ruge sent them. At 11:10 a.m., Bourett went to inquire about the FAXes. She noticed that Ruge had already charted the FAXes as having been sent at 10:30 a.m. on the nursing notes of the affected patients. She then asked Ruge if she had already sent the FAXes. When Ruge said that she had not sent them, Bourett asked why she had already charted them in the notes. Ruge then amended the notes to reflect the correct time of their transmittals at 12:30 p.m. The County contends that this was a falsification/failure to document various medical records.

As far as this FAX incident is concerned, Ruge stated that she expected Bourett to come to the floor around 10:30 a.m. because she had called her shortly before. Bourett did not come when Ruge expected her and did not arrive until close to 12:30 p.m. When Bourett did arrive, Sherry changed the nursing notes in front of her. Bourett made no attempt to correct Ruge at that

time.

The County terminated Ruge on June 10, 1993, for this series of incidents citing "failure to follow facility policy/procedure, falsification/failure to document and failure to notify change of condition indicating grossly poor work performance" as reasons for the discharge.

Lammers, the incoming L.P.N., testified along with other co-workers of Ruge. According to Lammers, when she came on duty she asked Ruge if Ruge had called the eye doctor regarding the cataract surgery patient's fall to let him know about it because he had just had surgery. When Ruge replied that she had not called, Lammers quickly called the doctor. Lammers testified that she did not think that Ruge was still present when she called the doctor and did not believe that Ruge knew about her calling the doctor.

Lammers also testified regarding the patient who had fractured her pelvis. She claimed that as she examined Ruge's notes as to the patient's status, the N.A.'s spoke with her immediately regarding Ruge's notes telling her "You have written here that the patient can ambulate, bear weight and is o.k., but she's not o.k. Come with us." Lammers then accompanied the N.A.'s to see the patient. When the N.A.'s tried to move her, she just cried out in pain. Lammers then performed a proper assessment and called her supervisor who notified the patient's doctor to arrange for the patient to be sent for X-rays. The X-rays showed a fractured pelvis, anterior and posterior pubis.

Lammers on both direct and cross-examination swore that Ruge told her on report that the patient had fallen, but was o.k., that she could bear weight and ambulate. She reiterated that Ruge had not told her of any complaints of pain on the part of the patient.

Christine TenPas, an N.A., also testified regarding the patient with the broken pelvis. She claimed that when the patient rang for help the second time, she and Janet Decker, another N.A., responded. According to TenPas, the patient was not bearing weight and was complaining of a lot of pain. When the N.A.'s went up to the desk to inform Ruge, they told her that the patient was crying and having a lot of pain and that she was not bearing weight. Ruge then came down to the patient's room. Ruge stood in the doorway approximately eight feet away from the patient. The N.A.'s helped the patient to stand. Ruge said "o.k." and returned to the nursing station. TenPas maintained that Ruge did no further assessments or any hands-on evaluation of the patient. TenPas then testified that she and Decker told Lammers when she came on duty that the patient wasn't bearing weight and was complaining of pain. Lammers checked by moving the patient's legs and found the broken pelvis. While TenPas did not claim to be a nurse, she definitely felt that the patient had undergone a change

in her medical condition.

The nursing notes written by Gail Scheiser, an R.N., of a report given by Lammers regarding the incident state as follows: Lammers stated that Sherry told her the patient "can bear weight, ambulate but complains of right leg pain after the p.m. Nursing Assistants called her in and she assessed no weight-bearing."

POSITIONS OF THE PARTIES

County

The County argues that it has a legal obligation to care for its residents/patients. Because the law grants to every nursing home resident specific rights which include but are not limited to the right to receive adequate and appropriate care within the capability of the facility to so provide, the County has a special legal obligation to the patients for whom Ruge was providing care. It stresses that Ruge's conduct does not meet the standards of care required by her license to practice as an L.P.N. in the State of Wisconsin. The County maintains that she has to perform pursuant to the regulatory provisions of the Wisconsin Administrative Code in order to continue to hold her license. In the County's view, falsifying or altering patients' records is subject to discipline and failure to administer medications constitutes misconduct and unprofessional conduct. It believes that, while Ruge may not have physically abused her patients, by failing to administer the medications she subjected them to additional discomfort and pain until they received the next medication dosage or proper assessment of their medical condition.

