BEFORE THE ARBITRATOR

In the Matter of the Arbitration of a Dispute Between DISTRICT 1199W/UNITED PROFESSIONALS FOR QUALITY HEALTH CARE, SEIU, AFL-CIO, CLC and ROCK COUNTY, WISCONSIN	Case 288 No. 51886 MA-8769

Appearances:

Mr. Paul Burmeister, Union Representative, 1619 Monroe Street, Madison, Wisconsin 53711-2021, appearing on behalf of District 1199W/United Professionals for Quality Health Care, SEIU, AFL-CIO, CLC, referred to below as the Union.

Ms. Charmian J. Klyve, Deputy Corporation Counsel, Rock County Courthouse, 51 South Main Street, Janesville, Wisconsin 53545, appearing on behalf of Rock County, Wisconsin, referred to below as the County or as the Employer.

ARBITRATION AWARD

The Union and the County are parties to a collective bargaining agreement which was in effect at all times relevant to this proceeding and which provides for the final and binding arbitration of certain disputes. The parties jointly requested that the Wisconsin Employment Relations Commission appoint an Arbitrator to resolve a dispute reflected in a grievance filed on behalf of Jo Anne Barker, referred to below as the Grievant. The Commission appointed Richard B. McLaughlin, a member of its staff. Hearing on the matter was held on February 20, 1995, in Janesville, Wisconsin. The hearing was not transcribed, and the parties filed briefs and reply briefs by April 18, 1995.

ISSUES

The parties did not stipulate the issues for decision. I have determined the record poses the following issues:

Did the County have just cause to issue a one day suspension to the Grievant for her conduct on July 8, 1994?

If not, what is the appropriate remedy?

RELEVANT CONTRACT PROVISIONS

ARTICLE II - MANAGEMENT RIGHTS

The management of the Rock County Health Department and direction of the working force is vested exclusively in the County, including but not limited to the right to hire, suspend or demote, discipline, or discharge for just cause . . .

ARTICLE XV - PROGRESSIVE DISCIPLINE

The Employer and the Union agree that the principle of progressive discipline shall be followed. That sequence may include oral or written counseling, written warnings, suspension without pay and discharge . . .

Written reprimands will remain in effect for a period not to exceed one year and at the end of such period, shall be removed from the employee's personnel file. Records of suspensions will remain in an employee's personnel file for a period of two years.

BACKGROUND

The grievance challenges the County's imposition of a one day suspension, summarized in the following memo, dated July 19, 1994, 1/ from Matthew Haeger, the County's Director of Nurses, to the Grievant:

> This is to satisfy the next step of the disciplinary process as stated per the union agreement between the Rock County Health Department and District 1199W/United Professionals for Quality Health Care. This step is a one-day suspension from work without

1/ References to dates are to 1994, unless otherwise noted.

> pay . . . regarding unsafe nursing practice.
>
> (The Grievant) was informed that current agency medical policies do not allow a nurse in the Rock County Health Department to administer a third measles, mumps, and rubella given after the individual's first birthday. (The Grievant) was informed that it was her responsibility as a professional registered nurse to have a thorough working knowledge of the current medical and agency policies related to immunizations, and that if there are questions on whether to give or not to give a vaccine, she should contact the nursing supervisor or nursing director.
>
> The one-day suspension will be completed on Wednesday, July 20, 1994.

The suspension reflected a consensus decision reached by Haeger, Helen Krause, the County's Public Health Director, and Karen Cain, the Grievant's Nursing Supervisor.

Krause testified she viewed the suspension to be an appropriate reflection of the Grievant's committing too many practice errors over too short a period of time. Haeger testified he viewed the suspension to reflect the seriousness of the prior discipline and the need to halt an ongoing pattern of practice errors. Cain testified the incident giving rise to the discipline reflected an ongoing problem requiring discipline.

