BEFORE THE ARBITRATOR

In the Matter of the Arbitration of a Dispute Between

MONROE COUNTY

and

ROLLING HILLS REHABILITATION CENTER EMPLOYEES LOCAL 1947, AFSCME, AFL-CIO

Case 133
No. 54266
MA-9608

Appearances:

Mr. Daniel R. Pfeifer, Staff Representative, Wisconsin Council 40, AFSCME, AFL-CIO, Route 1, Box 333, Sparta, Wisconsin 54656, appeared on behalf of the Union.

Mr. Kenneth Kittleson, Personnel Director, Monroe County, Monroe County Courthouse, Sparta, Wisconsin 54656, appeared on behalf of the County.

ARBITRATION AWARD

On July 5, 1996, Local 1947, AFSCME, AFL-CIO and Monroe County, filed a request with the Wisconsin Employment Relations Commission to have the Commission appoint William C. Houlihan, a member of its staff, to hear and decide a grievance pending between the parties. The matter was subsequently assigned to Mr. Houlihan, who conducted an evidentiary hearing on December 23, 1996, in Sparta, Wisconsin. Briefs were filed and exchanged by February 26, 1997.

This dispute involves the discharge of employe A.P.

BACKGROUND AND FACTS

The County and the Union have been signatories to a series of collective bargaining agreements. The relevant provisions of the applicable agreement are set forth below. This dispute involves the discharge of employe A.P. A.P. was terminated on March 7, 1996 by the following letter:

> As a result of persistently poor performance of your LPN duties, you are being terminated from your position at Rolling Hills effective as of March 7, 1996.

The grievant has been employed by the Monroe County Rolling Hills Nursing Home since March 29, 1988. During her tenure, she has been the subject of significant discipline. The Employer submitted a summary of discipline which included 18 entries between March of 1993 and March of 1996, the day of discharge. The Union takes issue with the characterization of many of the incidents. The Union contends there are but 7 instances of discipline. While reasonable people may differ as to the precise number of prior disciplines, it is uncontested that the grievant has received significant discipline including a meaningful number of disciplinary measures aimed at her inattentiveness to her patients, and her charting. Specifically, on January 11, 1996, she was given a 5 day suspension for inattentive care and failure to chart. At that time she was warned that another incident such as the one involved would result in her termination.

Among the patients under the care of the grievant on March 2, 1996 was patient number 1795, an elderly gentleman suffering with Huntington Corea. Among the symptoms associated with this disease include a propensity to thrash about in bed. The patient was mildly sedated and bedridden. He periodically bruised his arms and legs, and got his legs stuck/wedged in the slats of his bedside rails. On Saturday, March 2, nursing assistants Nancy Volenze and Sharon Bebee discovered patient 1795's leg sticking through his bed slats. According to Ms. Volenze, they removed his legs, put them back into bed, rolled down his socks, and discovered that his leg bore a red mark. Ms. Volenze testified that she reported this matter to the grievant, and following a direction to do so, applied Bacterine. It was her testimony that the mark was red, that there was no drainage, and that it extended from the knee to the ankle. It was her testimony that the wound was not open on Saturday, March 2. Following her report to the grievant, it was her understanding that the grievant would chart the matter. Ms. Bebee testified to essentially the same event. Notably, she saw that the patient had his leg in the slats. She participated in its removal, and saw the abrasion on the leg. It was her testimony that there was no torn skin, no blood, and that the wound resembled a carpet burn. It was her testimony that she told A.P., assuming the latter would check.

The grievant testified, and acknowledged, that Volenze and Bebee had indicated to her that patient 1795 had sustained a leg injury. She testified that she checked the patient, rolled down his sock, felt the wound, and felt the matter was not serious. She described the wound as a small reddened area. She understood that Bacterine had been applied and believed that a repositioning of the leg would cause blood to circulate and the wound to self-heal.

On Sunday, March 3, Ms. Volenze attended patient 1795. It was her testimony that his leg was still red. There was no charting of the incident which had occurred on the prior day. Volenze approached Jane Parseneau, the Resident Care Coordinator. Parseneau acknowledges

that Volenze advised her that patient 1795 suffered from a bruise on his leg. It was Ms. Parseneau's testimony that she believed that A.P. would both take care of the injury, and the charting. She testified that she noted that there had been nothing reported from March 2.

