BEFORE THE ARBITRATOR

In the Matter of the Arbitration of a Dispute Between

THE BROWN COUNTY MENTAL HEALTH CENTER REGISTERED NURSES

and

BROWN COUNTY

Case 642
No. 58795
MA-11063

Appearances:

Mr. David Campshure, Staff Representative, Wisconsin Council 40, AFSCME, AFL-CIO, appearing on behalf of The Brown County Mental Health Registered Nurses.

Attorney John Jacques, Assistant Corporation Counsel, Brown County, appearing on behalf of the County of Brown.

ARBITRATION AWARD

Wisconsin Council 40, AFSCME, AFL-CIO, hereinafter the Union, requested that the Wisconsin Employment Relations Commission appoint a staff arbitrator to hear and decide the instant dispute between the Union and Brown County, hereinafter the County, in accordance with the grievance and arbitration procedures contained in the parties' labor agreement. The County subsequently concurred in the request and the undersigned, David E. Shaw, of the Commission's staff, was designated to arbitrate the dispute. A hearing was held before the undersigned on July 20, 2000, in Green Bay, Wisconsin. There was a stenographic transcript made of the hearing and the parties submitted post-hearing briefs and reply briefs in the matter by October 17, 2000. Based upon the evidence and the arguments of the parties, the undersigned makes and issues the following Award.

ISSUES

The parties stipulated that there are no procedural issues and that the statement of the substantive issue is as follows:

> Did the County have just cause to suspend the Grievant for his actions on February 12, 1999? If not what is the appropriate remedy?

CONTRACT PROVISIONS

The following provisions of the parties' Agreement are cited in relevant part:

ARTICLE I

MANAGEMENT RIGHTS

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 him for such period of time involved in the matter.

The Employer shall adopt and publish reasonable rules which may be amended from time to time. Except for rules, regulations and directives from the State of Wisconsin, approving agencies such as the Joint Commission on Accreditation of Hospitals, or other governmental agencies having jurisdiction over the institutions; however, such rules shall be subject to the grievance procedure.

. . .

ARTICLE 7

WORK DAY – WORK WEEK – INCLEMENT WEATHER

Employees shall work an eight (8) hour and twenty (20) minute work schedule (includes lunch period of twenty (20) minutes).

. . .

ARTICLE 24

GRIEVANCE PROCEDURE – DISCIPLINARY PROCEDURE

The parties agree that prompt and just settlement of grievances is of mutual interest and concern. Employees are encouraged to orally discuss concerns which might lead to a grievance with their supervisor prior to filing a grievance.

. . .

The parties agree that the decision of the arbitrator shall be final and binding on both parties to the Agreement. The Arbitrator shall not have the authority to add to, subtract from, change, alter, modify or delete any of the specific terms of provisions of this Agreement, and his/her ruling will be restricted to an interpretation of the contractual part of this Agreement only.

. . .

No employee shall be reprimanded, suspended or discharged except for just cause.

SUSPENSION: Suspension is defined as the temporary removal without pay of an employee from his/her designated position. The Employer may, for disciplinary reasons, suspend an employee. Any employee who is suspended, except probationary employees, shall be given written notice of the reasons for the action, and a copy of such notice shall be made a part of the employee's personal history record, and a copy shall be sent to the Union. No suspension for cause shall exceed fourteen (14) calendar days.

. . .

DISCIPLINARY PROCEDURE: The progression of disciplinary action normally is 1) oral, 2) written, 3) suspension, (sic) 4) dismissal. However, this (sic) should not be interpreted that this sequence is necessary in all cases, as the type of discipline will depend on the severity of the offense.

Oral warnings shall be maintained in effect for six (6) months, written warnings for twelve (12) months and disciplinary suspensions for eighteen (18) months during which the repetition of an offense can result in a more serious disciplinary action. In all such cases, the employee shall have the right to recourse to the grievance procedure.

The grievance committee chairman or his/her designated representative shall be present during all disciplinary hearings and shall receive copies of all communications concerning disciplinary actions.

BACKGROUND

Brown County owns and operates the Brown County Mental Health Center. The Center provides mental health and skilled nursing care services to clients. The Union represents the non-supervisory registered nurses (RN's) at the facility. The Grievant, Thomas Burke, is an RN and an 11-year employee at the Brown County Mental Health Center.

