BEFORE THE ARBITRATOR

In the Matter of the Arbitration of a Dispute Between

FEDERATION OF NURSES AND HEALTH PROFESSIONALS, LOCAL 5001, AFT, AFL-CIO

and

MILWAUKEE COUNTY (DETENTION CENTER)

Case 504
No. 59838
MA-11422

(Aliposa Grievance)

Appearances:

Shneidman, Hawkes & Ehlke, S.C., by **Attorney Jeff Sweetland,** 700 West Michigan, Suite 500, P. O. Box 442, Milwaukee, Wisconsin 53201-0442, for the labor organization.

Deputy Corporation Counsel Timothy R. Schoewe, Milwaukee County, Milwaukee County Courthouse, Room 303, 901 North Ninth Street, Milwaukee, Wisconsin 53233**,** for the municipal employer.

ARBITRATION AWARD

The Federation of Nurses and Health Professionals, Local 5001, AFT-AFL-CIO and Milwaukee County (Detention Center) are parties to a collective bargaining agreement which provides for final and binding arbitration of disputes arising thereunder. The federation made a request, in which the county concurred, for the Wisconsin Employment Relations Commission to appoint a member of its staff to hear and decide a grievance over the interpretation and application of the terms of the agreement relating to discipline. The commission designated Stuart D. Levitan to serve as the impartial arbitrator. Hearing in the

matter was held in Milwaukee, Wisconsin on July 19, 2001, and was not transcribed. 1/ The parties filed written arguments by September 4; the federation filed a reply brief on September 20; the county on September 28 waived its right to do the same.

1/ Unless otherwise specified, all dates herein are 2001.

ISSUE

The federation states the issue as follows:

Was the grievant issued a five-day suspension for just cause? If not, what is the appropriate remedy?

The county states the issue as follows:

Did Aliposa violate civil service rules as alleged? If so, was the five-day suspension reasonable?

RELEVANT CONTRACTUAL LANGUAGE

1.05 MANAGEMENT RIGHTS

The County of Milwaukee retains and reserves the sole right to manage its affairs in accordance with all applicable laws, ordinances, resolutions and executive orders. Included in this responsibility, but not limited thereto, is . . . the right, subject to civil service procedures and the terms of this Agreement related thereto, to suspend, discharge, demote or take other disciplinary action[.]

. . .

5.01 DISCIPLINARY PROCEDURES

(1) In cases where an employe (sic) is suspended for a period of 10 days or less by the employe's department head, pursuant to the provisions of sec. 63.10, Wis. Stats., the Federation shall have the right to refer such disciplinary suspension to the arbitrator[.]

5.02 REPRESENTATION AT DISCIPLINARY OR DISCHARGE HEARINGS/MEETINGS

. . .

(6) Discipline or discharge shall be administered in a manner consistent with Rule VII, Section IV, of the Rules of the Civil Service Commission.

OTHER RELEVANT PROVISIONS

CIVIL SERVICE RULE VII – SEPARATIONS; SUSPENSIONS
Section 4 – CAUSES FOR DISCHARGE, SUSPENSION OR DEMOTION AND/OR REEVALUATION

(1) The following are declared to be cause for discharge, suspension or demotion. . .

. . .

(l) Refusing or failing to comply with departmental work rules, policies or procedures.

. . .

(u) Substandard or careless job performance.

. . .

(3) At the termination of the hearing, if the Commission determines that the allegations have not been proved, the complaint [against the accused] shall be dismissed. If the Commission finds that the allegations have been proved, the Commission shall take action as it deems necessary and proper to remedy the effects of the violation and shall issue Findings of Fact and Conclusions of Law.

. . .

(5) This rule shall not be used for the purpose of replacing or circumventing ordinances, procedures or contractual provisions for the adjustment of employe grievances.

BACKGROUND

On the evening of February 3, 2001, registered nurse Rhode Aliposa committed a medication error by dispensing a Claritin-D to the wrong juvenile at the Milwaukee County Juvenile Detention Center (JDC). This grievance concerns the five-day suspension the county administered in the aftermath of that incident.

Aliposa has been a full-time registered nurse at the Milwaukee County Juvenile Detention Center since June, 1997. She began her nursing career in native Philippines in 1954, later serving 20 years as a surgical nurse. She came to the United States in 1989, and became licensed as a registered nurse in 1991. She started work as an RN at the Milwaukee County Mental Health Complex (MHC) on April 12, 1993, and transferred to the JDC a little over four years later, where she currently works from 2:30 p.m. to 11:00 p.m. There is no nurse on duty overnight. Katherine James, the Juvenile Correctional Officer supervisor, is her head of shift.