Bebee also testified as to her observations on Sunday, March 3. Her testimony was that she believed she saw the same injury again. Ms. Bebee, however, became confused as to whether it was Sunday or Monday, March 4, when she next saw the patient's leg.

Sherri Brueggeman, a nursing assistant, testified that she worked on March 2, 3 and 4 and that she cared for patient 1795. It was her further testimony that on Sunday, March 3, she changed his linens, his socks, gave him a bath, and lotioned his body. She testified that there were no marks on his legs on Sunday, March 3.

Mary Smith, a nursing assistant, testified that she worked both Saturday and Sunday. It was her testimony that she washed patient 1795 both days, changed his socks and gown both days, and that he had no marks on his body.

On Monday, March 4, Irene Pollack, an LPN, discovered patient 1795's legs stuck in the bed slats. She helped remove his legs, but did not examine them at that time. Subsequently, at approximately 10:00 a.m., Pollack was approached by Sherri Brueggeman, who reported that the patient had suffered injuries. It was Brueggeman's testimony that on Monday, March 4 she found the patient stuck with his legs stuck in the slats. She indicates that she released his leg, and saw what she regarded as a fresh leg injury. It was her testimony that she reported that injury to Pollack and indicated her belief that it had just occurred. Brueggeman's testimony is consistent with that of Pollack, in that Pollack was drawn to the patient through Brueggeman's report. Pollack testified that she checked the patient, and found abrasions which looked fresh to her. She testified that there was no draining, and no scab. Pollack testified that she did not regard the bruises as serious enough to call a doctor or a registered nurse.

Later that day, Pollack informed Eleanor Mylotte, Director of Nurses, that she had found a resident's leg bruised and scraped. Pollack advised Mylotte that she had filled out an incident report on the findings, thinking that it had occurred on her shift. When she gave the report to the evening CNA's, she was informed by them that they had told A.P. on Sunday that the resident's leg was scraped and bruised from getting his foot stuck between the side rails. They indicated that they had asked A.P. to check on the resident's foot and that she did not do so. Mylotte reviewed the chart, and noted that there had been no entry. Mylotte discussed the matter with the RN who had supervised staff on Sunday, and was advised that she had received no report.

Mylotte went to patient 1795's room, and examined the injury to his leg. It was her observation that the injury was not a fresh injury, due to the fact there was no drainage and scar tissue was present. Based upon her investigation, Mylotte concluded that the grievant had failed to attend to the patient, and to chart the injury received on Saturday. Mylotte did not talk with either Brueggeman or Smith during the course of her investigation.

On March 7, a disciplinary conference was conducted. During the course of the conference, Mylotte notes that the grievant acknowledged "Well, I guess since I didn't chart on it, I didn't do it." Mylotte concluded that the grievant should be terminated, and provided her with an already prepared letter of termination.

ISSUE

The parties stipulated to the following issue:

Did the County violate the collective bargaining agreement by terminating the employment of the grievant, A.P., on March 7, 1996? If so, what is the appropriate remedy?

RELEVANT PROVISIONS OF THE COLLECTIVE BARGAINING AGREEMENT

ARTICLE 3 - MANAGEMENT RIGHTS

The County possesses the sole right to operate county government and all management rights repose in it, subject only to the provisions of this Agreement and applicable law. These rights include, but are not limited to, the following:

. . .

D. To suspend, discharge and take other disciplinary action against employees for just cause;. . .

. . .

ARTICLE 22 - GENERAL PROVISIONS

. . .

Section 5. The County shall not discipline or discharge an employee except for just cause. Any employee discharged and later through proper hearing is found

innocent of the charges, said employee shall return to his/her former job with the County paying said employee all wages and benefits he/she would have earned had he/she been working, less any compensation received from Unemployment Compensation or other sources during the period of discharge.

POSITIONS OF THE PARTIES

The Employer's brief recites the operative facts and poses the question, "How long should an employer carry a Licensed Practical Nurse who consistently fails to perform the most rudimentary duties of her position?" The Employer goes on to argue that the grievant had been counseled, warned or disciplined no less than 16 times in the past 3 years for substandard work performance, usually involving failure to chart or report incidents.

In its review of the facts, the County notes that employes Volenze and Bebee both identified a photograph, taken on March 7, as the same injury they had previously observed on March 2. Both indicated they had brought the matter to the grievant, to no consequence.