The circumstances that gave rise to the discipline and subsequent grievance relate to a patient and the nursing care provided to that patient on the early morning of February 12, 1999. The patient was admitted to Unit 8 on February 3, 1999. Unit 8 is a 25-bed wing of the facility where day-to-day nursing care and living assistance is provided to clients.

On February 11, 1999, the Grievant worked the night shift on Unit 8. The night shift is scheduled to begin at 10 p.m. and end at 6:20 a.m. Employees have a five-minute "window" in which to punch out so that they do not create unauthorized overtime. Also assigned to Unit 8 was Debra Moore, who has been a Certified Nursing Assistant (CNA) on that Unit for 14 years; Karen Hermann, Licensed Practical Nurse (LPN) floater assigned to Unit 8 on the 6:00 a.m. to 2:20 p.m. shift and who has been an LPN in the facility since 1991; Charlotte Ferry, Unit Ward Clerk; and Kay Webb, House Manager/Night Supervisor from 11:00 p.m. to 7:30 a.m.

At approximately 6:20 a.m. on February 12, 1999, CNA Moore brought the patient from her room to the nurses' desk in a wheelchair. Moore is assigned to care for certain patients, including the patient in question, and had previously washed and dressed the patient. CNA Moore prepared a statement on February 19, 1999 regarding what transpired:

> Client ashy when I went in to get her dressed. She was diaphoretic and c/o (complained of) not feeling good. I got her dressed and put her in wheelchair took her to the desk and told Tom to take a look at her. He was getting ready to leave and I said I would do an O2 (Oxygen) sat(uration) on her. He said okay. I did the sat(uration) and told him it was 74. He said to take a temp(erature). I did and he took his stuff and was leaving to go down on the elevator and said she wasn't in any immediate danger and Heather would be in at 7 a.m. The he left and the supervisor was called.

Moore testified that the patient was "kind of gray and real sweaty, diaphoretic" when Moore was getting her up. Moore asked the patient if she were sick and was told by the patient that she did not feel good. She dressed the patient and brought her up to the nurses desk in a wheelchair. Moore told the Grievant that the patient did not look good to her and asked him to look at the patient. The Grievant was getting ready to leave at this point as it was near the end of his shift. The Grievant said something about getting vitals and Moore said she would do an "O2 saturation", got out the oximeter and took the patient's reading, which was somewhere in the low 70's. Moore testified that he said "Okay" when she said she would do an "O2 saturation" and that she thought the Grievant heard her give the results. Before she could obtain the patient's vitals, the Grievant stated that the patient was not in any danger and that the next RN would be in at 7:00 (a.m.) and then left. Moore finished taking the patient's vitals after the Grievant left. Moore did not ask the Grievant to stay and does not think he said, "That's not my problem" when he left. Moore disagrees that the patient was typically pale and felt she did not look like she normally did and was diaphoretic, including when she was brought to the desk. Moore concedes that the patient was anxious at times and sometimes complained of not feeling well. Moore also concedes it is possible the Grievant came around to the desk to observe the patient and may have touched her. Moore testified that she got the patient up and dressed because it is the general rule to do so unless the patient is reported to have a problem or does not wish to get up. Moore felt the patient was becoming more acute and that is why she brought the patient to the desk, at which time the patient was grimacing, her color was "very poor", and she was sweating profusely. Moore felt the patient needed to be assessed.

LPN Hermann also prepared a written statement on February 19, 1999 regarding February 12, 1999:

> I asked Tom @ approx 0615 to please stay and assess TO (patient) for possible cardiac distress. p CNA wheeled her to the nurses station stating she didn't look good. CNA reported client as being diaphoretic with poor color, when she questioned the client, (client) stated "I don't feel good". I asked client how she didn't feel good, her response was my left shoulder hurts. I agreed that her color was ashen. Tom RN's response was get vitals, so the CNA took the

> temp and had not-yet gotten the blood pressure, P(ulse) & R(espiration) before Tom had announced, she was not in distress and he was leaving. I informed him that we would not have an RN until 0700. His response was "That's not my problem, does the House Manager know this" I called the house manager and, Tom was on the elevator (U8) before I could speak to her. (Add) 1st action p comming to nurse stn. CNA took first O2 sat(uration) where was low (7?%) Tom witnessed the O2 sat(uration) procedure.

