BEFORE THE ARBITRATOR

In the Matter of the Arbitration of a Dispute Between

SHEBOYGAN COUNTY HEALTH CARE FACILITIES EMPLOYEES, LOCAL 2427, AFSCME, AFL-CIO

and

SHEBOYGAN COUNTY

Case 348
No. 62445
MA-12288

(Dawn Ohlschmidt Termination)

Appearances:

Ms. Helen Isferding, Staff Representative, Wisconsin Council 40, AFSCME, AFL-CIO, 1207 Main Street, Sheboygan WI 53083, appearing on behalf of Local 2427.

Mr. Michael Collard, Personnel Director, Sheboygan County Personnel Department, 508 New York Street, Sheboygan, WI 53081, appearing on behalf of Sheboygan County.

ARBITRATION AWARD

Pursuant to the provisions of the collective bargaining agreement between the parties, Sheboygan County Health Care Facilities Employees, Local 2427, AFSCME, AFL-CIO (hereinafter referred to as the Union) and Sheboygan County (hereinafter referred to as the Employer or the City) requested that the Wisconsin Employment Relations Commission designate a member of its staff to serve as arbitrator to hear and decide a dispute concerning the termination of Dawn Ohlschmidt from her position as a Nurses Aide at the County's Sunny Ridge Nursing Home. The undersigned was so designated. A hearing was held on August 5, 2003, in Sheboygan, Wisconsin, at which time the parties were afforded full opportunity to present such testimony, exhibits, other evidence and arguments as were relevant to the dispute. The parties submitted the case on oral arguments at the close of the hearing, with the understanding that the Arbitrator would issue an expedited award within two weeks.

Now, having considered the testimony, exhibits, other evidence, contract language, arguments of the parties and the record as a whole, the Arbitrator makes the following Award.

To maximize the ability of the parties we serve to utilize the Internet and computer software to research decisions and arbitration awards issued by the Commission and its staff, footnote text is found in the body of this decision.

ISSUE

The parties stipulated that the matter was properly before the Arbitrator. The substantive issues before the arbitrator are:

1. Did the County have just cause to terminate the Grievant, Dawn Ohlschmidt?

2. If not, what is the appropriate remedy?

RELEVANT CONTRACT LANGUAGE

The collective bargaining agreement provides that Management has the right to make and enforce reasonable work rules, and to discipline employees for proper cause. Disputes over the exercise of these rights are subject to the grievance procedure and binding arbitration.

BACKGROUND

The Employer provides general governmental services to the people of Sheboygan County, Wisconsin. Among these services is the operation of several health care facilities, including the Sunny Ridge Nursing Home. The Union is the exclusive bargaining representative for the employees of the health care facilities, including those employees in the classifications of Housekeeper, Nurses Aide and Licensed Practical Nurse (LPN). The Grievant, Dawn Ohlschmidt, was employed by the County from 1993 until her termination in 2003. She initially worked as a Housekeeper and in 1998, became a Certified Nursing Assistant (CNA). At the time of her discharge, she was a full-time Aide assigned to the first shift on unit 3 South. That unit contains a mixed population of elderly residents and Alzheimer's patients.

The Grievant was discharged effective March 14, 2003, after it was reported that she had used unnecessary force with a resident who did not wish to get up that morning. The incident was initially reported to RN Sharon Brott by the Grievant, who told her that an elderly female resident, [F], was bleeding from a skin tear. The resident was observed to have torn skin on her hands and bruising on her upper arms. The Grievant and the part-time Aide working with her, Lori Konkel, were both suspended pending investigation. Konkel and the Grievant each provided a written statement to management as part of the investigation. Konkel's statement described events as:

> I went into the room, put linens on [F's] bed, said good morning and asked her if she was ready to get up. [F] stated she was not. I then went to wash and dress [M]. Dawn entered the room as I was finishing [M's] cares. She helped me transfer her to her wheelchair and combed her hair while I began to make [M's] bed. As we worked in the room, [F] kept putting her call light on, asking us to turn out the lights. It was apparent at that point that she was becoming upset. I asked Dawn to give me someone else to get up. As I finished [M's] bed, Dawn went over to [F] and told her it was time to get up. [F] stated that she doesn't get up 'til 7. Dawn said that it was almost 7 so she'd help her get up. As I finished [M's] bed, [F] began screaming "help"! I turned to see Dawn trying to put on her ten hose as [F] screamed and flailed her arms. Dawn told me to hold [F's] arms. I took hold of her arms just above the wrists. She broke free and tried to scratch and grab at Dawn and me. I held her arms again. This time I noticed blood on her right hand. We laid her back in bed and left the room.