On March 4, Irene Pollack had the injury brought to her attention. Her initial observation was that the injury was fresh and new, and she reported it as such. When approached by Beebe, who indicated to her that the resident's injury was not new, Pollack reported the matter to Director of Nursing Eleanor Mylotte for investigation. Mylotte concluded that the injury to the resident's leg was reportable, and that the grievant had not documented the incident in the resident's chart. When Mylotte confronted the grievant, she initially claimed that she had gone in and looked at the resident's injury, and then abruptly reversed her story and stated, "Well, I guess since I didn't chart on it, I didn't do it." According to Mylotte, the grievant then pointed to the transgressions and failings of other employes and claimed they were tolerated. In essence, the grievant claimed she was being singled out.

The County contends that the testimony of Mary Smith, and Sherri Brueggeman should be discarded. The County believes neither to be credible, and takes issue with written statements they prepared which are undated.

In summary, the County believes that due to the severity of the incident, and the grievant's lengthy disciplinary record, the only appropriate outcome is her termination.

It is the position of the Union that the County "dropped the ball" both procedurally and substantively. The Union contends that the County conducted a sloppy investigation which resulted in an errant conclusion.

With respect to procedure, the Union contends that the grievant was denied due process, her right to tell her story, before the Employer made a decision. The Union notes that the County had made its decision to terminate the grievant before she showed up for work on March 7. Her time card had been removed, she had been replaced for the entire shift by another worker, and the termination letter was written and signed prior to the March 7 meeting between the parties.

The Union notes that during the course of the March 7 meeting, the grievant was quoted as saying, "Well, I guess since I didn't chart on it, I didn't do it." The Union characterizes that as a sarcastic remark directed at a supervisor with whom the grievant had a tenuous relationship. The Union attacks Mylotte's investigation, in that the Union contends Mylotte assumed the injury she observed on March 4 was the same injury that existed on March 2. It was not the same. The Union takes issue with the testimony of Volenze and Bebee at least insofar as the testimony was that the grievant did not examine the patient's leg on March 2. The only direct testimony on that subject came from the grievant, who indicated that she did examine the patient's leg, found a reddened area which she believed had been caused by lying for too long in one position.

The Union notes that several shifts passed between the March 2 discovery of the reddened area and the March 4 discovery of the bruised and bleeding leg. The Union asks the question, "If the injury to this patient was so severe as to warrant a discharge, how could such an injury have gone unnoticed for two whole work days?" The Union answers its own question through the testimony of Brueggeman and Smith. The Union notes that the Union president sought out Brueggeman and Smith who indicated that they had cared for the patient, that there were no bruises on the patient, and that no member of management had ever approached them to investigate this incident. It was Brueggeman who reported the March 4 injury to Pollack.

The Union points to record testimony to the effect that not all injuries and bruises are charted. Some element of discretion is inevitably required in that minor matters are not universally reported.

The Union points to the cross-examination of Irene Pollack who testified that she believed the injury had occurred on her shift. She further testified that the injury looked fresh when she first observed it.

The Union notes that the grievant was fired because the County believed that the serious injury sustained by the patient on March 4 was the same injury, which incurred on March 2 and that the grievant had not appropriately cared for them. This is clearly not the case. The Union believes that the Employer is now shifting the focus of its determination to discharge to the more technical failure to chart. The Union contends that this is inappropriate and unfair.

DISCUSSION

All testimony, including that of the grievant, is that patient 1795 suffered some sort of bruise or sore on Saturday, March 2. All testimony in the record is to the effect that it was not open and bleeding, nor was it deemed serious by any person. All testimony suggests that the injury was treated. It also appears that it was never charted. All testimony points to the grievant as being the individual responsible for the charting. The grievant does not disavow this responsibility but essentially her testimony makes two claims: the first is that the matter was not serious enough to warrant charting. The second is that injuries or burns of this kind and nature are frequently not charted, with no punishment or sanction forthcoming.

The real dispute in this proceeding is just how serious an injury patient 1795 had as of March 2. That question is substantially in dispute. It was the testimony of Volenze and Bebee that there was a serious scrape. They testified to it being a long scrape the length of the man's lower leg. Each witness identified a photograph taken on March 7, which showed a long injury running the length of the lower leg and indicated that is the injury they saw on March 2. The grievant testified that she saw a red mark which she believed was the product of lying in one position for too long. It was the testimony of Smith and Brueggeman that there was no visible injury at all. Both testified to caring for the grievant over the two-day period that followed the reported March 2 injury. Both testified to giving care, to bathing, to changing the man's bed linens and clothing without noticing any red mark. If the wound photographed by the Employer on March 7 was the same wound experienced by the patient on March 2, it would have been a serious matter indeed. To so conclude requires me to discredit the testimony of Smith and Brueggeman in its entirety.