At about 9:00 o'clock on the evening of February 3, Aliposa was to dispense a tablet of the prescription drug Claritin-D to a juvenile, B.[1] She called B's name several times, but got no response. Finally, a male youth approached her and identified himself as B. Neither Aliposa nor a correctional officer standing in the immediate vicinity verified his identify. Aliposa gave the youth the tablet and a glass of water. It was then that the correctional officer asked the youth if he was in room S, where B was housed; the youth replied in the negative, stating he was in room M. Aliposa then checked the boy's bracelet, which identified him as L. Aliposa rebuked L for what he had done, and he walked away. Shortly thereafter, B appeared and was given his medication.

Aliposa told the JCO not to worry about L having received the Claritin D, which she thought would be helpful in addressing some sinus congestion he was suffering.

At about 11:00 P.M., Aliposa made the following entry in L's progress notes:

2300 – youth took Claritin D 1 tab po @2100. Voiced no concerns.

This is medical short-hand for "youth took one tab of Claritin D by mouth at 9:00 P.M. Voiced no concerns."

The Juvenile Detention Center has neither a formal rule nor any particular form for reporting medication variances or errors. The Mental Health Complex, where Aliposa formerly worked, does have a section in its Policy & Procedure Manual entitled Medication

1 Throughout, juveniles are designated by the first initial of their last name.

Error/Variance, Policy Number NS # 66 "M" III, which requires a nurse who has made a medication error/variance to notify a physician regarding all such errors/variances and patient status; complete the documentation on Medication Error/Variance Report; notify the Nursing Program Coordinator, Administrative Resource and/or Designee; document in "clear, concise and comprehensive nursing notes" the error/variance, the patient status, patient response and details of physician notification. This policy also requires the "person discovering medication error/variance" to complete and initial a Medication Error/Variance Report "by the end of his/her shift."

Aliposa remained on duty until about midnight, by which time L did not report any adverse reaction from having taken the Claritin D.

On February 22, Detention Center Superintendent Thomas Wanta conducted a hearing into the incident. At that hearing, Aliposa submitted a written narrative, addressed to JCO Supervisor Katherine James, which read in part as follows:

> You will probably need to recall that at about 6:00 P.M. that evening, I called you to let you know that I was sending a youth who was on sanction that weekend to the ER for acute asthmatic attacks. I called you so that arrangements could be made for escort to the ER. I called 911, prepared the Hospital Referral form and stayed with the youth until the paramedics took him to the (illegible) ER. I attempted to call to inform his family with your approval.
>
> At about 6:40 P.M. W1 called me because a youth was hurt at the gym and had a bleeding lip. At about 7:40 P.M. S2 who were at the north gym at the time called because a youth was hurt, allegedly hit her head on the wall. Point of injury was assessed, cold pack + Tylenol 650 mg by mouth was given as comfort measure + to prevent potential bleeding.
>
> While passing the 8:00 P.M. medications, more youths come with new problems + issues like cuts + scratches from playing in the gym, sprained + swollen fingers etc. areas affected were assesses + comfort measures + other routine interventions were done.
>
> Finally I got to E2 @ about 9:00 P.M. I had to see only two youths but I ended up seeing four – the other two with new complaints to be addressed. One youth who had medication was in the shower, so I waited until he was ready to come our. Meanwhile, the youth that was sent out to the ER came + the JCO escort wanted to know if I can come + see him + the hospital report. Since I still had to give medication to one youth in E2 and to another one youth in E1, I just had

the youth sent back to his room where I can see him after the two were taken care of.

While waiting for the youth, the JCO called his name several times. After so many calls, one youth came running up to us. The JCO was just about a yard away from where I was. I asked him if he was (TB) and he answered, "Yes, I am." I asked him the second time before I handed him the pill (Claritin D) and a cup of water. As soon as he took the pill with the water and was ready to go back to his room, the JCO asked if he was the youth in Room S & he said he was in Room M.

At this point, I confronted him for deliberately deceiving the JCO & me with his identity. The youth voiced no concern the rest of the shift. I knew that one tablet of Claritin D will not harm him. In fact, he had been complaining of signs & symptoms of colds for days before that. I know it is an antihistamine medication which helps relieve congestion & runny nose. There is no potential for danger or injury. I did not see any reason to notify the HOS when I had other priorities that needed my time & attention.

I then proceeded to E1, gave one youth his medication, then on to W2 to see the youth that returned from the EI with the diagnosis of asthmatic exacerbation, did a quick assessment, went through the ER discharge report, saw two other youths in W2 & gave them medications.

By the time I was back in the medical office, S1 called for two youths with new complaints. One youth who is on psychotropic medications just had his (illegible) doubled this day & he complained of "chilly sensation, feeling warm & dizzy." It is now about 10:20 P.M. I had to check his temperature and blood pressured to rule out acute neurological reactions. His vital signs were within normal range so Tylenol 650 mg was given. The other youth needed relief for tooth ache.

After all these, I had to pull files for ten youths that needed documentation. I had medications to inventory and transcribe on two different forms and new in-takes to be seen, take B/B & (illegible).

I was able to leave DT at midnight when I should have been off at 11:00 P.M. in all this time there was no report from E2 that needed immediate concern.