Haeger testified that the State of Wisconsin, in 1990, changed its policy regarding the appropriate number of dosages required to immunize a child against Measles, Mumps and Rubella (MMR). Prior to 1990, three injections were required. The State changed this requirement to two injections. In the "VACCINE ADMINISTRATION SCHEDULE" maintained by the County's Medical Advisor, the appropriate dosage for a child's MMR immunization is described thus, under the heading "SCHEDULE":

> 1st dose 15 months of age.
> 2nd dose at 5.

The Vaccine Administration Schedule states the following under the heading "ACCEPTABLE ALTERATIONS:"

> 1st dose can be given as early as 12 months of age. 2nd dose can

be given as early as 4 years of age up to a person born on or after 1957. Minimum time between 1st and 2nd dose is 1 month.

This schedule is based on standards developed by the Advisory Committee on Immunization Practices of the USPHS; and by the American Academy of Pediatrics. The County has incorporated those standards as its own policy. The governing standard developed by the ACIP/AAP for MMR reads thus:

ROUTINE IMMUNIZATIONS STARTED DURING INFANCY (< 15 MONTHS OF AGE)

Age 1/	Immunizing Agents . . .
. . .	
12-15 months	DTP/Hib . . . MMR
At school entrance (4 thru 6 yrs.)	DTaP. . . OPV . . . MMR 9/
. . .	

1/ These recommended ages should not be construed as absolute, i.e., two months can be 6-10 weeks, etc.

. . .

9/ For the 1994-95 school year, children in all grades except 5th and 11th will be required to demonstrate having received two doses of MMR administered after the first birthday and separated by no less than 30 days. For the 1995-1996 school year and thereafter, all children in all grades will be required to demonstrate having received 2 doses of MMR after the first birthday.

. . .

To implement these policies, the County Public Health Department, referred to below as the Department, maintains forms to track immunization administration. One of those forms, developed by the State of Wisconsin, identifies, on a chart, that two MMR dosages are to be given to each child. The County also developed its own immunization cards, to be completed by a nurse administering an immunization, and retained by the parent of the child receiving the immunization. The card developed by the Department in 1992 includes a table consisting of seven columns

headed by the notation of the specific immunization, such as MMR or Polio. Under each of these headings appears five blank boxes. In those blank boxes, a nurse administering an immunization shot will write in the date the shot was given. Under the MMR column, three of the blank boxes have been shaded in to reflect that only two dosages are expected. Prior to 1990, the card maintained by the County had only two of the boxes in the MMR column shaded in to reflect that three dosages were expected.

Haeger testified that immunization standards were covered during employe orientation, at the time a policy was first implemented or changed, and at periodic staff meetings.

The incident prompting the suspension occurred on July 8. On that date the Grievant was working in an immunization clinic. A parent brought in a child who had been born on December 13, 1988. The child's immunization card was a form developed by the Department in 1987, thus containing three blank boxes under the MMR heading. In the top box under the MMR heading appeared the following entry: "3-14-90*." In the next box under the MMR heading appeared the following entry:

> *see back
> 6-20-94

On the back of the card appeared the following: "* given 2nd MMR due to lost record. Karen Cain." The Grievant chose to administer another MMR, placing the entry "7-8-94" in the third blank box under the MMR column. On the immunization card, multiple immunizations were given on the listed dates, with the exception of the "3-14-90" entry under the MMR column. That is the sole entry on the card for that date.

The State of Wisconsin funds immunizations, and Health Aides employed by the County track patient immunization records. One of those Aides noted the third entry on the immunization record and brought the matter to Cain's attention. Cain brought the matter to Krause's and to Haeger's attention, thus setting the stage for the suspension at issue here.

The disciplinary incidents which Krause, Haeger and Cain reviewed in determining to issue the suspension are summarized in memos from Haeger to the Grievant. The first such memo is dated November 9, 1993, and states:

> This is to satisfy the first step of the disciplinary process as stated per the union agreement between the Rock County Health Department and District 1199W/United Professionals for Quality Health Care. This step is written counseling . . . regarding unsafe

> practices at an immunization clinic.
>
> (The Grievant) was informed that each nurse is responsible for ensuring that the syringes they use for administering a vaccine are properly filled with the correct dose of a vaccine prior to inserting the needle into a client. (The Grievant) was informed that in the future, vaccines should be drawn up after each client has been assessed to determine what vaccines they need.