The County submits that Ruge's failure to provide proper care to the patients not only put them in jeopardy, but also put the license of the facility in jeopardy as well. It notes that Ruge's evaluations, even the March 27, 1992 evaluation upon which the Union relies, contain entries that improvement is needed in the area of "greater knowledge of medications and usage in regard to diagnosis" and that as a goal Ruge needed to "fine tune your assessment skills" and to "continue to strengthen the skills of (a) documentation and (b) consistency in work habits." Ruge's evaluations over the years have not been satisfactory in the County's opinion. As far back as 1990, it advised her in these evaluations that her assessment skills were weak. She received a verbal discipline for poor performance in January of 1991 based upon her poor assessment skills. Because of the continuing nature of Ruge's problems and the continuous poor evaluations, it is clear, in the County's opinion, that Ruge was aware that she was not performing to the County's standards but failed to follow recommendations for improvement.

In response to Ruge's contention that she had, on several

occasions, given information to the incoming L.P.N. to complete making a phone call, assessing a resident, or doing other work which she should have completed on her shift, the County strenuously maintains that these tasks, especially reaching the physician and making the appropriate notations on the patients' charts, were her responsibility. Pointing to the April incidents, the fact that Ruge was unable to reach the physician is not an excuse for failing to inform him of the patient's status because she needed to note that she was unable to contact the doctor on the patient's chart and to notify her supervisor of this inability to contact him. She did neither. The same thing occurred in June. She failed to notify the physician of another resident's fall in the appropriate manner. Citing Lammers' testimony, the County submits that Ruge did not ask Lammers to call.

The County stresses that with respect to the June incidents, not only did Ruge fail to make the proper notifications, leaving her shift without doing so, but she also failed to make the appropriate reassessments, leaving this work for the L.P.N. on the next shift. Ruge's failure to make the proper reassessment prolonged the patient's distress. With regard to Ruge's testimony regarding administering the proper medications, the County insists that it is uncorroborated in all respects and refuted with respect to the controlled drug sheet.

The County argues that Ruge has a history of poor performance and had been placed on notice that further infraction of the job performance standards could lead to termination. It believes that it followed progressive discipline policy with respect to both the suspension and the termination. It points out that Ruge did not grieve any of the other previous disciplinary actions.

The County believes that it has satisfied the just cause standard for the discipline imposed. A fair and complete investigation of the charges was made. After the charges were investigated, Ruge was given the opportunity to explain or refute any of the allegations but she had no response except to claim that she had given the medications, told another to do her work, documented that she had sent the FAX, etc.

The County submits that it has the right to expect its L.P.N.'s to follow the procedures and obey the directives given to them by their supervisors. Ruge's failure to do so placed the patients and the facility in jeopardy due to her substandard care.

In its reply brief, the County stresses that Ruge's testimony that she asked Durfee to call the doctor regarding the April 29 fall is not corroborated by Durfee whom it did not call as a witness. On April 30, it alleges that Ruge was very aware that her late entry on the patient's record was being reviewed by Bourett.

It cites the testimony of Lammers, McCabe, the Home Administrator, and Bourett who all stressed that a staff person must make the patient comfortable and complete his/her care before going off of duty. It points to Lammers' testimony to refute the contention that Ruge knew the eye doctor was called. Pointing to Bourett's testimony that she did not observe Ruge change the nursing notes times for sending the FAXes, the County claims that Ruge did not do this in the presence of Ms. Bourett.

In countering Ruge's assertions that she did not have Union Steward Carolyn Mueller available to represent her when she was disciplined in May regarding her suspension, the County contends that the administration advised her early in the day that she would be meeting with the Administrator and others with respect to discipline and that Ruge had the opportunity to secure representation of her choosing in the morning. It was not Ruge's decision as to when to meet with the Administrator but rather her responsibility to make arrangement to have a steward present, if she so chose, when the County decided to meet with her.

In conclusion, the County requests that the termination be sustained and that the grievance be dismissed in its entirety.

Union

The Union argues that the County did not have just cause for either discipline because it has failed to meet its burden of proof in establishing that Ruge was guilty of the accusations alleged.

With respect to the reasons advanced for the suspension, it strenuously maintains that Ruge gave the Ritalin in a timely and proper fashion. Ruge maintains that a second sheet of the controlled drug records which is missing would establish that she properly administered and recorded the medication.