In view of all these, I vehemently protest your accusation of substandard & careless job performance. I deserve to be heard before you judge me. Ask me. Listen to me before you go to someone who is not concerned in this issue. After that deliberate act of deceit do I have to be harassed & emotionally abused? Nobody was hurt. No life was endangered. I had to prioritize my time & attention to the most important problems at the time.

On March 1, Detention Center Superintendent Thomas Wanta issued the following memorandum:

DATE: March 01, 2001

TO: Kathy Malone, Bureau Manager, Court & Delinquency Services, CCC, Candace Richards, Manager, Human Resources, DHS

FROM: B. Thomas Wanta, Superintendent, Detention Center

SUBJECT: Imposition of Discipline

Representation at Hearing

Ms. Rhode Aliposa, RNI, was present at the hearing, held on February 22, 2001, as were her representative, Ms. Joanne Belich, Chief Steward from Local 5001. Present from Detention Administration were Ms. Katherine James, Juvenile Correction Officer Supervisor. I presided as the hearing officer.

Allegation

Basis for the proposed discipline is for failure to abide Civil Service Work Rule 7, Section 4, (u) "Substandard or careless job performance."

The allegation is that on Saturday, February 03, 2001 at approximately 9:00 p.m. Ms. Rhode Aliposa displayed lack of attentiveness and/or substandard or careless job performance in that Ms. Aliposa dispensed a prescription medication to a child, to whom the medication was not prescribed, located in the East II pod. Further, Ms. Aliposa failed to notify or communicate with the Juvenile Correction Officer Supervisor on duty or to communicate to other medical personnel of this incident.

Documents used as part of hearing

The following documents were reviewed prior to the hearing:

1. Separate incidents reports authored by Ms. Rhode Aliposa, JCO James Rick, JCO Rosalind Coleman, and JCO Javier Ferreira.

2. Memorandums from Mr. Terrell Martin and Katherine James, JCO Supervisors.

3. Mediation Log of juvenile involved. (no documentation of drug given)

4. Medical Progress Notes of juvenile involved (documentation of drug variance)

5. Hand written document from Ms. Rhode Aliposa (Received at hearing)

I reviewed these documents and Ms. Rhode Aliposa's personnel file and advised all those present at the hearing of same.

Ms. James presented and stated the allegation above.

Ms. Rhode Aliposa stated that the incident did occur on Saturday, February 3, 2001. She stated she was on East II to dispense medication to a child (initials TB). The child was in the shower. She waited for him to finish. Another youth approached her and she asked him if he was "TB"? The youth responded, "yes". She asked him a second time and he responded "yes" again. He was then given a claritin D tablet, prescription medication, by Ms. Aliposa. Ms. Aliposa stated she knew right away that she gave the child the wrong medication. I asked Ms. Rhode Aliposa if she checked the child's identification bracelet? Ms. Aliposa stated that she didn't bother to look at the juvenile's bracelet. I then queried Ms. Rhode Aliposa as to who she informed of the medication error? She responded by saying "I did not notify anybody". I asked if she wrote a note or any written communication to the nurses department to follow up with the child upon their arrival and/or JCO Supervisor on duty? She responded "No". I asked if she thought of notifying the child's parent(s)? she stated "no". I followed up the question with "did you inform the child of the medication error? Ms. Rhode Aliposa responded that she did not explain or

inform the youth what drug was given to him. Ms. Rhode Aliposa then went on to state she was experiencing a "hectic day" and did not think there was "an urgency".

Ms. Belich, Local 5001, stated that we need to establish a written policy on Medication errors. That notifying parents and guardians of drug variance is not the procedure that nurses regularly follow. Ms. Belich further stated that Ms. Rhode does not have a pattern of given wrong medication and she would hate to see a suspension for this incident. Ms. Belich also stated that a decision is required from this hearing officer within seven working days pursuant to the nurses contract.

Past Disciplinary Record at the Detention Center

April 29, 1999	Substandard or careless Job performance	Written Reprimand 7-6-99
	Failed to properly respond to a "critical value" lab Report regarding a youth.	
May 25, 1999	Substandard or careless Job performance	Written Reprimand 7-6-99
	Failed to properly respond to a request For medical intervention to a youth who a Allegedly swallowed a plastic juice lid on a pod.	

Based on the two above incidents Ms. Rhode was required to attend and participate in a training coarse (sic) on medical assessment and/or decision making. Ms. Rhode completed the required course in 1999.

Findings

During the disciplinary hearing and based on the reports received it is evident that Nurse Rhode Aliposa gave a youth a prescription medication in error on February 3, 2001. Further, it is undisputed that she never attempted either verbally or in writing to notify medical staff or management staff of this error. Thus, placing the youth in potential medical danger and hindering this agency response if this child had experienced an adverse reaction to the "prescription" medication given. It was the child himself who reported to JCO staff the next

day that he felt "high and dizzy" due to medication given to him by a nurse which he thought was done in error. As such, it was the child's self report that initiated this investigation.