Hermann testified that Moore brought the patient to the nurses desk in a wheelchair and stated the patient was complaining she did not feel well. Moore also stated that the patient's color was bad and that she was diaphoretic when Moore got her up. Hermann testified she did not think the patient looked good either. The patient stated she did not feel good. Hermann testified that in response to her asking the patient how she did not feel good, the patient stated that her left shoulder hurt. Hermann further testified that Moore said she would take the patient's oxygen saturation level and did so, and that the results were in "the 70's". While she could not say that the Grievant saw the reading on the screen or heard the results, Hermann testified that the Grievant was present when it was done, and that she asked him to stay because the RN on the day shift was not coming in until 7:00 a.m., to which the Grievant responded, "That's not my problem" and asked if the House Manager knew that. Hermann testified that the Grievant then suggested the patient's vitals be taken and that Moore was taking the patient's tympanic temperature when the Grievant stated he was leaving and said that the patient was not in any distress, and that he then left before the vitals could be completed. Hermann called the House Manager, Webb, as the Grievant was leaving and Webb arrived seconds later. Hermann conceded the patient was normally paler than average due to her heart problems, but that given her color, her complaining of chest pains and her history of heart problems, she felt she needed to report it as a "change of condition" to an RN for assessment. Hermann feels that it is normally the case that an RN will be called to the patient's bed to do an assessment, rather than getting the patient up and dressed.

> The Grievant prepared a signed statement on February 13, 1999 that stated:
> On 2-12-99 @ 0623, 3 minutes after my shift had ended, I was about to leave the unit when a CNA brought up client # 50473 in a w/c (wheelchair) and stated client didn't look good. Client was awake and stated "I don't feel good" She did not indicate to writer any specific area of pain. A tympanic temperature was gotten indicating client was a febrile color was pale no indication of respiratory distress noted. House manager was still on duty and 50 feet down the hall if medical intervention were needed. There were also 2 LPNs on the unit. Client was a no code and no hospitalization. I left the unit @ 0626. 1/

1/ The Grievant also submitted a "clarification" on June 28, 1999, which is largely mirrored in his testimony at hearing.

The Grievant testified that on February 12, 1999 CNA Moore brought the patient to the nurses' desk at 6:23 a.m. and asked him to take a look at her. He indicated he was standing between the patient and the elevator. He observed her sitting in a wheelchair, dressed, with her hair combed, and asked her what was wrong. The patient responded that she was not feeling well. He stated the patient was not diaphoretic, that her skin was normally pale and that she was often anxious. He then informed the staff that she looked "okay" to him, that a nurse would be in at 7 o'clock, but that the house manager was available should they need her. The Grievant left the unit and punched out at 6:26 a.m. The Grievant denied that he was informed that the patient had complained of chest or left shoulder pain, denied that he was informed of an oxygen saturation reading of 74, denied directing staff to conduct an oxygen saturation procedure, and denied directing staff to obtain the patient's vitals. The Grievant stated that had he been aware of an oxygen saturation reading of 74 or of the patient's claims of chest or shoulder pain, he would have stayed on the unit to assist the patient. The Grievant feels that if a patient has a problem, the CNA normally calls the RN to the patient's bed.

Kay Webb, House Manager, was called to assist on Unit 8 on February 12, 1999 after the departure of the Grievant. Webb testified that when she arrived on the unit the patient was ashen colored and in "some respiratory distress", raspy and short of breath. Webb testified that the patient was not diaphoretic, when she (Webb) arrived, but that the CNA had reported the patient was "very diaphoretic". Webb was also informed that the patient had complained of some shoulder pain. Webb reviewed the patient's chart and assessed the patient's condition. Webb testified that in conducting the nursing assessment she looked at the patient's overall condition including her skin color, listened to her heart, did an oxygen saturation reading (74 finger, 84 toe), listened to her lungs (raspy) and obtained a blood pressure reading (within normal limits). Webb concluded that the patient had the symptoms of a heart attack and directed that the patient be placed on oxygen. Webb then telephoned the physician who returned the call at 6:55 a.m. with orders for oxygen and nitroglycerin.

Progress notes from the facility indicate that on February 12, 1999 at 6:30 a.m. the patient was "in respiratory distress", her color was "ashen, she was claiming left shoulder pain" and the "CNA reported she (client) was diaphoretic upon awakening this AM". Written into this document within the same line as other numerical results above the notations for blood pressure was the oxygen saturation reading of 74 to 84. These notes indicate that by 7:45 a.m. the patient was no longer in pain and that her "skin (was) pale, slightly damp and warm to the touch."