The second memo is dated January 6 and states:

> This is to satisfy the next step of the disciplinary process as stated per the union agreement between the Rock County Health Department and District 1199W/United Professionals for Quality Health Care. This step is a written warning . . . regarding unsafe nursing practice.
>
> (The Grievant) was informed that each nurse is responsible for ensuring timely follow-up on all cases assigned to them by the nursing supervisor. Failing to provide follow-up on a communicable disease case for approximately 3 months is an unsafe practice. (The Grievant) was informed that each nurse needs to develop a system for monitoring the status of each of their cases on a regular basis. Additional supervision by the nursing supervisor through weekly or every two weeks case review was offered.

The first memo covered the Grievant's administration of an empty syringe into a patient. The County ultimately funded ongoing HIV testing for the patient. The second concerned the Grievant's failure to provide ongoing follow-up for a child diagnosed with lead poisoning.

The Grievant testified that she has four years of experience as an RN, and roughly two and one-half years of experience as a Public Health Nurse. She testified that on July 8, a mother brought her child in for immunization. The Grievant did a general assessment of the child, and noted that only one immunization appeared on the immunization card for "3-14-90." She questioned the mother regarding this and the follow-up MMR, but found the mother's recall to be limited. She then reviewed available records and policies at the Immunization Clinic. She found no solid corroboration of the "3-14-90" entry, and determined to administer an MMR. She did not, at the time, view this to be the third MMR. Rather, she viewed it as the second, reliable MMR. If she was wrong, she felt the over-immunization was appropriate. The Grievant did not

call Cain regarding her notation on the immunization card.

Further facts will be set forth in the DISCUSSION section below.

THE PARTIES' POSITIONS

The County's Brief

The County states the issues for decision thus:

> Did the Employer act consistent with the union bargaining contract, ARTICLE II and XV, when it suspended (the Grievant) for one day without pay, after (the Grievant) had been disciplined on two prior occasions within the previous nine months, if not what is the appropriate remedy.

After an extensive review of the evidentiary background, the County asserts that Article XV clearly and unambiguously establishes the progressive discipline system which governs the disciplinary process. That system has, the County contends, been followed regarding the Grievant. Noting that the November 9, 1993 and the January 6, 1994 warnings were not grieved, the Union concludes that the one day suspension at issue here was mandated by Article XV.

The County's next major line of argument is that the one day suspension is appropriate discipline given the Grievant's "pattern of failing to follow the public health department policies and practice." Each instance of discipline meted to the Grievant manifests, in the County's view, a similar type of conduct. The third MMR given by the Grievant constitutes a medication error. That such errors are infrequent underscores, the County argues, the weakness of the Grievant's nursing practices. The Grievant's supervisors have, the County asserts, made "repeated efforts . . . to strengthen (her) nursing practice skills." Those efforts have not, however, been well-received by the Grievant, who has complicated the effort to improve her skills by refusing some of the instructional opportunities provided her.

The County contends that the immunization policy is not unclear and was announced to all employes. If the Grievant did not understand the policy, it was, according to the County, her responsibility to clarify any ambiguity. Her failure to contact the nurse who charted the June 20, 1990 MMR underscores the weakness of her nursing practices, according to the County.

Viewing the record as a whole, the County concludes that "the Employer's one day suspension without pay, should be upheld."

The Union's Brief

The Union states the issues for decision thus:

> Did the Employer violate the collective bargaining agreement and just cause standards when it suspended (the Grievant) on July 20, 1994 for one day. If so, what is the appropriate remedy.