On Monday, March 4, there was another incident. There was eyewitness testimony to the fact that patient 1795 had his legs stuck between the slats of his bed. Whether this incident aggravated a pre-existing wound or originated a new wound cannot be determined from this record. Pollack's first review of the injury persuaded her that it was fresh. She testified in detail that there was no draining and no scabbing of the wound. While she did not regard it as a serious scrape, she did regard it as freshly occurring. Her testimony in this regard is incompatible with Eleanor Mylotte. Mylotte testified the injury was not recent as of March 4; that there was no ointment or salve present. She testified that she saw an older, smaller bruise on the right leg/foot running approximately two and one-half inches in addition to that described by Pollack.

I believe the investigation was flawed. Mylotte never talked with Smith or Brueggeman. It was Brueggeman who reported the March 4 injury to Pollack. Both Brueggeman and Smith were caregivers over the two-day time frame that spanned March 2 through March 4. It is difficult for me to understand why the individual who discovered the patient wedged between

bed slats and who reported his injury would not be contacted for her perspective on how the injury occurred. Mylotte concluded that the grievant had known about, and failed to chart, a serious patient injury for three days. Yet she did not follow up with certain members of the caregiving staff who attended the patient during the period in question. It would certainly seem to me that the Director of Nurses would seek to determine how many people were aware of this wound, and what they did about it.

On March 7, the Employer photographed the patient's leg and showed the photo to Volenze and Bebee, who identified the bruise as that which they had previously discovered over the March 2-3 weekend. For me to accept this requires me to ignore the fact that the patient lodged his leg between the bed slats on March 4 and that Brueggeman and initially Pollack believed this incident had left a mark on his leg.

Management did not interview all of patient 1795's weekend caregivers. One consequence of its failure to do so was that Brueggeman and Smith's observations were not a part of the record and were not taken into consideration at the point of discharge. The County urges me to disregard their testimony. Brueggeman testified that she believed the injury to have been caused on March 4. The Employer urges that I disregard her observations in this regard also. I am not willing to disregard all of their testimony. Brueggeman discovered the patient's injury on March 4. She was ideally positioned to comment on how fresh the injury was. Pollack agreed with her assessment. I am unwilling to ignore that fact. Mylotte, who also observed the patient, disagreed. However, in her written summary, Mylotte notes that the presence of "2 1/2 old yellow" on right foot. This observation is not inconsistent with the testimony of A.P. who indicated on March 2 that she saw a "small reddened area" when she went to check on the patient.

The testimony of Brueggeman and Smith is incompatible with that of Volenze. Ms. Bebee's testimony became somewhat confused. Bebee could not recall whether she saw the patient on Sunday or Monday. Bebee testified that she was not aware of the fact that the patient had been injured/reinjured on the morning of March 4.

There was no effort in the pre-disciplinary investigation to uncover and reconcile the many seemingly incompatible facts. I am not free to simply ignore testimony and facts which are incompatible with the Employer's conclusion.

The letter of termination is conclusory, as to the specific basis for discharge. The final grievance step answer is more revealing and indicates that A.P. was "Terminated following incident involving not responding to an injured resident following report by two CNA's." Nothing in the record supports a conclusion that A.P. did not respond.

I do not regard A.P.'s remark during the course of the disciplinary conference to be an admission. The record suggests that she is prone to wisecracks and the context of this

conversation more suggests sarcasm than confession.

I believe the weight of the evidence suggests that the patient did injure himself on March 2. I believe that A.P. did look in on him and concluded that the injury was not serious enough to chart. Whether her judgment in that respect was well founded is impossible to tell. I am comfortable concluding that the Employer has not established that her call was wrong.

AWARD

The grievance is sustained.

REMEDY

The Employer is directed to reinstate A.P. and to make her whole, consistent with Article 22, for any wage and/or benefit losses she has incurred as a result of this discharge. The Employer is directed to expunge A.P.'s file of reference to this matter.

JURISDICTION

I will retain jurisdiction in this matter for purposes of resolving any dispute which may arise with respect to the remedy.

Dated at Madison, Wisconsin, this 7th day of October, 1997.

William C. Houlihan /s/

William C. Houlihan, Arbitrator

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