On August 23, 1999, a Brown County Corrective Action Report was issued to the Grievant wherein the County charged the Grievant with the following violations:

> Failure to perform his nursing duties in accordance with the standards of practice set forth in Chapter N6 and N7, WISCONSIN STATUES (sic) AND ADMINISTRATIVE CODE RELATING TO NURSING.

1. Tom Burke did not perform a client assessment because the client looked, in his opinion, the way she always looked (based on his contact of six work shifts since the client's admittance on 2/3/99 and date of incident on 2/12/99). His decision was based on a 3-minute period of time spent with the client, the LPN and the CAN.

2. Tom Burke didn't provide supervision and direction to the LPN and CAN in what they perceived to be a crisis situation.

3. Prior to leaving the work area, Tom Burke didn't inform the House Manager of a crisis or potential crisis situation when in fact four minutes after his departure the House Manager determined there was a crisis and proceeded to do a complete client assessment.

Admin. Code, Chapter N6.03(1)

> Tom Burke did not, ". . .utilize the nursing process in execution of general nursing procedures in the maintenance of health, prevention of illness or care of the ill. The nursing process consists of the steps of assessment, planning, intervention and evaluation.

Admin. Code, Chapter N6.03(3)(b)

> Tom Burke did not, "Provide direction and assistance to those supervised;"

Admin. Code, Chapter N 7.03(1)(a)

> Tom Burke's conduct is deemed negligent because of the following conduct:
>
> (a) Violating any of the standards of practice set forth in ch N6;
> (b) An act of omission demonstrating a failure to maintain competency in practice or methods of nursing care;
> (c) Failure to observe the conditions, signs and symptoms or a patient, record them, or report significant changes to the appropriate person; (sic)

As a result of these alleged violations, the County imposed a three work day suspension on the Grievant. The suspension was grieved and the parties, being unable to resolve their dispute, proceeded to arbitration before the undersigned.

POSITIONS OF THE PARTIES

County

The County first asserts that the Grievant is contractually bound by Article 1 of the Agreement to follow the state regulatory requirements for state nursing facilities and their employees. In addition, the County's job description for staff RN's specifies that nurses will conduct assessments. It is the primary duty, and most important responsibility, of a professional staff nurse to assess and monitor a patient's condition and seek medical intervention when necessary.

The County asserts that the basis for the discipline occurred in a three minute time period on February 12th, during which the Grievant performed a totally inadequate nursing assessment of a patient. The Grievant failed to take an oxygen saturation level, failed to check the patient's breathing and heartbeat with a stethoscope, failed to monitor respiration by timing breathing and failed to observe and document the patient's vital signs.

The County asserts that the Grievant could not have been justified in his actions because less than four minutes after the Grievant left the unit, Nursing Supervisor Webb diagnosed the patient to be in respiratory distress. Medical intervention ensued in the form of oxygen to stabilize the patient's oxygen saturation level. Later that morning, between 6:30 a.m. and 7 a.m., physician's orders were prepared that confirmed that the patient was in respiratory distress and medical intervention was required.

While the Grievant may have conducted a "visual" assessment and touched the patient's hand, this was grossly inadequate to properly assess the patient's condition and need for medical intervention. The County disputes the Grievant's determination that it was not necessary for him to do more than this. There were four undisputed facts of which the Grievant had knowledge that required him to stay and complete an adequate nursing assessment per the standards for professional nurses: 1) The CNA brought the patient to the Grievant and requested a nursing assessment; 2) the patient complained she was not feeling good; 3) the patient was obviously pale and anxious; and 4) an oxygen saturation reading was readily available by means of an oximeter. The County asserts that the Grievant did not have the right to exercise nursing judgment, but rather he had a non-delegable duty to perform an adequate nursing assessment as a result of a patient complaint and the request by the CNA.

The County asserts that the Grievant left knowing that a patient was in need of a nursing assessment. The Grievant was expected to either call another nursing professional or take the necessary precautions to ensure that another nursing professional was present to conduct the assessment and provide care.