After a review of the evidentiary background, the Union contends that the just cause standard places a burden of proof on the County and that seven questions define the just cause standard. Prior to addressing those questions, however, the Union posits two major lines of argument.

Noting that the sole cited basis justifying the discipline is the Grievant's improper administration of a third MMR to a patient on July 8, the Union asserts, as the first of its major lines of argument, that the County has failed to produce credible evidence to support this allegation. Neither the position description nor the staff meeting agenda submitted by the County can do so, according to the Union. The Union argues that the position description is too general to be applicable to the MMR and that the agenda do not establish that MMR administration procedures were discussed at any meeting attended by the Grievant prior to July 8. Beyond this, the Union argues that two dosage cards admitted into evidence do not clearly establish that only two MMRs may be administered to a patient. Those immunization policies admitted into the record establish, according to the Union, that the Grievant properly administered the MMR on July 8. At most, according to the Union, the relationship of the policies is subject to interpretation. The Union asserts that no less logical than the County's assertion that the policies must be read to mandate only two MMR's administered at least thirty days apart is the assertion that the Grievant could have been disciplined under the policies for failing to give the MMR she administered on July 8. A more realistic reading of the evidence, according to the Union, is that the policies called for the Grievant's exercise of professional judgment, and that her decision to over immunize the patient was both prudent and appropriate.

The Union's second major line of argument is that the Grievant "is a highly qualified and good public health nurse." The two items of earlier discipline are, the Union contends, irrelevant to the July 20 discipline under the terms of Article XV. The performance evaluations submitted into evidence show only "that the overall performance of (the Grievant) is good."

Turning to the seven questions defining its view of just cause, the Union argues that the County failed to warn the Grievant of the disciplinary consequences of administering a precautionary MMR. Beyond this, the Union argues that the Grievant followed County policies "to the letter." Testimony establishes, the Union argues, that the County made no attempt to investigate the July 8 medication administration before imposing the suspension. That no investigation occurred belies, the Union concludes, any conclusion that the investigation could have been "fair and objective" or that it could have produced "substantial evidence or proof of guilt." That no other employe has been suspended for a med error establishes, according to the Union, that the County "is attempting to discipline (the Grievant) . . . and used this incident as a cause to do so." That the Grievant exercised her professional judgment appropriately and caused no harm to the patient establishes, the Union contends, that the suspension bears no relation to the seriousness of the Grievant's conduct.

The Union concludes that the County lacked cause to discipline the Grievant. To remedy this violation, the Union "asks the arbitrator to reinstate (the Grievant) the one day of pay which

she missed due to her suspension and that the discipline be removed permanently from her personnel file . . ."

The County's Reply Brief

The County states the initial portion of its reply brief as a motion to strike from the record those portions of the Union's brief not based on "evidence admitted at the hearing." More specifically, the County asserts that the Union improperly mentions a conversation between the Grievant and her Union representative regarding the November 9, 1993 discipline. Since her representative did not testify and since the conversation contradicts the Grievant's testimony at hearing, the County concludes that the record should be limited to the Grievant's testimony. Beyond this, the County challenges the propriety of the Union's contention that the two prior warnings cannot be considered when evaluating the July 20 suspension. The County contends that because those warnings occurred within one year of the suspension, it was obligated, under Article XV, to consider them. That there was no testimony on any risk to the patient of a third MMR precludes, according to the County, any consideration of the assertion that the patient suffered no harm from it.

Turning to those portions of the Union's brief which can be said to have some record support, the County argues initially that the Grievant had no basis to administer the third MMR. Its policies clearly establish that each patient receives a total of two MMRs spaced at least one month apart. The County asserts that a third MMR should be given only if there is substantiated doubt that a patient has received two MMRs. The County argues that no such substantiated doubt existed on July 8. Any problem the Grievant had with the patient's documentation should have been immediately referred to her supervisor. After a detailed review of the evidence, the County concludes that the assertion of ambiguity in County immunization policy or its implementation through staff meetings is more apparent than real.