The Grievant's statement described events as:

> Resident was very verbal and combative while trying to provide morning cares. She grab at me and her clothing and dug her nails into her hands and arms. Was hitting herself. She also was screaming and then I left her laying on her bed and went and reported to the nurses, about her hand bleeding and her behavior.

After interviewing Konkel, the Grievant, Katherine Bagemehl, a CNA working the same unit, and a number of other personnel who had been on duty, management determined that the resident had expressed a desire to be left alone and not forced to get up before 7:00 a.m., and that the Grievant had insisted that she get up, forcibly attempting to dress her. Management concluded that the resident resisted and the Grievant, assisted by Konkel, physically restrained her and struggled with her, resulting in the bruising and skin tears. Management concluded that this violated the patient's right to refuse treatment and that the physical confrontation constituted resident abuse.

The Grievant was terminated for resident abuse. Konkel was judged to be less culpable because she was a part-time Aide temporarily assigned to the unit, who was working at the Grievant's direction, and because she immediately conceded that what had happened was wrong and expressed regret. Konkel was assessed a five-day suspension. Management judged the Grievant more culpable because she was full-time on the unit, familiar with the residents, seemed to be the primary actor in the confrontation, and did not express any understanding that what was done was wrong. Management judged that this, in combination with a suspension meted out a month earlier for making inappropriate remarks to a resident, indicated a high risk that the conduct could be repeated.

The instant grievance was filed protesting the discharge. It was not resolved in the lower steps of the grievance procedure and was referred to arbitration. At the arbitration hearing, in addition to the facts recited above, the following testimony was taken:

CNA Lori Konkel, testified that she had been temporarily assigned to work 3 South on March 14th with the Grievant. Katherine Bagenehl and Sharon Martinez were the other team of CNA's on the unit. At approximately 6:30 a.m., she went into [F's] room and asked her if she was ready to get up. [F] said no, so Konkel asked her roommate if she wanted to get up. She said she was ready and Konkel helped her bath and dress herself. While she was doing this, the Grievant came in the room. [F's] call light was on and when she was asked why, [F] said it was because she wanted them to turn out the lights in the room, because she did not want to get up.

When she finished with the roommate, Konkel asked the Grievant to assign her to another resident, but the Grievant did not reply. She made the roommate's bed and while she did so, she could hear the Grievant and [F] arguing, with [F] saying she did not want to get up before 7 a.m. and the Grievant saying it was almost 7 so she would help [F] get up. [F] quieted down for a moment and the Grievant got some water to bathe [F] and took out her clothes. She asked Konkel to help her dress [F]. By this time [F] was screaming for help. The Grievant told Konkel to hold [F's] hands down. She grabbed [F] by the arm. [F] continued to scream and pulled free, but she was able to get hold of her wrist. Meanwhile, the Grievant had [F's] other arm and was trying to pull her pants on. [F] was still screaming for help and flailing with her arms and neither Konkel nor the Grievant was having much success in restraining her. At that point, Kathy Bagemehl came in from across the hall and asked what was going on. When Bagemehl entered, Konkel and the Grievant abandoned their efforts to get [F] up and let her go. Konkel noticed some blood on her blouse and saw that [F] had a skin tear on her finger. They put [F] back to bed. Konkel told the Grievant "I will never let this happen again" and went to report the incident. She encountered RN Eileen Brandt in the hall and told her what had happened. Within 10 minutes, she was called into the nursing supervisor's office.

Konkel testified that she knew that residents had the right to refuse treatments and cares and that she and the Grievant had been wrong to try and force [F] to get up when she did not want to. She felt particularly bad about the physical harm to the resident.