Insofar as the second incident on the same day is concerned, the Union asserts that Ruge's failure to contact the physician is mitigated by her telling the incoming L.P.N., Pat Durfee, that she could not reach the doctor and Durfee agreeing to notify the family and the physician. It stresses that Ruge put the "busy signal" information in the nursing notes. In the Union's view, it is normal that things that do not get done on one shift will be finished on the next. This, it suggests, is just one more example of teamwork. Durfee was to complete the physician's call, but she did not call and failed to enter any report regarding this matter. The Union would argue that to the best of her knowledge when Ruge left that day, all the bases were covered. Further, the Union stresses that Ruge made the late entry in the chart the next day before she had any knowledge of the County's intent to discipline her.

Regarding the allegations which the County asserts justify the termination, the Union claims that all of the allegations made by the patients that Ruge failed to administer their medications are inadmissable as hearsay because they are not substantiated by either written statements or the testimony of the patients. According to the Union, the County has submitted nothing but conflicting and incredible hearsay. The Union points to Exhibit 19 which establishes that Ruge did properly administer all the required medication to the affected patients. To buttress these contentions, the Union suggests that two of these patients have as a part of their normal routine, a practice of going to the nurses station and hanging around the desk until they receive their medication. They do not go on to other activities until they receive these medications. Missed meals and/or missed activities would have raised a flag with aides and activity personnel after the first dose was supposedly missed, but no flags were raised because the patients received the appropriate medications. The Union notes that Ruge even reordered one of the patient's inhalers; and she would have had to handle the inhaler in order to have knowledge that it needed refilling.

As far as her failure to notify the eye doctor was concerned, Ruge, the Union suggests, knew the eye doctor was called because before she left work because she heard the incoming L.P.N., Lammers, make the call. In any event, the County's policy and practice requires calls to the patient's physician or medical doctor for a fall, and not to an eye doctor. Lammers' calls to the eye surgeon was not too late and he was made aware in a timely fashion of the patient's fall.

In answer to her failure to properly reassess the patient with the fractured pelvis, Ruge disputes Lammers' testimony. Ruge maintains that she did observe that the patient could not bear weight and reported this fact to Lammers saying the patient was now complaining of right leg pain. The Union points to Exhibit 29 as evidence that Ruge did report the patient's condition to Lammers so that Lammers was properly notified of the patient's condition.

Ruge asserts that her supervisor watched her change the records with respect to the FAX entries and never said or did anything but "roll her eyes". According to the Union, Bourett never even corrected Ruge at the time she was making the changes. If what Ruge did was wrong, why didn't Bourett stop her and/or correct her? To discipline her at a later date only shows the intense determination on the County's part to terminate her. The Union contends that the essence of the County's actions with regard to the FAX incident is that the County approved of her actions, then disapproved at a later date. Moreover, correcting a record by writing over it has been done in charting by other employes with no known disciplinary actions resulting.

In its reply brief, the Union suggests that the County is painting a picture of the grievant's work performance which does not exist. The County falsely portrays Ruge's actions when it claims that Ruge did not advise the eye surgeon of the patient's fall. The truth is that Ruge heard Lammers convey the information, and that should suffice.

The Union maintains that despite Lammers' testimony regarding the reassessment or lack thereof with respect to the patient with the fractured pelvis, Gail Scheiser, a non-testifying nursing note writer, confirms that Ruge made the reassessment. While the testimony as to exactly what Ruge told Lammers is conflicting, Ruge's testimony should be believed regarding her reporting to Lammers regarding the results of that assessment.

What is before the arbitrator, in the Union's view, is whether the County violated the contract by discharging Ruge, not whether some state statute is violated or some administrative code compromised. The only tasks of the arbitrator are to decide whether Ruge did indeed do what she is accused of and secondly whether or not discharge is appropriate. Pointing to Ruge's most recent evaluation, the Union submits that if it was perceived that Ruge had problems, she worked hard to correct them. In that evaluation all parts of her job performance were checked as satisfactory and her goals were to fine tune assessment skills, and to continue to strengthen skills in documentation and consistency of work habits. It notes that even Bourett's evaluation showed no unsatisfactory areas.

The Union attempts to rebut the Ritalin count by stressing that Nancy Guillette, the nurse who performed the count, did not discover the discrepancy until three (3) days later. This supports the conclusion that the County cannot prove that Ruge did not give the Ritalin.

The Union firmly asserts that the County has not proved that Ruge did anything wrong. It is not treating her like other employes. Moreover, if Ruge made a mistake in the past, she has not repeated it in the future. The Union believes that the County has not shown proper cause and that Ruge's grievance should be sustained. It asks that she be reinstated and made whole.