The Union's contention that the two prior instances of discipline should not be considered in viewing the imposition of the Grievant's suspension ignores established arbitral precedent as well as the language of Article XV, according to the County. Beyond this, the County argues that the contention that the County was "looking for the grievant to slip up" flies in the face of its efforts to afford her additional training.

The County then asserts that the seven standards cited by the Union to define just cause are both undocumented by the Union and irrelevant to standards of conduct governing nursing practice. Those standards are, the County concludes, traceable to State and Federal law and to County policy.

Even if it is presumed the seven questions applied by the Union are applicable to the evaluation of a work rule, the County contends the evidence establishes it has met those seven

questions. 2/ That the medications policies promulgated by the County have a direct bearing on the County's legitimate business interest in the delivery of sound health care cannot be disputed, according to the County. No less apparent, according to the County, is that the Grievant was fully aware of County immunization policy and on the consequences of not adhering to it. Beyond this, the County asserts it consistently tracks and documents med errors. That the Grievant has received more serious discipline than other employes reflects only the weakness of her past work record. The County then asserts that since the essential facts underlying the discipline are undisputed, the Union's contention that the County's investigation of the matter was in some sense deficient has no substance. That the July 8 MMR constituted another in a series of "nursing practice errors" establishes, the County asserts, that the suspension "is appropriate to the infraction."

The County concludes that under any standard defining just cause, it has proven the merit of the Grievant's suspension.

The Union's Reply Brief

The Union initially challenges the County's statement of the issue for not including any reference to "just cause." Beyond this, the Union contends that the County's brief misrepresents a number of facts and misstates as fact a considerable amount of argument. More specifically, the Union points to, among other points, the County's statement, without further elaboration, that the Grievant did not sign the grievance; the County's attempt to assert as fact circumstances surrounding the prior warnings which are not stated on the face of those warnings; the County's presumption that the July 8 MMR was the third received by the patient in spite of confusion surrounding this point; and the County's attempt to broaden the basis of the discipline beyond that stated in the suspension letter.

The Union notes that the language of Article XV is broad enough to permit discipline to progress in the levels applied to the Grievant. The Union asserts, however, that any such progression presumes "that it progresses for similar problems." The Union concludes that the discipline meted to the Grievant is for dissimilar instances of conduct. Lumping this conduct together as "unsafe nursing practice" establishes, the Union asserts, no more than that the County has sought not to correct the Grievant's conduct but to punish her.

The Union then contends that the MMR policy is not clear. Noting that County witnesses acknowledged a third MMR could, in certain circumstances, be appropriate and that testimony establishes the existence of an oral "over-immunization" policy, the Union concludes that the

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2/ The County uses the standards stated by "Shawe and Rosenthal, Employment Law Deskbook."

unambiguous "two MMR per child" policy asserted by the County does not exist.

That it has refuted County attempts to paint the Grievant generally as a poor employe, and specifically as improperly addressing the patient's needs on July 8 establishes, the Union concludes, the County's failure to meet its burden of proving cause for the suspension. The Union concludes the "arbitrator should make the grievant whole in every way."

DISCUSSION

The issues I have adopted are an amalgam of the parties' positions. There is little substantive difference between their statements of the issues. The just cause standard is set forth in Article II, while a specific statement of the principle of progressive discipline is set forth in Article XV. Application of the just cause standard is rooted in both of these articles.

The parties pose a threshold issue regarding what constitutes the just cause standard. The Union posits seven questions traceable to Arbitrator Carroll Daugherty. 3/ The County disputes whether these questions are applicable, but for purposes of argument poses a variant of those questions to indicate the strength of its case. This aspect of the grievance has only an academic impact. Adopting either of the standards does not impact the issues posed in this case.