Ms. Rhode Aliposa decision not to inform nursing staff and management staff of a medication error is a major error in judgment. This error in judgment and her past disciplinary record is compounded by her (to this day) non acceptance that her error (not to notify her peers or management staff) is poor judgment. This hearing officer has serious concerns regarding her ability to provide appropriate nursing services to the youth we serve. Medical staff like all staff will make errors. However, not to take appropriate actions following an error and document same can not and will not be tolerated.

Basis for the proposed discipline is for failure to abide Civil Service Work Rule 7, Section 4, (u) "Substandard or careless job performance."

The hearing officer reviewed Ms. Rhode Aliposa's previous disciplinary record at the Detention Center as part of this inquiry.

Imposition of Discipline

A suspension of five (5) days without pay is ordered. They may be served individual or sequentially at the discretion of Detention management within ninety (90) days of this decision.

B. Thomas Wanta
Superintendent

POSITIONS OF THE PARTIES

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

Except for the medication error itself, Aliposa acted properly and did not violate any rule. It is not disputed that Aliposa made a medication error, which could have been avoided by checking the identify bracelet. However, Aliposa was not in any way derelict in the way she recorded and reported the matter. She reported the contact in her daily report, forwarded that report to the proper recipients at the end of her shift, and noted the incident in the juvenile's progress notes. She did not note the incident in the juvenile's medication log

since she understood that log was only for recording the patient's receipt or refusal of the medications already listed.

As a professional expected to use her own judgment, Aliposa did not report 30 of the 31 contacts she had that evening. She did not make a special report on this incident because, in her nursing judgment, the single Claritin D tablet did not place the juvenile at any risk.

None of the things the county now insists Aliposa should have done were required by any written or even verbal policy, procedure, instructions or guidelines at the Center. While the Mental Health Center had very specific instructions for responding, documenting and reporting medication errors, the Detention Center had nothing. While the superintendent says any medication error is a serious event necessitating immediate communication with the supervisor, prior to this incident such an event was not even serious enough to merit even a verbal announcement. The Center has still not issued anything in writing in this regard.

Without any such guidelines or directions, the Center left all reporting entirely to Aliposa's judgment, which she exercised in evaluating the possible effects of the error. The superintendent may have disagreed with her decisions, but in the absence of a directive to the contrary, her decisions cannot reasonably be characterized as the county has done.

The superintendent insinuates that Aliposa made a conscious decision not to inform staff of the situation. There is no evidence at all to support this assertion. Aliposa did record the contact in the daily report, which she distributed at the end of her shift. Aliposa may not have treated the situation as an emergency requiring immediate notification of the supervisor or other extraordinary measures, but she did inform other personnel.

The superintendent also cites as an example of Aliposa's allegedly substandard performance her refusal to agree that she was guilty of poor judgment. But the right to disagree with management decisions is at the core of the right to grieve, and an employer may not punish such disagreements as "improper attitude" without infringing with the employee's protected rights.

Accordingly, a five-day suspension was excessive and without just cause. Aliposa's only infraction was the medication error itself, which the superintendent indicated did not prompt the suspension because "medical staff

like all staff will make errors." Aliposa was not guilty of substandard or careless job performance in the way she responded, documented and reported the medication error. The five-day suspension should be replaced with a reprimand for the medication error, and all pay, benefits and seniority lost as a result of the suspension should be restored.

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

The primary facts are not in dispute. After being informed of her medication error in dispensing prescription medication to a detained child for whom it was not prescribed, Aliposa did not take steps to record or report the error.

Aliposa practiced nursing in her native country beginning in 1954, and moved to the United States in 1989. She could not meet the requisite minimal qualifications to nurse here until two years later. While a county employee she was once denied a salary increment, and has been reprimanded for performance measures on separate occasions. The reprimands were not grieved.

After giving medication to the wrong detainee, Aliposa told the correctional officer not to worry. She did not report the medication error, although at some later point, time unknown, she did make an entry. No entry was made, however, on several required forms, and no one could have known of the error because Aliposa did not record or transmit the event to anyone. It the person to whom the medication was erroneously administered complications, as did happen, appropriate medical attention would be delayed or not administered because Aliposa not only erred, but also failed to abide by her obligation to complete the medical record.

The superintendent testified without contradiction as to the gravity of the error, its potential for damage, and Aliposa's recurrent conduct. After the progressive discipline to address her performance issues, including denial of salary increments and reprimands, the next step would be suspension. Here, there were two reasons to impose discipline – the medication error itself, which was easily preventable, and Aliposa's failure to accurately record what happened.

Department work rules contradict Aliposa's argument that no specific rules mandate that she record things in a specific way. She also knew, based on her work at the county's Mental Health Complex, to take appropriate action in the

event of a medication error. Why wouldn't that same standards apply at both places?

