BEFORE THE ARBITRATOR

In the Matter of the Arbitration of a Dispute Between

ROCK COUNTY

and

THE ASSOCIATION OF MENTAL HEALTH SPECIALISTS

Case 334
No. 60343
MA-11585

(Raymer and Crawford Suspensions)

Appearances:

Mr. John S. Williamson, Jr., Attorney at Law, 103 West College Avenue, Suite 1203, Appleton, Wisconsin 54911, appeared on behalf of the Association.

Mr. Eugene R. Dumas, Deputy Corporation Counsel, Rock County, 51 South Main Street, Janesville, Wisconsin 53545, appeared on behalf of the County.

ARBITRATION AWARD

On September 9, 2001, Rock County and the Association of Mental Health Specialists filed a request with the Wisconsin Employment Relations Commission requesting the Commission appoint William C. Houlihan, a member of its staff, to hear and decide a grievance pending between the parties. A hearing was conducted on February 12, 2002 in the Rock County Courthouse, Janesville, Wisconsin. A transcript of the proceedings was made and distributed on February 22, 2002. Post-hearing briefs and a reply brief were submitted and exchanged by April 30, 2002.

This Award addresses the suspensions of Registered Nurses Kathleen Crawford and Jill Raymer.

BACKGROUND AND FACTS

Rock County operates the Rock County Health Care Center, located in Janesville, Wisconsin. The County is a signatory to a collective bargaining agreement with the Association of Mental Health Specialists, a group of professional health care employees employed at the Health Care Center. The two grievants, both registered nurses, are employed at the Health Care Center. The Health Care Center has two physicians on staff; Dr. Rao, an internist and Dr. Frachette, a psychiatrist.

In March of 2001, patient "K" was a resident of the Health Care Center. Dr. Rao was patient "K"'s primary physician. Dr. Frachette had been called in to attend to patient "K"'s psychiatric needs. Each physician had prescribed certain medications for patient "K". Dr. Frachette had prescribed Serentil and Klonopin. Each was being administered 5-6 times per day.

Patient "K" had only recently been transferred to the Health Care Center. He had previously been a patient at Rock Haven, another Rock County facility. While at Rock Haven, "K" had been under the treatment of the two physicians, and was undergoing the same medication treatment.

Nurses Crawford and Raymer both worked on the unit where "K" was a patient. Each provided nursing care for patient "K". A portion of that care included the administration of the prescribed medications, which were being administered through a tube. Patient "K" would regularly place a portion of this tube in his underwear, forcing the nurses to retrieve it.

On Sunday, April 1, 2002, nurses Crawford and Raymer accompanied Dr. Rao on his rounds. Raymer raised the possibility of altering the medication regime for patient "K" with respect to Klonopin and Serentil. Raymer explained "K"'s behavior, and indicated that if the medication were administered three times a day it would be easier on nursing staff. Rao indicated there was no medical reason the medications could not be given in less frequent doses. He did express a concern that there may be some reason the patient was receiving more frequent doses, but ultimately indicated it was acceptable to modify the frequency of administration. Raymer wrote up the change, and Rao signed it. Crawford subsequently charted the changed medication regimen. In making the modification, Raymer indicated all medications should be administered three times per day. It was her intent that this be applicable to the Klonopin and Serentil only.

The modified medication schedule was administered for two days. Only the Serentil and Klonopin were administered three times a day. All other medications were administered as they had been previously. There was no incident or missed dosage. It appears that the various attending staff members understood the intent of the modification.

On April 4, the pharmacy called the floor, concerned about how the new medication order was written. Dr. Frachette, who was unaware of the modified medication schedule, took the phone call. It was at this time that he discovered that his medication order had been modified. Frachette had a conversation with the pharmacist, with Raymer standing approximately 15 feet away. It was his testimony that he directed in a loud voice that the original dosage be reinstated. He said he did so in a manner that Raymer must have heard. Raymer testified that while she was aware that Frachette was on the phone, she did not hear his conversation, and she left the area while the conversation was ongoing. By the time she returned, Frachette had departed. Upon her return to the unit, Raymer saw that Frachette had changed the medication order. She was concerned about the change and called Pam Hendrickson, the nurse practitioner, who was on call to cover for Dr. Rao. Raymer testified that she did not search out Frachette because he had left the area. Raymer indicated to Hendrickson that the order had been changed, that she was concerned that Frachette had made the change without being fully aware of all of the facts, and further indicated that she was concerned about the transition dosage level in that "K" had already received two doses at the higher level that day. Given those concerns, she asked Hendrickson if it would be acceptable to not implement Frachette's modification until she had time to talk to Frachette. Hendrickson indicated that she could go ahead, and do so.