CNA Katherine Bagemehl testified that she was working across the hall when she heard someone screaming "Help me, help me!" She assumed that a resident had fallen on the floor. She and her partner, Sharon Martinez, were in the midst of caring for a resident and transferring the resident to a wheelchair. When they finished, she went into the hall to see what was happening. She went to the room where the screaming was coming from, opened the door and saw [F] sitting at the edge of the bed, with the Grievant holding one of [F's] arms up in the air, while Konkel held the other arm down with both hands. The Grievant was using her free arm to yank on [F's] pants. [F] was struggling with the two Aides. Bagemehl asked "What is going on in here?" and the Grievant said "She doesn't want to get up – she's complaining that the light is on – it's time for her to get up anyway."

The Grievant then stopped trying to pull [F's] pants on and said [F's] hand was bleeding. She and Konkel released their grips and [F] sat at the edge of the bed crying. Bagemehl went back across the hall to finish with her patient. The Grievant and Konkel came in and said [F's] hand was bleeding and that they were not going to get her up. They said they were going to go tell the nurse and they left.

Bagemehl then returned to [F's] room. She saw blood on [F's] hand and it looked to her as if [F] might have driven her nail into her palm. She noticed blood on [F's] arm and finger as well. [F] was crying and told her she did not know why they did that to her and that just because her roommate wanted to get up early did not mean she had to get up early. Bagemehl tried to stop the bleeding, but was not able to. She then went to get a nurse.

Bagemehl testified that she was shocked by what she saw,and that she believed it was clearly resident abuse. Asked why she delayed in reporting if, given that policies demand immediate reporting by witnesses of abuse, she said that the Grievant and Konkel had said they were going to report it and she delayed to see if she could stop the bleeding. She acknowledged that she probably should have gone to the nurse right away, but repeated that she was shocked by what she witnessed. She estimated that [F] was screaming for about five minutes before she entered the room.

Bagemehl said she had been instructed in the past by nurses to get patients up even if they were reluctant, particularly diabetics who needed to have food, but she said she would never fight with a patient who did not want to get up.

CNA Dawn Ohlschmidt testified that she entered [F's] room after Konkel had begun getting [M] up and dressed. She spent 10 minutes or so helping Konkel and during that time, Konkel made some comment about [F] not liking to have the light on. They finished with [M] and left to help another resident. When they returned to [F's] room, she got some water and [F's] clothes. She bathed [F] and put her hose on her legs. After [F's] hose were put on and as they started helping her with her pants, [F] suddenly became enraged, yelling and swinging her arms at them. She had on leg of her pants on, so she had to either finish putting them on completely or take them off. She could not leave her half dressed. [F] hit and grabbed the back of her shirt and Ohlschmidt tried to pry her fingers off. At this point, Bagemehl and her partner, Sharon Martinez, walked into the room. Konkel noticed some blood on her blouse, and they laid [F] back down on the bed, with her pants still half on and half off. She went to Sharon Brott to report what had happened and stopped on the way back to tell Martinez and Bagemehl that the nurse had been notified.

Ohlschmidt testified that she had been repeatedly ordered by the nurses to get patients up, even if they don't want to get up. This incident happened very quickly and there was very little time to react. While the resident did injure herself, Ohlschmidt said there was not much she could have done to prevent it. Reading over her written statement, she said that it was accurate, but not detailed, and she noted that she had been told to write it up immediately before she left the facility. Thus, she did not have much opportunity to reflect on the incident before writing the statement.

On cross-examination, Ohlschmidt said she believed she and Konkel did a transfer of another resident in between morning cares for [M] and trying to get [F] up. She agreed, however, that Konkel was still finishing up with [M] while she started work with [F]. At that point, no one had told her that [F] did not want to get up and [F] had not said anything. According to Ohlschmidt, [F] did not complain until she suddenly started screaming as her pants were put on and she was taken by surprise. Ohlschmidt agreed that physically forcing a resident to get up against his or her will would be the wrong thing to do, but denied that that was what happened here. She repeated that this was a sudden rage by [F] and that, at most, five minutes passed from her first objection to the point at which they laid her back down.