DISCUSSION

Both the suspension and the discharge in the instant case involve determinations which ultimately must be premised upon the County's expectations with respect to the nursing standard of care which is to exist in its nursing home facility. A review of the evidence adduced at hearing convinces the undersigned that there exists in the County's facility a high standard of nursing care on the part of both management and staff in their interaction with the patients. As the County has correctly noted, failure to treat

the patients/residents in accordance with this high standard might very well subject the facility to civil actions, license revocation, and other undesirable regulatory actions, as well as subject the patients themselves to substandard and inadequate nursing care. It is against the background of this high standard of nursing care that Ruge's actions or omissions must be measured.

Something more must be said about the credibility of the witnesses. This arbitrator did not find the grievant to be particularly credible. She has credited her testimony when it was unrebutted but has not credited it when it was contradicted by other witnesses. The undersigned has given special weight to the testimony of other non-managerial staff members finding their testimony as to the practices in the facility and the normal, usual, and appropriate standard of care to be particularly instructive.

Suspension

The two allegations which the County asserts support the suspension, Ruge's failure to dispense Ritalin to a patient and her failure to contact another patient's physician after he fell, are acts of omission. In evaluating the medix record and controlled drug substance sheets and the testimony of both Ruge and her superiors, the undersigned must find that Ruge did not dispense the Ritalin as she claims. The counts of tablets in the pack on both April 28 and April 30 are virtually undisputed. Without evidence of some falsification or substitution of the second page of the controlled substance records, the inescapable conclusion is that Ruge did not give the patient Ritalin for the day of April 29. The omission in and of itself would justify a suspension of the grievant because of the nature of the drug involved, Ritalin being a highly regulated and monitored controlled substance.

The County does not base its five-day suspension solely upon this incident. Rather, it also alleges that Ruge improperly failed to contact a patient's physician to notify him of a fall and to chart her failure to so notify the physician, or to notify her supervisor of her inability to get through to the doctor's office prior to leaving her shift. Ruge does not dispute that she did not contact the physician but argues that she made arrangements to have the incoming L.P.N. make the call prior to leaving. The County counters that it was Ruge's responsibility to ensure that the contact was made and properly charted. In the absence of credible testimony that the facility was lax about who followed up upon whom in the notification and charting tasks or that employes routinely "covered" for each other in this manner (rather the evidence at hearing, in particular, the testimony of Lammers, suggests that just the opposite was the case), this arbitrator must conclude that it was Ruge's responsibility to make the contact with the physician, to chart that such contact

occurred or to chart her inability to make said contact and to inform her supervisor of her inability to do so.

While mindful that Ruge alleges that she did make a notation in the nursing logs, this log was not produced at hearing, and it is clear that she made no such notation in the patient's chart. In her hurry to leave the shift, it appears that she left for others what she should have made sure of herself --- calling the doctor. In view of the serious repercussions which may have resulted from her failure to notify the physician and failure to chart this fact, the County was warranted in imposing discipline for this incident.

The two infractions in combination certainly establish cause for the disciplinary suspension. Ruge simply did not perform in accordance with the County's expected standard of care in either instance. Her five-day suspension was not too severe under the circumstances.

Discharge

Having found that the five-day suspension was properly imposed and constitutes appropriate progressive discipline, the question of whether the evidence supports the County's termination must now be addressed. Essentially, the County relies upon four separate incidents to justify Ruge's discharge.

With respect to the allegations that Ruge failed to dispense the medications to the three patients who allegedly complained about not having received their medications, the undersigned agrees with the Union that the County has failed to carry its burden of proof as to these particular allegations. Without calling the patients to testify and be subjected to cross-examination, reliance upon second-hand testimony from management officials who investigated the allegations is insufficient. It does not establish that Ruge did in fact fail to dispense the medications to this arbitrator's satisfaction. This is especially the case where the Union submitted evidence showing that at least two of the patients tended to hang around the nursing station until they received their medications before going on to meals and/or other activities. Therefore, the County may not rely upon these allegations to support its decision to discharge Ruge.

The question then becomes whether the remaining allegations are sufficient to justify the termination. The two other incidents alleged to have occurred on June 2 are, in the opinion of the undersigned, much more serious and, if proven, would constitute grounds for discharge. This is the case because these omissions impact substantially on the quality of care and comfort of the affected patients. The County relies upon the testimony of its supervisors, the N.A. on the shift that day, TenPas, and the incoming L.P.N., Mary Ann Lammers, to support its contentions.

Lammers' testimony as a co-worker of Ruge's --- subject to the same standard of care as Ruge --- was particularly persuasive. She appeared genuinely chagrined and slightly disgusted at Ruge's failure to follow-up on both occasions.