Hendrickson testified that she felt caught in the middle of something she did not fully understand, and she immediately called Dr. Frachette. Frachette indicated that it was not acceptable to him to leave Rao's order in effect. Hendrickson thereafter called the floor and got Nancy Stone, the Head Nurse, and indicated to Stone that Frachette's order was to be implemented. Stone met Raymer at the elevator as Raymer returned to the unit, and advised her to stop trying to change Frachette's order. Raymer did so.

On April 6, 2001, an investigative session was conducted by Lucille Vickerman, Associate Administrator, into the conduct of Raymer and Crawford. Various witnesses were interviewed. As a consequence of this interview, Raymer was given a 30 calendar-day suspension without pay and directed to complete an education and observation period. Crawford was given a 5 working day suspension, and was also required to complete an education and observation period. Raymer's disciplinary letter, dated April 26, 2001, provides as follows:

> Dear Ms. Raymer:
>
> Effective April 27, 2001, you are reprimanded and suspended for thirty (30) calendar days without pay. This action is being taken due to the violation of the Nurse Practice Act Chapter 6 – 6.03 and Chapter 7 – 7.03. Further, negligence as defined in the Nurse Practice Act constitutes the same standard as negligence referenced in HFS 132 and Conditions of Participation Title 18-19.

1. On or about April 1, 2001, you violated Chapter N6 6.03 when you failed to meet the basic requirements of Professional Nurse Practice. You did not conduct a necessary nursing assessment prior to approaching a staff physician seeking an order change for a long established regimen for the administration of the medications Klonopin and Serentil to resident #14-158.

2. On or about April 1, 2001, you documented in the clinical record of resident #14-158 as having received an order from Dr. R.R. The order you documented was not the order given. It was dangerously misleading and lacks the specificity to be safely implemented by any registered nurse. The order you documented requires that resident #14-158 have all medications being received be changed to a new administration sequence. In your execution of this order, however, you modified only Klonpin and Serentil. This is a violation of Chapter N7 – 7.03(b).

3. On or about April 4, 2001, you were negligent in your professional performance when you failed to accept and implement a medication order without sufficiently compelling clinical justification for finding it inappropriate. Dr. P.F.'s legitimate order restoring the administration of Klonopin and Serentil to resident #14-158. was not performed. This is in violation of Nurse Practice Act Chapter 7 – 7.03(d).

4. On or about April 4, 2001, you were negligent in your professional performance when you acted to seek advise from Nurse Practitioner P.H. requesting to have Dr. P.F.'s order rescinded. This is in violation of Nurse Practice Act Chapter 7 – 7.03(e).

As a result of the above-referenced events, you are considered negligent in the performance of your professional duties as a Registered Nurse. Both your omission and co-mission of inappropriate acts indicates a form of conduct by heedlessness or carelessness and which constitutes a departure from the standard of ordinary care.

Future instances of conduct as referenced above will result in additional disciplinary action up to and including discharge.

. . .

EDUCATION REQUIREMENT

In addition to your reprimand and suspension, you are required to complete an education and observation period that will commence Tuesday, May 29, 2001. You are to report at 8 am on May 29th. A that time you are to report to Mrs. Lucy Vickerman, Associate Administrator Nursing Services, who will provide you with the program context and schedule for observation of your practice.

On May 7, 2001, the following disciplinary notice was issued to employee Kathleen Crawford:

The above disciplinary action was taken against you today for: (check one or more)

__	tardiness	__	leaving post without permission
__	absenteeism	__	slow down, or refusal to work
__	assault or fighting	__	loafing or laxness on job; failure to perform assigned tasks
__	drinking on job		
__	insubordination	__	inability to perform job
__	use of profane or abusive language	__	poor performance
__	dishonesty	**xx**	negligence
__	violation of work rule	__	damage to or loss of property
xx	Other (state reason)	Violation of Nurse Practice Act, Chapter 6	

. . .