The error should not have happened at all, and it should have been recorded in various logs. Given the past record of the employee and the two occasions of misconduct here, the imposition of a suspension was not only reasonable, but also perhaps lenient.

The acts of misconduct did occur, and the only real issue goes to disposition. Given the record and past disciplinary history, a five-day suspension is most reasonable.

In further support of its position, the federation replies as follows:

The county errs in stating that Aliposa did not take steps to record or report the error. She reported the incident in both her daily report (which she forwarded to the appropriate recipients, including her supervisor) and in the juvenile's progress notes.

The county errs in stating no entry was made on several required forms, when in fact there was no policy in place dictating how a medication error was to be recorded. Therefore, there are no required forms for reporting one.

The county errs in stating that the juvenile developed complications, when no credible, competent evidence of any such complications was presented, but only hearsay. If the juvenile had actually suffered any consequences, the county could have presented witnesses to testify about them. That the county presented no such witnesses can only mean the juvenile suffered no complications or ill effects whatever from the Claritin D.

Unlike the Mental Health Center, the Juvenile Detention Center had no policy in place to report medication errors, leaving nurses like Aliposa to their own judgment. Aliposa exercised her judgment in a reasonable and professional manner, and in no way was she either substandard or careless.

The five-day suspension was not for just cause, and should be replaced with a reprimand for the medication error. All pay, benefits and seniority lost as a result of the suspension should be restored.

DISCUSSION

Rhode Aliposa has been a nurse for almost fifty years. One busy night last February 3, a young man at the Milwaukee County Juvenile Detention Center scammed her into giving him a Claritin-D that had been prescribed for another youth. That started a chain that led to the county suspending Aliposa for five days without pay, from which discipline Aliposa and the union grieve.

The formal Imposition of Discipline from Superintendent Thomas Wanta states two elements -- that Aliposa "dispensed prescription medication to a child to whom it was not prescribed," and that she then "failed to notify or communicate with the Juvenile Correction Officer Supervisor on duty or to communicate to other medical personnel of this incident."

I address each element in turn.

It is a serious matter when a health care professional makes a medication error, even more so in a custodial setting. And it is even more serious still when the misdispensation is to a juvenile detainee.

And that is what Nurse Aliposa did. She gave prescription medication to the wrong juvenile detainee, all because she didn't bother to check the boy's wristband.

To be sure, it had been a hectic day and night; it's always pretty busy at the detention center, where on the night in question there were 78 boys in four pods and 14 girls in one. There were the referrals and paperwork for the emergency hospital transport for one asthmatic youth, some kids were hurt in fights and accidents, plus the assorted fevers and colds. All in all, Aliposa saw 31 separate juvenile detainees that shift, and ending up staying over for a full hour.

One of those she saw but shouldn't have was L, who lied to her about being B.

Aliposa is not solely responsible for the dispensing error. The boy affirmatively presented himself as B. She then twice asked the boy if he was the named juvenile; he twice replied that he was. Juvenile Correction Officer James Rick was also present, and also failed to check for identification. Given the JCO's affirmative responsibility in the administration of medication and the keeping of the medication logs (*See,* DETENTION CENTER DOCUMENTATION, JT 7, pps.5-6), Aliposa could reasonably have expected the JCO to play at least some role in the process. Finally the JCO did ask the boy a question which indicated that he was L, not B. Aliposa rebuked him sharply and he left, and she proceeded to administer the Claritin to B upon his arrival.

But it was Aliposa's responsibility to verify the boy's identity before giving him the pill. That's why the county requires the youth to wear the wristband – to verify identity. Failure to verify the boy's identity constituted careless job performance of such a degree as to justify discipline.

The record indicates that the county issued JCO Rick a written reprimand for his role in this matter. The county argues that Aliposa's punishment should be greater for two reasons – she has a higher standard of care as the actual dispenser of the medication, and progressive discipline should lead from her two prior reprimands to suspension.

I agree, especially as to her professional responsibility; as the nurse, Aliposa had a higher standard of responsibility for health care matters. I am less inclined to rely on the two 1999 incidents, which ostensibly were addressed by the training course Aliposa completed later that year.

Superintendent Wanta's written imposition of discipline indicates that his primary focus was the subsequent reporting of the incident more so than the incident itself. "Medical staff like all staff will make errors," he wrote. *"However, not to take appropriate actions following an error and document same can not and will not be tolerated." (emphasis added)*. This indicates that Wanta felt the actions Aliposa took after the incident were more serious than the incident itself.

The JCO who also exhibited substandard or careless job performance got a written reprimand. Given her heightened responsibility as the health care professional, Aliposa was subject to heightened discipline, namely suspension.

I turn now to what happened after the medication error.

The crux of the county's case is that Aliposa failed to alert other center personnel, both correctional and health care. The union contends that Aliposa made a reasonable judgment as a veteran health care professional as to the seriousness of the situation, and documented it accordingly and appropriately.