The seven standards are, in any event, not universally accepted, and I am reluctant to imply them into the parties' agreement. In the absence of a stipulation from the bargaining parties, I believe a just cause analysis turns on two elements. First, the Employer must establish the existence of conduct by the Grievant in which it has a disciplinary interest. Second, the Employer must establish that the discipline imposed for the conduct reasonably reflects its disciplinary interest. This does not state a definitive analysis to be imposed on contracting parties. It does state a skeletal outline of the elements which must be addressed and relies on the parties' arguments to flesh out that outline.

The parties' dispute extends to both elements, but the most troublesome aspect of the dispute focuses on the first. The application of the second cannot be considered significantly in dispute if the first is met. More specifically, if the MMR administered by the Grievant on July 8 can be treated as a medication error contravening clear policy, the imposition of a one day suspension must be regarded as a reasonable reflection of the County's disciplinary interest under Articles II and XV. The Grievant must function on her own, under limited supervision. The prior incidents of discipline could appropriately be reviewed by the County under the terms of Article XV. Against this background, the imposition of a one day suspension for a series of practice errors spanning such a short period of time cannot be dismissed as unreasonable.

3/ See Enterprise Wire Co., 46 LA 359 (Daugherty, 1966).

Thus, the parties' dispute turns on whether the County has demonstrated the existence of conduct by the Grievant in which it has a disciplinary interest. While this determination is a troublesome one, the evidence will not support the County's contention that the MMR administered by the Grievant on July 8 constitutes, as the suspension memo puts it, "an unsafe nursing practice."

That the record is without evidence of how, if at all, the third MMR can be considered unsafe fundamentally undermines the assertion that its administration constitutes an "unsafe" nursing practice. The County characterizes it as a med error, but the evidence on this point is weak. The existence of the third MMR appears to have been discovered by Health Aides not as a medical error posing safety concerns, but as a cost item. The evidence is less than clear on this point, but indicates the Aides noted the third MMR constituted an unneeded medication which the State should not fund.

The County's arguments focus less on the safety aspects of the third MMR than on the potential implications of continuing practice errors. Under this line of argument, the issue is less one of patient safety on July 8 than on the potential ramifications of the Grievant's failure to adhere to County policy. To address this line of argument, it is necessary to determine how, if at all, the Grievant's conduct on July 8 constitutes a practice error.

What constitutes a practice error is, as each testifying witness acknowledged, a difficult point to assess. As a disciplinary matter, the point has two dimensions. The first is whether the July 8 MMR constitutes an improper exercise of nursing judgment. The second is whether the July 8 MMR constitutes the best exercise of nursing judgment.

The record will not reliably support the County's contention that the Grievant's conduct on July 8 constitutes an improper exercise of nursing judgment. Ambiguity surrounds both the immunization card presented to the Grievant on July 8, and the policy governing the decision to immunize. The card's reference that, on June 20, 1990, the child was "given 2nd MMR due to lost record" can reasonably be read to make the administration of the 3-14-90 MMR dubious. As the Grievant noted, no other immunizations were administered on 3-14-90. It is apparent, on the face of the card, that this makes the "3-14-90" reference unlike any other on it. The parent's inability to clarify the matter to the Grievant on July 8 added doubt to the significance of that entry. More significantly here, Cain's notation that the second MMR was given "due to lost record" itself makes the "3-14-90" reference dubious. If the record of the first MMR was lost, it is not apparent, on the face of the card, how the "6-20-90" MMR could reliably be viewed as the second. Against this background, the Grievant's conclusion that she was, for all practical purposes, administering a second MMR cannot be dismissed as unreasonable.

Beyond this, the County's contention that its immunization policy dictated that the Grievant not administer the July 8 MMR is tenuous. Though the parties dispute the clarity with which

employes have been apprised of the County's "two per life" MMR policy, this dispute has no bearing on the grievance. From the start of her employment, the Grievant applied the two MMR standard. On July 8 she administered the MMR thinking it was a second dosage, but willing to assume that if it was not, the over-immunization was sound practice. The issue posed here is whether her willingness to assume the risk that the July 8 MMR might be a third dosage was an improper exercise of her discretion.