On or about April 1, 2001, you violated Chapter NB 6.03 when you failed to meet the basic requirements of Professional Nurse Practice Act. You and a co-worker approached a staff physician to change the administration schedule of Klonopin and Serentil for resident #14-158. You implemented a new schedule that would reduce the number of times these medications would be administered during a 24-hour period. Your statement, "I agreed with Jill that 6 x/day wasn't necessary if we could condense it rather than wake him up at night. It was in his best interest not to be disturbed 6 x/day." And these actions were taken without conducting a nursing assessment of resident #14-158.

> In accordance with Article II 2.01 of the current AMHS labor agreement, you are reprimanded and suspended without pay for five (5) working days. The suspension dates are as follows: Tuesday, May 29, 2001, Wednesday, May 30, 2001, Thursday, May 31, 2001, Sunday, June 3, 2001, and Monday, June 4, 2001. You are to return to work at 8 am on Tuesday, June 5, 2001.
>
> Future instances as listed above will result in additional discipline up to and including discharge.
>
> In addition to your reprimand and suspension, you are required to complete an education and observation period that will commence June 5, 2001. On your return to work on at 8 am on June 5th, you are to report to Nancy Stone, RN, Nursing Supervisor, who will provide you with the program context and schedule for observation of your practice.
>
> . . .

The suspensions were served. Raymer testified that her two-day in-service consisted of writing essay questions and a letter on what she learned from her experience. Crawford testified that her in-service consisted of an eight-hour day of writing essays on the Nurse Practice Act. Ms. Raymer filed a grievance on May 3, 2001. Ms. Crawford filed a grievance on May 11, 2001.

On July 3, 2001, Ms. Vickerman sent the following letter to the Department of Regulations and Licensing Board of Nursing:

> To Whom It May Concern:
>
> Enclosed is an investigative report, with attachments, in regard to nursing acts performed by Jill Raymer, RN.
>
> These acts would appear to violate Chapter N6, Standards of Practice for Registered Nurses and Licensed Practical Nurses, and Chapter N7, Rules of Conduct. Thus, these materials are forwarded for the Board's review.
>
> Contact me if you have questions or otherwise wish discussion.

The same basic letter was sent relative to Kathleen Crawford.

The enclosure referenced in Ms. Vickerman's letter to the Department of Regulation and Licensing mirrored the substantive text of the disciplinary notices sent to Crawford and

Raymer. They were the respective internal documents forwarded from Vickerman to Ron Link, the Associate Administrator of the Home charged with discipline. The text of the Raymer document reads as follows:

TO: Ron Link
Associate Administrator

FROM: Lucy Vickerman
Associate Administrator

DATE: April 10, 2001

SUBJECT: Request for Review for Possible Disciplinary Action
Re: Jill Raymer, RN

Please see the attached summary of investigative findings, with attachments, in regard to the matter of allegations being brought against Jill Raymer, RN by Dr. Paul Frechette, Medical Director, and Nancy Stone, Head Nurse.

Your review for possible disciplinary action is requested. In my opinion, the findings of investigation support the following conclusions:

1. Ms. Raymer failed to meet a basic requirement of professional nursing practice, as defined in State Statute, Chapter N6, when she failed to conduct a nursing assessment prior to approaching Dr. Rao on 4/01/01 seeking an order changing a long-established regimen for the administration of Klonopin and Serentil to Resident #14-158.

2. The order Ms. Raymer documented in the clinical record of Resident #14-158 as having been received from Dr. Rao on 4/01/01 is dangerously misleading and lacks the specificity to be safely implemented by anyone. This should have been readily apparent to her.

3. Ms. Raymer moved outside the ordinary scope of professional nursing practice when she designated and implemented the doses of Klonopin and Serentil to be administered to #14-158 at 8A, 12N, and 8P as a result of implementing the order obtained from Dr. Rao on 4/01/01.

4. Ms. Raymer was negligent in failing to accept and implement, without sufficiently compelling clinical justification for finding it inappropriate, Dr. Frechette's legitimate order restoring the regimen for administration of Klonopin and Serentil to #14-158 that existed prior to 4/01/01 and moving, instead, to the Nurse Practitioner seeking to have Dr. Frechette's order rescinded.

5. Ms. Raymer was negligent in failing to accept and implement, without sufficiently compelling clinical justification for belief that doing so would harm or present the likelihood of harm to #14-158, Dr. Frechette's legitimate order restoring the regimen for administration of Klonopin and Serentil to #14-158 that existed prior to 4/01/01 and moving, instead, to the Nurse Practitioner seeking to have Dr. Frechette's order rescinded.