By accusing Aliposa of a "substandard or careless job performance," the county implicitly puts her professional judgment at issue. If she was right that the medical situation wasn't serious, then her level of reporting was sufficient; but if she was wrong, then her reporting of it was substandard and thus a violation of CSR 7, Section 4(u). I thus am in the unfortunate position of having to second-guess doctors and nurses on a medical matter.

To evaluate the reasonableness of Aliposa's actions, it is necessary for me to understand the medical situation she confronted upon realizing that she had given a Claritin-D to the wrong child.

Unfortunately, the parties chose to keep the record silent on many salient points about the drug and its effects, and there is no evidence as to the precise nature of Claritin D and its effects on juveniles such as L. While I am aware that Claritin combines antihistamine and nasal decongestant, I have no further information regarding side effects or when it is counter-indicated. Even such basic evidence as the entries from the Physician's Desk Reference or the manufacturer's product inserts would have helped me evaluate the true situation confronting Aliposa that night last February. 2/

2/ I could, of course, have had ready access to such material through the internet, but that would have been improper. Issuance of the award means I may now have the evidence I wished I'd had* before *issuing the award.

I don't even know the size of the dosage which L took, nor have any evidence as to the age, size or health of L -- all factors which would help define the reasonableness of Aliposa's exercise of her professional judgment.

Nor has the county offered in this proceeding several written documents already prepared for the initial disciplinary proceeding, including incident reports by JCO Rick and two colleagues and memoranda from JCO Supervisors Terrell Martin and Katherine James.

Nurse Aliposa has offered her sworn opinion as a veteran health care professional that the pill was, far from causing ill effects, in fact of benefit to the boy in helping dry out a sinus situation.

Here, some direct testimony from the boy would have also been useful. There are conflicting statements in the record about what, if any, ill effects he suffered, and when, if ever, he suffered them. Adding to the uncertain nature of the evidence is the hearsay nature of the testimony itself. All in all, a tough record upon which a layperson can base a medical judgment.

In a discipline grievance, it is the employer's burden to prove up its case. Absent evidence as to side effects or counter-indications of Claritin – D, or testimony about heightened concern for L due to his age, size or health, I must conclude that there are indeed no such side effects, counter-indications or special concerns for L.

That there is no evidence in the record that the *situation* was urgent argues strongly against a finding that the *reporting* should have been.

With that understanding as the medical fact upon which Aliposa's actions are measured, I turn now to the way Aliposa reported the incident, to evaluate whether it was with sufficient urgency. I find that her report reflected a substandard job performance, but not to the degree alleged by the county. Aliposa didn't do quite what was legitimately required of her, but she did more than the county has acknowledged.

The record contains the seven-page standard for policy and procedure to handle medication errors and variances at the County's Mental Health Complex (MHC). While assigned there, Aliposa responsible for following its precise terms. Those terms require a nurse to "observe and interpret responses to a medication error/variance," which include "patient identification error;" to "notify physician regarding all medication errors/variances and patient status," to complete documentation of the "Medication Error/Variance Report," to notify the "Nursing Program Coordinator, Administrative Resource and/or Designees," and to document "clear, concise and comprehensive nursing notes" that explain the error/variance, patient status, patient response and name and time physician notified."

There is no such detailed provision for the administration of errors and variances at the Juvenile Detention Center. Indeed, at time of hearing there was no written protocol at all. 3/

3/ Even after the Aliposa incident in February, the county still had not adopted any written protocol to handle medication errors and variances by the time of hearing in July. As the union correctly argues, this lack of comprehensive follow-up calls into question the urgency which the county views such situations.

Because the county has declined to adopt this protocol at the Juvenile Detention Center, it cannot hold the nurses there to its strict terms. However, while the nurses at the JDC cannot be held to the details of the protocol for the nurses at the MHC, this policy is the most detailed written protocol in the record the exhibit and as such does stand as the highest embodiment of the county's expectations of professional conduct when there is a medication error or variance. It is thus instructive to compare Aliposa's actions against the protocol's procedures.

Of the policy's five specific duties, Aliposa:

- did observe and interpret the responses to the medication error;
- did not notify a physician;
- did not complete the documentation on the Medication Error/Variance;
- did not notify the various administrative personnel, such as James;
- did document the error, response, status, but, again, not physician notification.

Of the duties she failed to perform, I don't believe the requirement for physician notification found in the MHC administrative policy are relevant in this instance (notwithstanding the document's over-all lack of authority over JDC nurses). The requirement for physician notification is obvious for the MHC, where most of the medications are psychotropic. It is less so where the standard medication is Tylenol 650, Motrin 500 and Claritin D, as is the case at the JDC. Because the JDC has no written protocol, I can only go practice and by what seems medically reasonable. I don't think it was medically reasonable to expect Aliposa to notify a doctor at 9:30 P.M. that she had just given a Claritin D to the wrong juvenile. Even if she were bound by this manual, her failure to comply with this provision would not show any substandard performance.