In the wake of this incident, the State Department of Health and Family Services was called in. They did not interview the Grievant, but did speak with administrators and others and reviewed the facility's records. Based on this review, they concluded that abuse took place, fined the facility and ordered retraining of the staff on the subjects of resident abuse and the right of patients to refuse treatment, including refusing to get up if they do not wish to. As of the time of this hearing, no investigation of the Grievant personally had been completed, no finding of abuse had been entered against her and no determination had been made as to the Grievant's status with the DHFS. Additional facts, as necessary, are set forth below.

ARGUMENTS OF THE PARTIES

The Closing Argument of the County

The County takes the position that the Grievant was terminated for just cause and that the grievance must be denied. The evidence is clear-cut and leaves little room for argument. After a careful investigation, the County concluded that this employee was guilty of resident abuse. That conclusion is amply supported by the evidence at the arbitration hearing.

The resident in question did not want to get up when the Grievant wanted to get her ready for the day. It is clear that she made known that she wished to have the light turned off and be left alone. The Grievant claims that the resident's objections were very sudden and that she had no warning that she was unhappy. However, the other witnesses testified to an extended period of screaming by the resident and Konkel testified that she asked the Grievant to assign her to help a different resident prepare for breakfast because it was clear that this resident wanted to remain in bed. The Grievant refused to leave her alone and insisted that she get dressed. This led to a physical confrontation, with the Grievant and Konkel restraining the resident by force, and the resident being injured. Rather than back off and try to calm the situation, the Grievant insisted on going ahead with dressing the resident. This went on for five minutes, by the Grievant's own estimation. This time frame was confirmed by Bagemehl. Bagemehl responded from another room to the screams. She estimated that it took five minutes for her to finish in the other room and get across the hall and she said that she was shocked by what she witnessed. Neither Konkel nor Bagemehl has any motive to lie, yet both testified that the Grievant abused this resident.

There is simply no justification for the Grievant's refusal to back down in the face of the resident's objections. The resident has every right to refuse to get up if she doesn't want to – the fact that this might inconvenience the Aide is beside the point. It may be that the Grievant had no pre-conceived plan to abuse this resident and it may be that she did not directly inflict the physical injuries on the resident, but that, too, is beside the point. She has been trained in how to deal with belligerent residents and she has been trained to defuse confrontations. This is not a case where she was persistent in trying to persuade the resident to get up. This is a case where the resident resisted and the Grievant ignored her training and engaged in a physical confrontation to force this woman to get up. The result was that the resident was injured. That is resident abuse and the County has a zero tolerance policy towards resident abuse.

The Closing Argument of the Union

The Union takes the position that the County did not have just cause to discharge the Grievant and that she must be reinstated and made whole for her losses. This is an employee with nine and a half years of good service. There is little question but that she did not inflict the injuries that this resident suffered. The only question before the Arbitrator is whether her efforts to get the resident out of bed amount to grounds for summary discharge. Clearly, they do not.

The practice at the facility is that Aides do not simply walk away when a resident is reluctant to get up. The consistent directions from the nurses are to get them up, even if they do not want to get up. That is a practical necessity if the facility is to function. That is what the Grievant did. Nothing more and nothing less. The effort was initially uneventful. The resident was cleaned and partially dressed. Her hose were put on and her pants were halfway on when she suddenly went berserk. As soon as the resident became agitated, the Grievant stopped, but since the pants were only halfway on, she could not simply leave the resident in that state. It would have been dangerous. She either had to have the pants all the way on or all the way off. She had no choice but to complete the effort.

The County's reliance on a rule to the effect that residents can refuse to get up if they wish ignores the actual practice at the facility and ignores the fact that there is no such rule. The imposition of a capital penalty such as discharge requires overwhelming evidence of guilt, proof beyond a reasonable doubt and that level of proof cannot be satisfied in the absence of a clear rule. Here, the standards were so cloudy that the State mandated a staff in-service on the rules for getting patients up because this incident made it obvious that employees had no idea what standards should be applied. The Grievant cannot be discharged for violating a rule she knew nothing about.