6. Knowing full well that behavioral issues might arise as a consequence, Ms. Raymer moved outside the established HCC-3 Team process by approaching Dr. Rao independently to seek revision of the medication administration regimen for #14-158.

The attachment to Ms. Vickerman's Department of Regulation and Licensing letter relative to Ms. Crawford reads as follows:

TO: Ron Link, Associate Administrator

FROM: Lucy Vickerman, Associate Administrator

DATE: April 20, 2001

SUBJECT: Request for Review for Possible Disciplinary Action
Kathy Crawford, RN

Please see the attached Report of an investigation conducted to determine the extent to which Kathy Crawford, RN played a role in an incident which occurred on HCC-3 on 4/01/01 in which Dr. Rao was approached to change the administration schedule of Klonopin and Serentil to Resident #14-158 from the schedule which had existed from 10/24/01 to tid.

Your review for possible disciplinary action is requested. In my opinion the findings of investigation support the following conclusions:

1. Ms. Crawford failed to meet a basic requirement of professional nursing practice, as defined in State Statute, Chapter N6, when she failed to conduct a nursing assessment prior to concluding that a long-established regimen for the administration of Klonopin and Serentil to Resident #14-158 was unnecessary. (i.e. "I agreed with Jill that 6 x/day wasn't necessary if we could condense it rather than wake him up at night. It was in his best interest not to be disturbed 6 x/day."

2. Ms. Crawford did not seek clarification of an order that directed a tid schedule for *all* medications being administered to #14-158 when she knew that the intent was to modify the administration schedule to tid for only Klonopin and Serentil. Though she recognized it as erroneous she allowed the order to stand and, at the same time, partially implemented it by modifying the administration of Klonopin and Serentil to the tid schedule she believed intended.

On September 14, 2001, the Department of Regulation and Licensing responded to both Raymer and Crawford by identical letter. Those letters provides as follows:

The purpose of this letter is to inform you of the results of the review of a complaint we received against you.

The details of the complaint, including information which may have been obtained by us, were reviewed and discussed by a screening panel. Screening panels generally include legal staff, investigative staff, and members of the relevant profession.

Based on the screening panel's review and evaluation of the complaint, a decision has been made not to proceed any further with this complaint. However, the complaint will be retained on file in the Division of Enforcement for future reference.

ISSUES

The parties stipulated to two issues:

1) Did the discipline imposed upon Ms. Raymer violate the collective bargaining agreement? If so, what is the appropriate remedy?

2) Did the discipline imposed upon Ms. Crawford violate the collective bargaining agreement? If so, what is the appropriate remedy?

The Union advances two additional issues. The County contends that these matters are not properly before the arbitrator.

3) Whether the decision of the State Board of Regulation and Licensing dismissing all the charges that Jill Raymer, RN and Kathleen Crawford, RN violated standards of practice for registered nurses is *res judicata* for arbitration purposes. If so, should all the charges that Jill Raymer, RN and Kathleen Crawford, RN engaged in conduct that violated the State Board's standards of practices – registered nurses, be dismissed?

4) Whether the County had the authority under the collective agreement to impose discipline in addition to the reprimands and suspensions imposed on Jill Raymer and Kathleen Crawford? If not, what should the remedy be?

RELEVANT PROVISIONS OF THE COLLECTIVE BARGAINING AGREEMENT

ARTICLE 2 – MANAGEMENT RIGHTS

2.01 Except as otherwise specifically provided herein, the management of the County of Rock and the direction of the workforce is vested exclusively in the County, including, but not limited to the right to hire, the right to promote, demote, the right to discipline or discharge for proper cause, the right to transfer or layoff because of lack of work, discontinuance of services, or other legitimate reasons. . .

. . .

ARTICLE 3 – HEALTH AND SAFETY

3.01 It is the intention of the parties to maintain the conditions of employment in a safe manner. Should any employee become aware or conditions he/she believes to be unhealthy or dangerous to the safety of employees or patients, such employee shall report the condition immediately to his/her supervisor. All unsafe or unhealthy conditions shall be remedied as soon as is practicable.