Nor can the county expect the nurses at the JDC to complete the documentation on the Medication Error/Variance Report, for the simple fact that the county has never provided such a report at the JDC. Again, Aliposa's failure to comply with this provision shows no substandard performance.

The county's argument that Aliposa should be held to the terms of the MHC policy is further undercut by another of its provisions, namely that requiring a Medication Error/Variance Report to be "initialed *by person discovering* medication error/variance & completed by the end of his/her shift." It was nurse Odom who could be said to have discovered the medication variance the next afternoon, yet there is nothing in the record to indicate that she documented this as an error/variance, or that she was disciplined for not doing so.

The county has a stronger argument for timely notice to the supervisor, James, as the "administrative resource/designee." The head of shift at the JDC has a right to full and timely notice when there are medication variances. But, again, that responsibility is not Aliposa's alone. The DETENTION CENTER DOCUMENTATION/Juvenile Correctional Officer, Policy No. DC21C (JT 7) states as follows:

> If the appropriate medications have not been dispenses by the medical staff and/or made available to the J.C.O. staff for delivery, the J.C.O. shall immediately notify the J.C.O.S. on duty.

This JDC-specific policy is more relevant than the policy which applies at the MHC. Here, the appropriate medications were not dispensed by the medical staff. The JCO did not immediately notify the supervisor, James, nor did he prepare an incident report . The JCO who failed to perform this assignment was given a written reprimand. Aliposa's punishment for the same offense can be no greater.

In addition, there are four departmental documents on which Aliposa could have made entries highlighting the situation – Medication Log, Daily Report, Progress Notes and Incident Report.

It is undisputed that Aliposa made no entry on L's Medication Log (ER 2). The union explains this was because Aliposa understood this to be a record of medication *that was prescribed;* as the Claritin was not prescribed, she understood there was no need to record it in the Medication Log.

The text of the operative administrative policy by which Aliposa was bound, Detention Center Documentation, Policy No. DC 21C (JT 7), Section H, reads:

> **Medication Logs-** shall be utilized to ***document all medications*** given to each juvenile at the detention center. The log shall serve as an official document that records juveniles intake and/or refusal to use ***prescribed medications.***

The policy sets eight steps in the keeping of the medication logs, five assigned to the JCO and three to medical staff. In particular,:

> 3. Nurse shall document **all medications given** or refused on the medication log housed in the pod starting date, time, medication given and signature of nurse who delivered the medications.
>
> . . .
>
> 6. J.C.O. shall document **all medications given** or refused on the medication log housed in the pod starting date, time, medication given and signature of J.C.O. who delivered the medications.

Aliposa thus had an affirmative responsibility to document giving Claritin to L on his medication log, notwithstanding that it was not prescribed. As an official document, the medication log must reflect ***all medications given,*** and an employee's failure to so ensure constitutes substandard job performance.

The policy explicitly requires equal action by the nurse and the JCO, in identical terms. Equal responsibility means equal punishment for failure. As noted above, JCO Rick was issued a written reprimand for his role in this incident. Aliposa can suffer no worse.

Aliposa had responsibilities unique to her, though, in preparation of the Progress Notes and Daily Report. Again, the details of the procedure from the Mental Health Center are instructive in evaluating Aliposa's conduct.

Addendum I, page 2 of Policy NS # 66 "M" 111 provides:

> I. Legally, all medications administered or not administered as ordered, to a patient must be documented in the patient's record. Facts should be stated without judgmental words such as "in error" or "by mistake." Document in notes recording "Medication Variance" in the problem column.
>
> II. Documentation in Patient Medical Record
>
> . . .
>
> B. Wrong Medication, Dose, Time, Patient, Route, Extra Dose or Reason
> Document In Progress Notes:
> - Name of Medication, Dosage, Route
> - Name and Time Physician notified
> - Patient Status
> - Your signature and Classification

Even though, as noted above, a nurse at the MHC cannot be held to the policies from the MHC, this degree of documentation seems reasonable even at the JDC. I cannot believe a health care professional would seriously contend that a juvenile detainee's progress notes should not clearly state whenever there had been a medication variance – even for a antihistamine/decongestant.

Here is Aliposa's entire entry that evening:

> *2300 – youth took Claritin D 1 tab po @2100. Voiced no concerns.*

This entry provided the name of the medication, but not its dosage; it did not indicate physician notification, but I have already found that irrelevant in this situation; it did list patient status, and it was signed.

It did not, however, state anywhere in its terms that this was a medication variance. It was not until the next day – apparently following L's self-reporting -- that Aliposa reported the incident for what it was in L's progress notes, namely a medication variance.

The union points to Aliposa's commentary that L "voiced no concerns," as indicating she wasn't trying to hide anything, since such a comment would obviously alert a reader that concerns *might* have been voiced. On the contrary, I conclude that the comment is cryptic at best, and does not satisfy the need to document that there had been a medication variance.