The testimony of the other employees that they were shocked by this is refuted by the fact that it was the Grievant, not Konkel or Bagemehl, who went to the nurses station to report the incident. The rules are clear that failure to report abuse renders an employee culpable for

the abuse. Both Konkel and Bagemehl know this rule, yet neither rushed to report the monstrous crime they had witnessed. The fact is, of course, that neither considered it a problem until they were called into management to explain it and then each rewrote history to blame the Grievant. What happened here was a routine matter, regrettable because of the resident's unpredictable outburst, but hardly a case of resident abuse.

Rebuttal by the County

The County dismisses the Union's claim that this abuse was not reported by other employees and thus was not considered abuse. In fact, the abuse was reported within minutes of occurring by multiple employees. The County likewise disputes the Union's claim that the Grievant stopped her efforts to get the resident up as soon as it became apparent that it would be a problem. On the contrary, the evidence is that this incident went on for at least five minutes after it got out of hand. The Grievant conceded that time frame in her testimony and Bagemehl said she heard the screaming, finished her duties in the other room and went to the resident's room to see what was going on, a process that took five minutes at least. Rather clearly, the Grievant persisted well after the point at which her training would have dictated she back off and let things cool down.

The County stresses that proof beyond a reasonable doubt is an inappropriate standard in a case such as this. The County notes that the Union, the employee and the Employer all have a stake in this case, but that the public also has a compelling interest in protecting residents and insuring their right to a safe environment. That interest should not be compromised by imposing some extraordinary burden of proof.

Rebuttal by the Union

The Union stresses to the Arbitrator that he must not simply accept the County's assertions of what employees may have said in the investigation. He must give weight only to the witnesses who appeared at the hearing and the evidence from those witnesses is ambiguous at best. Konkel's alleged report was to a nurse who happened to be in the hall – a nurse who did not testify at the hearing and who could not therefore confirm Konkel's self-serving testimony that she reported this incident. The reliable evidence is that the other employees did not regard this as a serious incident until the supervisors began investigating. Thus, their later claims of shock and remorse ring hollow and should be disregarded.

DISCUSSION

The issue in this case is whether the Grievant engaged in resident abuse. If so, she is subject to termination under the County's zero tolerance policy for abuse and under the general understanding in the industry that intentional abuse of a resident constitutes just cause. The

parties disagree, of course, over whether abuse took place and there is a threshold question of what standard of proof the County must meet to make its case. The Union urges that nothing less than proof beyond a reasonable doubt should be required, while the County argues that a mere preponderance should be required.

The Appropriate Quantum of Proof

In determining the quantum of proof required to support a discharge, the principal consideration is the factual basis for the discharge. Where the employee is accused of conduct reflecting on her character or honesty, the neutral decision maker will generally require stronger evidence than he might if he was deciding a suspension for absenteeism. The long-term consequences for the Grievant are far more severe, encompassing not only the loss of her job but very likely difficulty in finding other employment in the industry. Even here, where the allegation is not so much intentional cruelty as it is a mixture of stubbornness and bad judgment, a conclusion that she was guilty of patient abuse will predictably haunt the Grievant's professional career. Having said that, "proof beyond a reasonable doubt" is a standard drawn from the criminal law. It is a safeguard against the power of the state to imprison citizens, and with the exception of a minority of arbitrators, it is not used in civil proceedings.

Articulating a standard of proof is a somewhat artificial exercise and the most honest answer to this question is probably to say that these charges require that, at the end of the day, the Arbitrator be convinced of the Grievant's guilt. To the extent that a standard can be accurately stated, I am persuaded that the appropriate balance between the compelling interests of the Grievant in her job and her good name and the very strong interest of the Employer in detecting and deterring serious misconduct is best struck by requiring that the charges be proved by the clear and convincing preponderance of the evidence. 1/

1/ Bornstein, et al., Labor and Employment Arbitration, (2d Edition, Matthew Bender), Volume 1 (Release No. 18, April 1998), at §506, footnote 1:

". . . it is almost certainly the "clear and convincing evidence" standard that will be applied (either expressly or by implication) by arbitrators in cases involving accusations of criminal conduct or moral turpitude . . ."

The Merits of the Case

The charge against the Grievant is resident abuse, in that she is accused of engaging in a physical confrontation with a resident, trying to force the resident to get up and dressed against her will, resulting in injuries to the resident. While she agrees that the conduct alleged would be abuse, she denies the conduct.