ARTCLE 10 – LEAVES OF ABSENCE

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10.07 Leaves of absence with pay

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D. In-Service Training

It is agreed that it is to the mutual benefit of the County and the employees within the bargaining unit for such employees to receive such in-service education as will assist them in the delivery of County services and is financially feasible. While attending such training or conference programs during the regular workweek, employees shall receive no more than his/her regular pay, and is not eligible for overtime compensation. In addition, employees assigned by appropriate management personnel to attend training programs during hours other than their regularly-scheduled work week, shall be compensated at their regular straight time hourly rate for hours in excess of forty hours per week. The County may require any employee to attend any in-service educational functions, but shall continue to pay such employee his/her regular rate of pay during any absence necessitated by such attendance, and shall further reimburse such employee for actual and necessary personal automobile mileage, by the most direct route, at the rate of $.32/mile, meal and lodging expenses including tips, provided that such expense be verified by suitable vouchers, registration fees and parking fees. In the event a common carrier is used instead of an employee's personal automobile, the employee shall be reimbursed the cost of traveling by common carrier.

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RELEVANT PROVISIONS OF THE WISCONSIN ADMINISTRATIVE CODE

Chapter N6

N6.03 Standards of practice for registered nurses.

(1) General Nursing Procedures. An NR shall utilize the nursing process in the 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. This standard is met through performance of each of the following steps of the nursing process:

(a) Assessment. Assessment is the systematic and continual collection and analysis of data about the health status of a patient culminating in the formulation of a nursing diagnosis.

(b) Planning. Planning is developing a nursing plan of care for a patient which includes goals and priorities derived from the nursing diagnosis.

(c) Intervention. Intervention is the nursing action to implement the plan of care by directly administering care or by directing and supervising nursing acts delegated to LPN's or less skilled assistance.

(d) Evaluation. Evaluation is the determination of a patient's progress or lack of progress toward goal achievement which may lead to modification of the nursing diagnosis.

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Chapter N 7 RULES OF CONDUCT

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N 7.03 Negligence, abuse of alcohol or other drugs or mental incompetency.

(1) As used in s. 441.07(1)(c), Stats., "negligence" means a substantial departure from the standard of care ordinarily exercised by a competent licensee. "Negligence" includes but is not limited to the following conduct:

(a) Violating any of the standards of practice set forth in ch. N6;

(b) An act or omission demonstrating a failure to maintain competency in practice and methods of nursing care;

. . .

(d) Failing to execute a medical order unless the order is inappropriate and licensee reports the inappropriate order to a nursing supervisor or other appropriate person;

(e) Executing an order which the licensee knew or should have known would harm or present the likelihood of harm to a patient;

. . .

POSITIONS OF THE PARTIES

In the view of the Employer, both grievants knew that both head nurse Stone and Dr. Frachette had dealt with patient "K" for months before his arrival at the Health Care Center. The County argues that there appears to have been almost a conscious attempt not to involve either Head Nurse Stone or Dr. Frachette in the effort to change the medication regimen for this patient.

In the Employer's view, the Management Rights clause of the collective bargaining agreement requires deference, in the absence of a substantial reason to act to the contrary, to the expert professional opinion of the Director of Nursing in interpreting the standards of acceptable performance governing bargaining unit employees subject to the Nurse Practice Act. This is particularly so where no witnesses offered a contrary professional opinion.

It is the Employer's view that the collective bargaining agreement, and the practices of the parties, established the Nurse Practice Act as a standard for acceptable performance and conduct, enforceable by discipline, up to and including termination.

The County points to the testimony of Dr. Frachette and to that of Director of Nursing Vickerman in support of its claim that the grievant's actions were inconsistent with the way medicine and nursing are practiced at the Health Care Center and that the team meeting was an appropriate and necessary vehicle for any nursing assessment.

It is the Employer's view that the state authorities (Wisconsin Department of Regulation and Licensing) charged with enforcing the Nurse Practice Act, along with a number of other professional codes regulated by the State of Wisconsin, must exercise great restraint in determining which of the many cases which come to its attention each year warrant the dedication of the limited resources available to it. The County contends that it is consistent with its position that the State in this case decided not to pursue further formal proceedings against the grievants, but to advise each grievant that "However, the complaint will be retained on file in the Division of Enforcement for future reference."