The record will not support the assertion that her exercise of discretion was improper. None of the policy statements pointed to by the County preclude the administration of a third MMR. There is no evidence a third MMR posed any risk to the child. Nor is there evidence that an over-immunization would be improper if the underlying records regarding earlier dosages were suspect. That the underlying record, on its face, is suspect has already been noted. Beyond this, the application of the ACIP/AAP policy is not as clear as the County asserts. The immunization schedule notes that, optimally, dosages are given at "12-15 months" and "At school entrance (4 thru 6 yrs.)." Footnote 9/ of that schedule requires a child to demonstrate "2 doses of MMR administered after the first birthday and separated by no less than 30 days." Footnote 1/ of the schedule states that "recommended ages should not be construed as absolute," but exemplifies the play in the recommendations as something less than years. Cain became aware that the 6-20-90 dosage was the second sometime after its administration. A reliable record of the 3-14-90 dosage was not discovered until after June 20, 1990. The two records were then merged, with Cain's notation regarding the second MMR. Cain was aware of this, but her reference to a "lost record" makes the "3-14-90" reference dubious on the face of the card. That the first two dosages were given so close together could reasonably be viewed, with the ACIP/AAP schedule as background, as an indication that the second dosage was given to establish a reliable record of a first dosage.

In sum, the record will not reliably support the assertion that the Grievant's administration of the July 8 MMR was an improper exercise of judgment. The issue thus becomes whether it constitutes the best exercise of judgment.

The County's contention that any doubt the Grievant had regarding the immunization card should have been referred to Cain is persuasive. That the references on the card are ambiguous has been noted, as has the possibility that the ACIP/AAP policy itself could be read to point to a precautionary third dosage. Whatever ambiguities are apparent on the card or the policies could, however, have been resolved in a call from the Grievant to Cain. Cain did sign her name to the immunization card. In sum, the best course available to the Grievant on July 8 would have been to refer her doubts to Cain.

It is arguable that the County retains a disciplinary interest in an employe's failure to follow the best practice available. Whatever disciplinary interest this may lend the County as an abstract matter breaks down, however, in an attempt to apply that interest to the events of July 8. Most significantly here, this abstract interest is not the interest advanced by the County in issuing the suspension. As the July 19 memo notes, the County asserted an interest in "unsafe nursing

practice." As noted above, no unsafe practice has been proven. Nor has any exercise of improper judgment been proven.

The discipline reflects less the Department's concern with the events of July 8 than with prior disciplinary events viewed in light of the Grievant's failure to follow the best practice on July 8. The facts of July 8, however, are insufficient to invoke the significant disciplinary interest asserted by the County here. The weakness of the evidence on the events of July 8 is exemplified by the variance between Haeger's and Cain's testimony on the source of the immunizations noted on the card presented to the Grievant on July 8. Haeger noted the "3-14-90" immunization was given by Department while the "6-20-90" immunization was not. Cain noted this was not the case. In itself, this discrepancy has no impact on the grievance. It manifests, however, that the discipline meted on July 19 is rooted in implications arising from incidents other than the events of July 8. The evidence on the events of July 8 is insufficient to demonstrate the existence of a disciplinary interest in the Grievant's conduct on that date. However significant the County's disciplinary interest was in the events underlying the November 9, 1993 and the January 6 warnings, the events of July 8 provide no basis to extend that interest to a suspension.

AWARD

The County did not have just cause to issue a one day suspension to the Grievant for her conduct on July 8, 1994.

As the remedy appropriate to the County's failure to have just cause, within the meaning of Articles II and XV, for the one day suspension, the County shall make the Grievant whole for the wages and benefits she would have earned but for the suspension noted in the memo of July 19. The County shall expunge from her personnel file(s) any reference to the suspension noted in the memo of July 19.

Dated at Madison, Wisconsin, this 4th day of August, 1995.

By Richard B. McLaughlin /s/
Richard B. McLaughlin, Arbitrator