The Grievant's defense is that she was confronted by a very sudden rage from a resident and she could not stop dressing the resident in the face of the rage, since to do so would leave her half-dressed and liable to trip and fall if she tried to get up. Certainly, there is a difference between reacting to a sudden rage and provoking that rage, and an employee must be given greater latitude in the former case before a particular act or course of action can be fairly characterized as abuse. Employees are given training in how to appropriately react, but training has its limits and if events unfolded as the Grievant described, it might be argued that her conduct, though not well thought out, was at least not so outrageous as to be abuse.

The difficulty for the Grievant's defense is that her version of events is flatly contradicted by both Konkel and Bagemehl. According to each of them, [F's] objections were quite clear before the Grievant started putting her pants on. She was screaming for help for a period of time before that effort started. According to Konkel, the Grievant essentially initiated the physical struggle by insisting that [F] be dressed when she resisted, and it was the Grievant who ordered Konkel to grab and hold [F's] arm. If Konkel and Bagemehl are to be believed, the Grievant is clearly guilty of resident abuse.

I cannot find any persuasive reason to discredit Konkel and Bagemehl. Certainly, Konkel has a stake in this matter, since she was also subjected to discipline and may have wished to safeguard her job by throwing blame on the Grievant. However, her detailed statement from the same day essentially tracks her testimony and accepts her part in the matter. It is difficult to see how this statement served her self interest. She would have been better off, from a disciplinary standpoint, telling the same story as the Grievant if that was what actually happened. There is no advantage in slanting the story to make both of them look worse.

Moreover, Bagemehl's statement regarding the timeline of the incident, when the screaming started and how long it went on, and her description of the Grievant's explanation of her actions – that [F] didn't want to get up but that it was time for her to get up – are all consistent with Konkel's statement and inconsistent with the Grievant's. Bagemehl's motive for lying is even less clear than Konkel's. She had no exposure here. She responded to a resident's cries for help, walked in on the incident, attempted to give care for the resident's injuries, then reported it to the nurse.

The record evidence is overwhelming that the Grievant deliberately engaged in a physical confrontation with an elderly resident in an effort to make that resident get up when it was apparent the resident was unwilling. Certainly, she did not start with a plan to use force, but that is not the point. When it became clear that [F] was intent on resisting, she had ample opportunity to back away and defuse the situation. She elected instead to escalate it. I have no doubt that the Grievant never intended the resident to be injured, but that is not the point, either. 2/ The injuries were a foreseeable consequence of the element of physical coercion and the Grievant is not blameless in that regard. Even if [F] had come through this incident without the bleeding and bruising, the use of force against her would be impossible to justify.

2/ Neither is the argument over whether nurses tell Aides to get residents up whether they want to get up or not really relevant to this case. It is not hard to believe that Aides are told to be persistent, but no one suggested that physical force was an acceptable option for making residents get up in the morning. The resident abuse here is not in insisting that [F] should get up before 7 a.m. At some point, that might constitute a violation of [F's] rights, but by itself, it would not call for summary discharge. The abuse here is in the physical force.

[F] may have been loud and disagreeable and difficult, but at the end of the day, she is a 99 year old woman who simply wanted to stay in bed awhile longer. She was entitled to do that and she was entitled to do that without having to engage in a physical struggle with the staff who are employed to look after her.

The Grievant is guilty of resident abuse. The facility presented evidence of a zero tolerance policy towards abuse and the Grievant's conduct does not entitle her to some extraordinary consideration with regard to penalty. While she had nine good years of service, her lead role in provoking this incident, the obvious wrongfulness of the conduct and her refusal to acknowledge that there was anything wrong with her conduct persuade me that the County was within its rights in deciding that termination was the appropriate penalty. Accordingly, the grievance is denied.

On the basis of the foregoing, and the record as a whole, I have made the following

AWARD

The Grievant was discharged for just cause. The grievance is denied.

Dated at Racine, Wisconsin, this 25th day of August, 2003. 3/

Daniel Nielsen /s/
Daniel Nielsen, Arbitrator

3/ As a service to the parties, this Award has been issued in draft form on August 19, 2003. This final version contains minor corrections and formatting changes, but is substantively identical.

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