The Employer argues that there is no basis in the record to conclude that the grievant has been treated disproportionately than have other employees who have engaged in similar conduct. As to the educational component, the Employer contends that the object of the

educational component was work-related and reasonably designed to assist the grievants in correcting lapses in judgment which led to their violations of the Nurse Practice Act. The Employer points to Article 10.07 D, which permits the County to require employees to attend in-service educational functions.

It is the Employer's position that the interpretation of the Nurse Practice Act by the Director of Nursing has in the past, and continues to be, a reasonable basis for the imposition of discipline of registered nurses employed at the Rock County Health Care Center, bargaining unit members or not. This is subject to the ability of the County to satisfy an arbitrator that there is a factual and textual basis for the Director of Nursing's conclusion that a violation of the Nurse Practice Act has occurred.

The Employer contends that it has followed the classic model of progressive discipline in attempting to conform the conduct of the grievants to the requirements of the Nurse Practice Act. The Employer notes that each of the grievants had an opportunity to be heard prior to the issuance of discipline. On each occasion, the grievant's own testimony insofar as credible support the conclusion that there had been a failure to conform to the precepts of the Nurse Practice Act. Each of the grievants failed to conduct any adequate form of nursing assessment prior to taking the professional actions at issue. It was this failure of the grievants to discharge their own responsibilities as nurses, not the possibly perceived failure to obey Drs. Frachette or Rao, that formed the basis for Ms. Vickerman's conclusion that there were violations of the Nurse Practice Act, and her recommendations for discipline.

It is the position of the Association that this arbitrator should treat the Wisconsin Department of Regulation and Licensing's decision "not to proceed any further" on the County's complaints as *res judicata* and, on that basis alone, set aside the discipline of Raymer and Crawford. The County has based its discipline solely on its claim that Raymer and Crawford violated professional nursing practice regulations Chapters 6 and 7. It then filed these charges with the state agency entrusted to administer, enforce, and interpret the regulations. The agency decided that Raymer and Crawford had not violated them by refusing to proceed any further with the complaint. This decision binds the County.

The Association points to RL 2.035(3)(4). If the disciplinary authority concludes the matter is not trivial, and the matter alleged would be, if true, a violation of any statute, rule or standard of practice, then a settlement conference or a disciplinary proceeding will commence. The matter was reviewed and no settlement conference or disciplinary proceeding were initiated. The Legislature has entrusted the Department of Regulation and Licensing to make determinations as to non-trivial violations of the nursing regulations. In the view of the Association, even the ablest arbitrator cannot be expected to bring the same level of expertise and competence to bear upon those determinations. Therefore, the Arbitrator should defer to their expert judgment, and rule for Raymer and Crawford on the merits.

The Association addresses each of the charges leveled against Raymer and Crawford, and disputes the validity of each charge. Raymer was charged with four violations of the Professional Nurse Practice Act. The first was that she failed to conduct a necessary nursing assessment. The Association contends that the charge entirely misses the mark. Raymer's request to Dr. Rao was not based upon an assessment. It focused on the patient's inappropriate behavior. It was Dr. Rao who made the necessary medical assessment that the number of times the medicine is administered could be reduced without adverse effects to patient "K".

The second charge was that Raymer's draft of Dr. Rao's order was allegedly dangerously misleading. The Association points out that neither Dr. Rao nor Dr. Frachette nor the six medical staff members who administered medicines to "K" found the order misleading, much less dangerously misleading. The Association contends that not every alleged error a nurse makes rises to the level cited by the Employer. Nurses are not required to be infallible.

The third charge against Raymer is that she failed to accept and implement Dr. Frachette's legitimate order. The Association contends that there is no evidence to support this charge, but rather the evidence establishes that she did accept and implement the order. What Ms. Raymer did was to seek out the appropriate person, Hendrickson, acting for Dr. Rao, to determine whether the order should go into effect that day. When Hendrickson determined that it should, Raymer accepted and implemented Dr. Frachette's order.

The fourth charge was that Raymer's request to Hendrickson to rescind Frachette's order violated Sec. 7.03(E). Even if Raymer should not have made the request, she clearly did not execute an order that would cause harm or present the likelihood of harm to a patient.

With respect to the charges against nurse Crawford, the Association contends that Ms. Crawford's sin was that she was physically present when Raymer asked Dr. Rao about making a change. All other arguments, particularly with respect to the nursing assessment, are made on behalf of nurse Crawford.