To be sure, just at that moment Aliposa had higher medical priorities than L (including the return of the asthmatic youth from the hospital), both in terms of medical care and documentation. Indeed, it was not until 11:00 P.M. that Aliposa was finally able to make an entry in her progress notes. By then, the youth had gone two hours without reporting any adverse reaction, and she could have reasonably hoped for the incident to pass without further consequence. 4/ For whatever reason, when Aliposa finally noted that L had taken a Claritin, she still did not note that this was a medication variance. She should have.

4/ Whether or not L would necessarily have reported an adverse reaction while Aliposa was still on duty is unknown. His first report of the incident was not until the next day.

Beyond the policy from the MHC, the county argues that Aliposa had an affirmative duty to provide nurses on the succeeding shifts with adequate information to ensure safety and quality health care for L. I agree, and hold that any failure in this regard would further constitute substandard job performance

I agree with the county that Aliposa should have documented the incident appropriately "so following shifts of nurses would not be hampered by lack of information if they had to take action." As it happened, nurses on the following shift *were* required to take action, at least after the self-reporting of L. The extent to which nurses the next day were indeed hampered by the limitations in Aliposa's report is thus a critical component to evaluating Aliposa's conduct.

A little after two in the afternoon on the fourth, Nurse D. Odom made an entry in L's progress notes that a youth needed to be seen "regarding taking a big white pill on PM's 2-4-01." Odom then noted that according to L's progress note dated 2-3-01, he "was given Claritin-D" at 11:00 P.M. by the nurse. The county is thus wrong in stating that "no entry was made ... on several required forms," and wrong in asserting that "(n)o one could know of Aliposa's error because she did not record or transmit the event to anyone."

Aliposa very clearly *did* transmit *the event* to nurses on the following shift, but *not* that the event *was an error*. Immediately upon the youth's self-identification, Aliposa's progress notes served to adequately inform personnel on the succeeding shifts that L had taken a Claritin, but *not* that this represented a medication variance.

This is some, but not all of what Odom needed to know. While Aliposa's notes told Odom what the pill was, it was only L's narrative that let Odom know the pill had not been properly prescribed. By her failure to make a contemporaneous entry noting that the Claritin was a medication variance, Aliposa performed in a substandard manner, and is thus subject to discipline.

By the time Odom saw L, though, he was fine. As she stated in his progress notes, she assessed him, and found to be "alert and oriented," that he denied any adverse reaction or complaints at that time and showed "no signs of distress," and that he "stated he was high on PM's 2/4/01 from taking a Claritin-D." Notwithstanding the error as to date, this seems like a reasonably reliable statement – that L got a buzz from taking the mystery pill, but he was fine the next day.

Thus, Aliposa's failure to note that the Claritin had constituted a medication variance did impede Odom's full understanding of the situation, but not in a way that posed a significant medical risk to L.

Aliposa also made an entry in Daily Report – a youth-by-youth index of her 31 separate health care interactions with various detainees. Again, that entry was accurate but intentionally silent about the medication variance. She wrote:

(L) – claritin D 1 tab po @2100

This is medical short-hand for "the patient was given one table of Claritin-D, by mouth, at 9 P.M.," and was her only reference in that day's Daily Report. Given the nature of this report, however, this does not seem the document on which the county reasonably expects a nurse to note a medication variance.

While it is apparent the county regards the incomplete reporting as more serious than the medication variance itself, I have no knowledge as to how precisely the county parceled out the punishment. I do know that the record establishes that the county has significantly overstated the degree to which Aliposa's report lacked sufficient information to enable nurses on other shifts to provide adequate health care.

When Aliposa did not include in her February 3 progress notes that there had been a medication variance affecting L, her performance was sufficiently substandard performance as to justify suspension. But because the county was excessive in describing the seriousness of the situation – the record does not establish that Aliposa had made a unreasonable evaluation of the potential impact on L's health, and does show that she did a better job reporting than the county acknowledges, and– its degree of punishment was also, by definition, excessive.

Arbitrators are divided on what to do when they conclude that the employer was right to discipline, but that the discipline was excessive. I believe that our authority is not limited to all-or-nothing, but extends to fashioning a result that establishes industrial justice – consistent, of course, with the essence of the collective bargaining agreement.

What Aliposa did in committing the medication variance and not promptly reporting it as such constituted a level of substandard job performance to justify suspension. But the situation was only half as serious as the county contends.

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

AWARD

1. That the grievance is denied in part and sustained in part.

2. That the county is directed to reduce Aliposa's suspension from five days to two and one-half days and make her whole for all differences in pay and benefits lost as a result of the original discipline.

Dated at Madison, Wisconsin this 21st day of December, 2001.

Stuart Levitan /s/
Stuart Levitan, Arbitrator

SDL/gjc
6316.doc