The Grievant's lack of credibility was shown by the testimony of Moore, Herrmann, Ferry and Webb. The Grievant's testimony was contradictory and his testimony that he was not told the patient's oxygen saturation reading, nor informed that she was complaining of pain in her left shoulder, is refuted by the testimony of these eyewitnesses who stated that the Grievant was given the information.

The County believes just cause was established by the Grievant's admission that he did not call for additional nursing staff for assistance, nor perform a full body assessment himself, and instead left the patient with non-professional nursing staff. The Grievant's acts and omissions jeopardized the life of the patient. But for the fortunate circumstance of the patient not dying during the four-minute absence of any professional nursing staff and Webb's prompt intervention, the County would have more severely disciplined the Grievant.

The Grievant's justification of his actions is an exacerbation and confirmation of his inappropriate motivation when he left the patient. The County believes that the Grievant is in need of remedial training both as to what constitutes an appropriate nursing assessment and about his attitude toward mentally ill, elderly, no code patients. The County concludes that the Grievant's attitude toward patients needed to change and firm disciplinary action was justified.

In its reply brief, the County takes issue with the Union's conclusion that no negative consequences resulted from the Grievant's leaving the patient and nursing staff. Continuity in nursing care is essential to patient health, and the interruption caused by the Grievant's departure was detrimental to the patient. Additionally, other nursing staff members were left without professional nursing coverage for four minutes.

In response to the Union's conclusion that the Grievant was "not fully aware of the patient's complaints and symptom", the County asserts that this is the result of the Grievant's failure to fully assess the patient. This failure to assess, which was opined by expert witness Finder-Stone to be below minimum nursing standards, was grossly inappropriate.

The Union's argument that the Grievant's appraisal of the patient and situation were accurate is factually erroneous. Webb made an accurate nursing assessment only four minutes after the Grievant left, concluding that the patient was in respiratory distress and ordered oxygen. The Grievant's refusal to admit his decision to leave was wrong requires that a strong message be sent to change his ways.

The County requests that the grievance be denied and an award issued in favor of the County.

Union

The Union asserts that the County did not have just cause when it disciplined the Grievant. The Union refers to the two-pronged test of proof in disciplinary cases wherein the employer must first establish wrongdoing and, assuming wrongdoing is proven, it must then be

demonstrated that the punishment invoked was the appropriate level of discipline. The Union emphasizes that the County must prove the guilt of the Grievant, rather than base the discipline upon the belief or suspicion that the Grievant might have been the guilty party.

Contrary to the claim that the Grievant abandoned the patient, the Grievant was not fully aware of the patient's complaints and symptoms. When the Grievant observed and touched the patient, she was not diaphoretic, she was not short of breath, and she stated to him that "she did not feel well."

The testimony of the County's own witnesses does not support a finding that the Grievant had knowledge of the oxygen saturation reading. LPN Hermann testified that she did not know if the Grievant heard the oxygen saturation reading, nor whether he heard the patient complain of pain in her left shoulder. CNA Moore acknowledged that she did not know if she had advised the Grievant of the patient's vitals. Lacking this knowledge, coupled with the patient's not showing other signs of distress, the Grievant was justified in his decision to leave the unit at the conclusion of his regular shift.

The Union asserts that the patient was not in immediate danger, based upon the Grievant's accurate evaluation of the patient, which was subsequently supported by County medical personnel. Although multiple tests were conducted after the departure of the Grievant, all vitals were within the normal range except for respirations, which were a little high. During the subsequent shift, tests were conducted including EKG, electrolytes and CPK, and all came back indicating that the patient was within her normal limits.

The Union questions CNA Moore's bringing the patient to the nursing station. If the patient was not feeling well and was in respiratory distress, why did Moore take her out of bed, wash her and bring her to the nurses' desk, rather than call for the Grievant to come to the patient's room?

Finally, the level of discipline administered is excessive. The Union initially notes the 11½ years of discipline-free performance by the Grievant with the County. The parties' Agreement articulates a progression for discipline beginning with an oral warning to written warning to suspension to discharge. Here, there were no negative consequences as a result of the Grievant leaving at the end of his shift and his evaluation of the patient was accurate. Thus, a three-day suspension was unjust.