Lammers' testimony that Ruge did not ask her to call the eye surgeon but rather that she, Lammers, inquired of Ruge as she was leaving, whether Ruge had called him to report the patient's fall, is credited over that of Ruge. Ruge's failure to make the appropriate notations on the Patient Information Form which was accompanying the patient to the eye doctor's only further buttresses Lammers' testimony as well as illustrates the serious lack in judgment which Ruge exhibited with regard to this omission. Notification of this nature was her, not Lammers', responsibility. While Lammers luckily was able to make the follow-up call in time so that the patient suffered no negative repercussions from Ruge's omission, the consequences to the patient could have been grave. Moreover, a liability problem due to Ruge's failure might have been created for the facility. The Union's argument that Ruge was not required to notify the eye surgeon, only the treating physician, is rejected. It is only common sense that the treating physician, in this case the eye doctor, be notified of a fall when the patient had just undergone surgery and still had sutures. Ruge's failure to comprehend this goes to her nursing judgment. In view of the incident which resulted in her being disciplined just a few weeks earlier for failure to have made a similar call, the undersigned must conclude that further discipline for this transgression is warranted.

The same day, Ruge failed to properly reassess the patient who incurred a broken pelvis. The undersigned cannot and does not credit Lammers' recollection as to Ruge's reporting that the patient was o.k. because it deviates from what she initially told the nursing note writer, Scheiser. Scheiser's notations indicate that Ruge reported to Lammers that the patient "can bear weight, ambulate but was experiencing some right leg pain." Nevertheless, the evidence adduced at hearing establishes that Ruge's reassessment of the patient was cursory, incorrect, and totally inadequate. Her report certainly did not reflect the status of the patient because the patient could not bear weight or ambulate. Ruge's failure to take the time to make a proper reassessment and to properly report the patient's condition caused the patient much more pain and discomfort than was necessary. It is clear that the N.A.'s were not satisfied with Ruge's reassessment as reflecting the true status of the patient or they would not have immediately come to report to Lammers so that she could reevaluate the patient. Even where, as here, the patient's husband was verbalizing concern with the patient's complaints of pain, Ruge did not take the time to perform a proper reassessment.

Under these circumstances, her failure to properly reassess the patient, and then to notify her supervisor of the change in

the patient's status, simply does not comport with the standard of care required for this patient by the facility. It should also be pointed out, that like Ruge's failure to contact the physician in April, this incident occurred at the end of the shift as Ruge was preparing to transition to the p.m. L.P.N.. It appears that Ruge was once again merely leaving another task unfinished or haphazardly performed to be taken care of properly by the next L.P.N. reporting onto the next shift. The dereliction of her duty to this patient, especially in view of the assessment difficulties which she was continually experiencing as evidenced by her evaluations, convinces the undersigned that discipline for this incident was also warranted.

Insofar as the FAX incident is concerned, in and of itself, it certainly would not support the grievant's discharge. The FAX incident does not stand alone, however. It was merely the proverbial "straw that broke the camel's back" for the County because it proved that Ruge was not properly charting the occurrence of events into the patient's charts despite warning, evaluations, and instructions to the contrary. The County then believed that it could not rely upon the veracity of her charting.

The two incidents occurring on June 2 along with the FAX incident establish cause for Ruge's discharge. She simply has not performed up to the standard of care that the County insists upon for patients in its facility.

The Union at hearing made an argument that Ruge was not permitted to be represented by the union steward of her choice at the disciplinary meeting of May 9 which resulted in her suspension. The record reflects that the County notified Ruge that it would meet with her on that date at a certain time. The County need not put off its disciplinary meeting until Ruge could secure representation by a steward with whom she would be satisfied. There is no indication that the County refused to allow Ruge union representation. Thus, this allegation on the Union's part is meritless.

Given the progressive nature of the discipline administered by the County and Ruge's inability or at least failure to make the necessary corrections in her work performance, it must be concluded that discharge is not too severe a discipline under the circumstances. It is my decision and

AWARD

1. That the County did not violate the collective bargaining agreement when it suspended Sherry Ruge on May 9, 1993, and discharged her on June 10, 1993, because it had just cause to impose both forms of discipline.

2. That the grievance is denied and dismissed in its entirety.

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Dated at Madison, Wisconsin this 13th day of April, 1994.

By Mary Jo Schiavoni /s/

Mary Jo Schiavoni, Arbitrator

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