It is the position of the Association that the County had no authority to subject Raymer and Crawford to specific supervision by Vickerman and Stone and compel them to write essays. The purpose of this supervision was to degrade and demean them. Raymer was also subjected to such insults as Vickerman's observation that she was a "brat", that she deserved a spanking, and that, by implication, she should not have become a nurse. No adult should be subject to such treatment.

DISCUSSION

The first matter presented for consideration is the impact of the Department of Regulation and Licensing decision not to proceed against either Raymer or Crawford. The Employer invites me to disregard the non-action of the administrative agency. In its brief, the Employer implies that a lack of resources explains the decision not to proceed. The Employer further contends that the agency's inaction is compatible with its decision to discipline, in that the agency retains the complaints on file. There is nothing in the record to support the Employer's contention in this regard. To the contrary, the agency's inaction in the face of what is alleged to be life-threatening and egregious behavior, would be inconsistent with its mandate. The Association contends that I should treat the decision of the Department of Regulation and Licensing not to proceed further as *res judicata* in this proceeding. The doctrine of *res judicata* typically operates to preclude the litigation of a matter already adjudged, decided, or settled by judgment. Nothing in the form letter from the Department of Regulation and Licensing indicates that this matter was ever adjudicated. There is no indication that this matter was ever litigated between these parties.

The record is silent as to why the Department of Regulation and Licensing chose not to proceed. The charges submitted to that board are detailed, use accusatory terms (i.e. "dangerously misleading", "negligent", "failed to conduct a nursing assessment"), and are submitted over a cover letter that concludes that violations of the code have occurred. While I am not prepared to apply the doctrine of *res judicata* to the inaction of the Department of Regulation and Licensing, I do regard the inaction of that body as inconsistent with the Employer's view as to the severity of the incidents involved.

The County contends that this matter should have been brought to the team. The record supports that contention. Team meetings appear to be an appropriate forum for discussion of such non-urgent matters. The County also contends that there appears to have been a conscious effort to avoid Head Nurse Stone and Dr. Frachette. At least as regards Dr. Frachette, that also appears to be the case. Dr. Frachette's testimony may shed insight into why that is. Dr. Frachette testified as follows:

> ". . .I did raise the question to Jill Raymer that if she had a question about my order, why wasn't I called? Because she's had no problem in the past calling me about any order I've written. And had she done that, we would not be here today."

Frachette's testimony continued as follows:

> "Also, we have a team meeting, which all of the members of the third floor who are involved in treating patients occurs once a week, and if there was concern about the particular patient receiving medications in a certain way, that's where it should have been addressed."

On cross-examination, Dr. Frachette testified further:

> "If she had called me and related her concerns – and I also stated that she's never had a problem doing that before. So why now? If she had called me and related her concerns, we would have discussed it. My answer would have been then and my answer is the same now, I would have told her that we are going to continue the order the way I have rewritten it. And that Dr. Rao and I would discuss it further, and if necessary, we would discuss it at the team meeting, and then we would arrive at a decision."

Dr. Frachette's testimony makes it clear he would not have been receptive to the proposed change in medication schedule.

While I agree that the matter should have been brought to the team, the real question presented is how serious a transgression it is to fail to do so? Dr. Rao signed the change order without any indication that the team was the appropriate forum for discussion of this matter. Upon signing the order, he indicated that he might talk with Frachette. Frachette's testimony suggests that he would not have been receptive to the change, that he would have talked to Dr. Rao, and "if necessary, we would discuss it at the team meeting." His testimony implies that there may have been no need for a team meeting following his discussion with Rao. Frachette further testified that had Raymer come to him, this discipline would not have occurred. This discipline did not arise because Raymer failed to bring the matter to a team meeting. It occurred because Raymer went to Rao instead of Frachette, and persisted after Frachette resinstated his original medication schedule.

The Employer contends that violations of the Nurse Practice Act may constitute a basis for the imposition of discipline. The Act establishes many of the bases of professional conduct of the nursing profession. If violated, they may well form the basis for discipline, subject to the application of the contractual just cause standard. The County further argues that under the Management Rights clause, I should defer to the opinion of the Director of Nursing as to the interpretation of those standards. I disagree. The Department of Regulation and Licensing is also an expert body. It did not defer to the Director of Nursing Vickerman, at least with respect to her conclusions that violations had occurred, and that discipline should be imposed. Moreover, the collective bargaining agreement authorizes arbitrators to interpret its terms. The contract directs arbitrators not to modify any of its provisions. This directive must include Article 2 and its just cause provision. The net effect of this Employer argument is that I

should defer to Director of Nursing Vickerman on the propriety of the discipline. The contract does not permit that.