In its reply brief, the Union disputes the factual conclusions reached by the County. If the CNA believed the patient was in accute distress, she should have called the Grievant to the patient's room, rather than bring her to the nurses' desk and give the impression that the situation was not serious. It is common for patients to generally state they are not feeling well. The Grievant's past experiences with the patient justified his determination that her color and level of anxiousness were not abnormal. The Grievant did not hear the oxygen saturation level reading, and if he had, he would have stayed with the patient.

Further, there was other professional nursing staff available to assist the patient. The House Manager was only 50 feet from the nurses' station and two RN's were working one floor below. Thus, there were three RN's capable of responding to the patient should it have been necessary.

The Union also questions the actions of Moore, Hermann and Ferry. Though these three witnesses testified that the patient was in dire need of nursing services prior to the departure of the Grievant, why was this not made undeniably clear to the Grievant? The Union reiterates that the Grievant would have stayed and assisted the patient had he been fully advised of the situation. Had he been aware of the patient's claim of left shoulder pain, had he been aware of the oxygen saturation level and had he been called to the patient's room for an assessment, which is the general procedure, he would have stayed.

Based upon the Grievant's clean record, his length of employment with the County, and the agreed upon principles of progressive discipline, the three-day suspension was excessive and not warranted. The Union requests that the grievance be sustained and the County ordered to make the Grievant whole for all lost wages and benefits. The Union further requests that the Arbitrator retain jurisdiction until such time as compliance with the ordered remedy is complete.

DISCUSSION

It is well established that in cases in which the validity of discipline is questioned, the employer bears the burden of establishing that the discipline was issued consistent with the parties' collective bargaining agreement. The parties have stipulated that the issue in this case is whether the County had just cause to suspend the Grievant.

In order to find just cause for discipline, it must first be shown that the Grievant engaged in the conduct for which he was disciplined. The County's Corrective Action Report indicates the Grievant was disciplined in part for failing to conduct an assessment. The STANDARDS of Clinical Nursing Practice define assessment as:

> "[a] Systematic, dynamic process by which the nurse, through interaction with the client, significant others, and health care providers, collects and analyzes data about the client. Data may include the following dimensions: physical, psychological, sociocultural, spiritual, cognitive, functional abilities, developmental, economic, and life-style."

Patricia Finder-Stone, the County's expert witness, testified that the "complete nursing assessment" process has four components: (1), ***inspection***: observing the patient's color, respiratory efforts, etc.; (2), ***palpation***: touching the patient's forehead, skin and extremities to determine if there is a temperature or perspiration; (3), ***percussion***: tapping body surfaces to determine if there is fluid, lumps or deviations from normal present; and (4), ***auscultation***: listening with a stethoscope to breathing sounds, heart sounds, etc. Finder-Stone testified that

it would take less than five minutes to do a complete rapid or "cursory" assessment and that given the concerns that CNA Moore brought to the Grievant's attention, he should have done such a cursory assessment.

Much of this case turns on the patient's condition at the time she was brought to the nurses' desk by Moore, and what the Grievant should have done at that point based on what he saw and what he was told by Moore and by the patient. There is some dispute about the patient's condition that morning and whether or not it was a change from her "normal" condition. As is not unusual, the three or four persons present the morning of February 12th when the patient was brought to the nurses' desk, saw and heard things somewhat differently. It is noted that there is no evidence in the record that Hermann, Moore or Webb had any motive for being less than truthful in their testimony as to what occurred on that day. 2/

2/ However, while Ferry testified she was also present, her testimony, when compared to that of Hermann, Moore and the Grievant, is exaggerated and largely inconsistent with theirs. Therefore, it has not been considered.

As to the patient's "normal" condition, LPN Hermann and RN Heather Drier, the RN on Unit 8 on the day shift, agreed with the Grievant that the patient's coloring was normally poor, i.e., pale. While Moore disagreed that the patient was usually pale, the "condition and progress" chart for the patient (Union Exhibit 5) indicates that on February 4, 5 and 8, 1999, the patient's skin was "pale, warm and dry." The Grievant testified that the patient was often anxious and also stated she at times would say that she didn't feel well, but conceded he could not think of any specific instances other than her complaining of back aches. Drier agreed that the patient was often anxious and Moore agreed that at times the patient had complained of not feeling well. It would be reasonable to conclude from this that the patient's color was normally paler than is usual for most people, that at times she was anxious and at times complained of not feeling well. The record also indicates, however, that she had heart problems and had a pacemaker.

As to the patient's condition the morning of February 12th, the Grievant stated that her condition was what it normally was as far as being pale and somewhat anxious, that she was not perspiring (diaphoretic), or in respiratory distress when he saw her, and that based on what he saw and her mental condition, the fact that she said she did not feel well was not enough to compel him to do an assessment or inquire further. It is also at this point that there is considerable dispute as to what was said and done by those present.

The Grievant denies that the patient was diaphoretic or that Moore told him that the patient was diaphoretic or had any medical problem when Moore got her up; all Moore said was that she wanted him to take a look at the patient. Moore's testimony and February 19th statement indicate she told the Grievant that the patient did not look good to her and that she then asked him to take a look at the patient. However, Hermann's statement and testimony was that Moore reported the patient as diaphoretic, having poor color and complaining of not feeling well when she got the patient up. It must be remembered in that regard, that the

situation continued for more than half an hour and it is possible Moore made the statement after the Grievant left. Hermann does not indicate whether the patient was diaphoretic when Moore brought her to the desk, but agreed that the patient did not look good to her either. However, it is noted that Webb, the House Manager and an RN, saw the patient shortly after the Grievant left and she testified that while Moore told her the patient was "very diaphoretic" when she got her up, the patient was not "sweaty" when Webb saw her. Thus, while it appears from the record that Moore at some point during the situation stated that the patient was very diaphoretic when she got her up, it is not clear that she did so in the Grievant's presence. It also appears that the patient was no longer noticeably perspiring by the time Moore brought her to the nurses' desk.

Despite the above conclusions, both LPN Hermann and CNA Moore thought the patient did not look well and felt that there was a change in her condition such that an assessment needed to be done by an RN. It is noted that Hermann and Moore, especially Moore, who had been assigned to care for the patient on a daily basis, were more familiar with the patient than was the Grievant, who worked the night shift during which the patient was normally in bed, if not asleep.

While there is agreement that the patient responded that she did not feel good when asked what was wrong, Hermann also claims she then asked the patient how she did not feel good and that the patient answered that her left shoulder hurt. According to Hermann, the Grievant was present when this occurred. The Grievant denies hearing anyone say anything about the patient having pain in her left shoulder and Moore makes no mention of it. The evidence is inconclusive as to whether the Grievant heard the patient or Hermann mention left shoulder pain, but it is clear that the patient did say she did not feel well.

There is agreement between Hermann and Moore that the latter took the patient's oxygen saturation level shortly after bringing the patient to the desk, while the Grievant was there, and that the level was in the low 70's. The reading was displayed on the screen of the oximeter used to take the reading and Moore testified she believes the Grievant heard her give him the results. The Grievant denies telling Moore to obtain an oxygen saturation reading (Hermann and Moore agree she did so on her own), or hearing or seeing the results if she took such a reading. Hermann and Moore are also in agreement that the Grievant suggested getting the patient's vitals, but that he only stayed long enough to hear the patient's temperature. Again, the Grievant denies telling anyone to take the patient's vitals, although he concedes he did hear Moore give the patient's temperature, but it was in the normal range. While it is possible the Grievant did not hear the patient's response to Hermann that her left shoulder hurt, here we have both Moore's statement and testimony that she took the patient's oxygen saturation level and informed the Grievant of the results and Hermann's corroborating statement and testimony that this was the case. Again, there is no evidence of any motive for Hermann or Moore to be less than truthful in their testimony.

Hermann also testified that while Moore was taking the patient's oxygen saturation level, she asked the Grievant to stay because the day shift RN would not be in until 7 a.m., and that the Grievant responded, "That's not my problem", and asked if the House Manager knew that. Moore did not hear the Grievant say it was not his problem; however, both Hermann and Moore testified that the Grievant said something to the effect that the patient was not in any danger and then left. According to Hermann and Webb, seconds after the Grievant left, Webb arrived at the desk. Webb testified that the patient was "ashen", and in some respiratory distress – short of breath and her breathing "gurgling, raspy". Webb did not consider the patient to be diaphoretic or in "acute" distress. The left shoulder pain and the patient being diaphoretic was reported to Webb. Webb took the patient's oxygen saturation level, getting a reading of 74 on her finger and 84 on her toe. Testimony indicates that a level of 90-100 is normal. Finder-Stone testified that a level below 80 is lethal. The Grievant conceded that an oxygen saturation level of 74 would have led him to stay and that oxygen is ordered when the level is below 90.