The Employer has levied four charges against nurse Raymer. The first is a failure to conduct a nursing assessment. It is unclear to me what assessment was lacking. The medication schedule change was sought for the convenience of staff, and to eliminate waking the patient at night. With respect to the second charge, Raymer did make an error on the order. As the Association notes, it appears that floor staff understood what the order was intended to convey. However, the pharmacist was confused by the order. That confusion led to the phone call.

With respect to the third charge, Raymer did attempt to have Frachette's reinstated order held up or delayed. It was her testimony that she wanted an opportunity to explain to Frachette the basis of the original change, and to assure that dosage administered was correct since the patient had already been given two of the larger dosages that day. She never refused to administer the modified dose. She contacted Hendrickson, who initially agreed with her concerns. In the overall context of what transpired, Raymer's behavior is troublesome. Raymer was the catalyst in having the medication regimen changed. She knew that she had caused Frachette's initial order to be modified. It does not appear that she made any effort to speak with Frachette. Similarly, there is no indication that Raymer made any effort to inquire as to how to transition "K" back on to Frachette's schedule. Rather, her efforts were directed at staying Frachette's new order. When told to administer Frachette's order, she did so.

There is nothing in this record that suggests that Raymer knew or reasonably believed that there was a likelihood of harm to "K". All testimony indicates that her actions included a concern with respect to the impact of the medication schedule on patient "K".

As to the discipline of nurse Crawford, the discipline ignores the fact that Dr. Rao approved of the change.

It appears that much of the discipline in this proceeding has been couched in terms of words and phrases used in the nursing code. This conformity to code phrases has resulted in mischaracterizations and exaggerations of the behaviors of the individuals involved.

The Employer contends that it has disciplined severely for violations of the Nurse Practice Act in the past. Evidence to that effect was placed in the record. This is not a disparate treatment case.

As to the educational component of the discipline, I find the essay writing to have been disciplinary in nature. The Employer is entitled to require attendance at in-service functions for the legitimate educational needs of its workforce. However, writing an essay on "what I

learned from my experience" can only be construed as punitive and disciplinary in character. The remarks attributed to Ms. Vickerman that she wanted to "spank" Raymer and that Raymer is a "brat" are professionally inappropriate in a disciplinary setting involving what this Employer has characterized as serious misconduct.

The Employer contends that it followed progressive discipline. I disagree. The Employer notes that it provided an opportunity for hearing, representation, and discipline based upon the record. All the foregoing suggests that Raymer and Crawford's due process rights were honored. However, the foregoing ignores the nature of progressive discipline. There is no indication that either of these nurses have been subjected to prior discipline. The concept of progressive discipline is predicated upon increasingly more severe discipline applied under similar circumstances. The disciplines meted out here are enormous, without indication that they have been preceded by less severe disciplinary measures.

AWARD

Several questions were presented in this proceeding. The first question, "Did the discipline imposed on Ms. Raymer violate the collective bargaining agreement?" Thirty days is a gross overreaction to what Raymer did. She did enter the wrong medication dosage, and she did engage in gamesmanship in avoiding Dr. Frachette relative to the mediation of patient "K". Her behavior did not rise to the very serious levels charged. The Employer is free to issue Ms. Raymer a written warning in these two areas. It is not free to issue time off suspensions.

2. "Did the discipline imposed upon Ms. Crawford violate the collective bargaining agreement?"

Ms. Crawford's role was essentially as an observer in the discussion involving Dr. Rao. Five days is a substantial time off suspension. The Employer contends this is a very serious transgression, yet Dr. Rao signed off on it. Rao and Raymer were the active participants. The record is silent as to the discipline imposed upon Rao. I find no basis upon which to discipline Crawford.

Questions 3 and 4 have been discussed in the **DISCUSSION** section of this Award.

REMEDY

The Employer is directed to remove the references to suspensions from both files and to make both employees whole for lost wages and benefits suffered as a consequence of their suspensions. The Employer is free to enter a written warning relative to Raymer as noted above.

Dated at Madison, Wisconsin, this 15th day of November, 2002.

William C. Houlihan /s/
William C. Houlihan, Arbitrator

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