It is concluded that the question of whether the Grievant should have stayed and done an assessment of the patient based upon the information he had at the time, must be answered in the affirmative. The patient complained of not feeling well. Hermann and Moore, both more familiar with the patient than the Grievant, felt the patient did not look good and that there was a change in her condition that required an assessment be done. While the patient was normally pale and at times anxious, she also had a history of cardiac problems. Those factors, by themselves, would seem to compel a closer look at the patient. By his own admission, the Grievant's "assessment" consisted of visually observing the patient and touching her hand. From this alone, he deduced that that she was not in any danger and that there was no need to inquire further into her condition, despite her history of cardiac problems and Moore's and Hermann's concerns. There is also the question of the patient's oxygen saturation level. While the Grievant makes a point of noting that in the end, the patient did not have a heart attack, and asserts this vindicates his judgment, he ignores the fact that by all accounts, the patient's oxygen saturation level was dangerously low and she was placed on oxygen to remedy that condition. The Grievant concedes he did not attempt to obtain the patient's oxygen saturation level and denies he saw or heard anyone else obtain such a reading. However, he concedes that had he known what the reading was – 74 – he would have stayed to assist the patient. Assuming for some reason that the Grievant did not see or hear the patient's oxygen saturation level reading, which appears unlikely from the record, his failure to obtain such a reading was itself culpable under the circumstances.

The Grievant is also charged with failing to "provide direction and assistance to those supervised." The Grievant also defends his decision to leave without doing an assessment by noting there was another RN present – House Manager Webb, fifty feet down the hall and two RN's on the floor below. However, other than asking Hermann if the House Manager was aware there would be a gap in RN coverage, the Grievant left Hermann and Moore alone to handle the situation. He did not tell Hermann to call Webb, nor do so himself, and did not stay to make sure there was someone present who could handle the situation.

In summary, the evidence is inconclusive as to whether the Grievant was told, or heard anyone say, that the patient had been diaphoretic and that she was complaining of left shoulder pain. The evidence, however, does establish that the LPN and CNA, who were more familiar with the patient than was the Grievant, felt her appearance and condition were sufficiently changed from normal to require an assessment, and that the Grievant was asked to stay and was asked to look at the patient. The fact that Moore brought the patient to the Grievant, rather than having the Grievant come to the patient, does not change this. The patient had a pacemaker and a history of cardiac problems, of which the Grievant was, or should have been, aware. The Grievant ignored the patient's dangerously low oxygen saturation level or at best, failed to obtain such a reading, and the Grievant failed to do a cursory assessment or to take steps to assure that another RN was present to do so before he left. For these reasons, it is concluded that the Grievant is substantially guilty 3/ of the violations of the standards of nursing care alleged in the letter of suspension issued August 23, 1999.

3/ The conclusion that there was a four-minute gap between when the Grievant left and Webb arrived is not supported by the evidence.

This brings us to the level of discipline imposed. The parties' Agreement provides for progressive discipline in the sequence of oral reprimand, written reprimand, suspension and dismissal, however, it does not require that sequence be followed in all cases. It recognizes the type of discipline imposed will depend on the severity of the offense. In that regard, it must be remembered that this is not necessarily a case of an individual purposely engaging in misconduct; rather, it appears to be an exercise of poor judgment on the Grievant's part. By dint of the high level of responsibility RN's are given for a patient's well-being, their exercise of judgment will always have serious implications. For that reason, they are not afforded the luxury of being able to exercise anything other than their best judgment. For whatever reason (punching out within the five-minute window is not sufficient), in this case the Grievant did not perform at the level reasonably expected of him. There has been no showing that the Grievant has been treated in an arbitrary or disparate fashion in being given a suspension in these circumstances. Even given the Grievant's previously clean record and length of service with the County, there is not sufficient basis in the record to find that the imposition of a three-day suspension is so excessive or unwarranted in this case that the County's decision to impose that penalty must be overturned. It is therefore concluded that the County had just cause to suspend the Grievant for three days.

Based upon the foregoing, the evidence and the arguments of the parties, the undersigned makes and issues the following

AWARD

The grievance is denied.

Dated at Madison, Wisconsin this 22nd day of February, 2001.

David E. Shaw /s/
David E. Shaw, Arbitrator

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