BEFORE THE ARBITRATOR

In the Matter of the Arbitration of a Dispute Between

LOCAL 1925A, AFSCME, AFL-CIO

and

WALWORTH COUNTY

Case 170
No. 66713
MA-13608

Appearances:

Laurence Rodenstein, Staff Representative, Wisconsin Council 40, AFSCME, AFL-CIO, appearing on behalf of the Union.

Lisa Bergersen, Attorney at Law, Lindner & Marsack, S.C., appearing on behalf of the County.

ARBITRATION AWARD

The Union and Employer named above are parties to a 2005-2007 collective bargaining agreement which provides for final and binding arbitration of certain disputes. The parties asked the Wisconsin Employment Relations Commission to appoint the undersigned to be the arbitrator on the grievance of N. H. A hearing was held on June 19 and 28, 2007, in Elkhorn, Wisconsin, at which time the parties were given the opportunity to present their evidence and arguments. The parties completed filing briefs on September 11, 2007.

ISSUE

The issue is:

> Did the County violate the collective bargaining agreement when it discharged the Grievant? If so, what is the appropriate remedy?

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BACKGROUND

The Grievant was a certified nursing assistant (CNA) at the County's nursing home, called Lakeland Health Care Center. She had been employed in that position for 22 years.

At the time of the incident that led to the discharge of the Grievant, there were 15 residents to be served food and beverages on the memory unit side of the facility. The food service workers would set up the trays with the food on the plate, and the CNA's would pour and add the liquids to the trays and deliver them to the residents. The CNA's would take the plates off the tray and put it on the tables or help residents who needed assistance, whether opening a package of jelly, cutting up food, or feeding a person.

Physicians may order dietary restrictions for residents. Some residents cannot have salt or sugar or carbohydrates. The consistency and texture of food may be an issue. Some have trouble swallowing food, and it may need to be ground up or blended. Residents with swallowing problems may need to have their liquids thickened. There is a checklist and as physicians' orders are changed, the nursing care plan is updated and a CNA card is updated.

Residents who have swallowing problems are at risk for injury and infection. If liquid goes into their lungs, they can develop respiratory infections and pneumonia. People could even die from this. Regular liquids are called thin liquids. The thickening agents are called nectar, honey, and pudding, which describe their increasing amount of thickness or consistency. There are packages to make liquids thicker, and they are put on the counter in the kitchen area during service time. Thickened liquids are used in every unit in the health care center.

Wendy Kujawa is the nurse manager for the memory care unit. She stated that there are several resources that a CNA can check for thickened liquid orders for a resident. There is a beverage list in the kitchen area. There is a list of all the residents with their meal requirements, their beverage preferences and restrictions. There is a dietary card or tray card to check for special things for that tray, such as special utensils or thickened liquids. There is a CNA summary card in the resident's room and a nursing care plan in the resident's chart in the charting room. Kujawa said whoever serves a liquid beverage to a resident is responsible for determining whether it needs to be thickened. The health care center has a policy on thickened liquids. While the Grievant was a long term employee, she was given an orientation in April of 2004 because she had been on an extended leave of absence from October of 2002 to April of 2004. Her orientation included a review of the thickened liquids policy.

On November 21, 2006, Certified Medication Administrator (CMA) Rose Barbian came to Kujawa and told her that a food service worker had given resident GS thin liquids. Barbian was distributing medications and when she looked at GS's records, she knew he was not to have thin liquids. Kujawa contacted Barbara Kropacek, the food and nutrition services manager, and told her that a CMA had observed a food service worker giving GS unthickened coffee. Kropacek talked to Barbian, who told her that she had seen Cynthia Sears, a food

service worker, giving GS coffee. Barbian also told Kropacek that someone came into the dining area and asked who gave GS the coffee that had not been thickened. Nobody said anything. Barbian thought she had seen Sears give out the coffee, but then Sears said that the Grievant had done it. When Kropacek asked Barbian if she was sure she had seen Sears give the coffee to GS, Barbian replied that she was trying to do her medication pass and was focusing on the dining room at the same time, but that she could have sworn that Sears had given him the coffee.

Kropacek found the Grievant next and asked her if she knew anything about GS getting any coffee. The Grievant said yes, that one of the food service workers asked if GS could have coffee and could the Grievant get him some. The Grievant was not sure about the food service worker's name, but thought it was Cindy, which would have been Cynthia Sears. The Grievant told Kropacek that she got GS the coffee but did not know that it was supposed to be thickened. The Grievant did not say that she was refilling a cup of coffee for GS at that time. The Grievant asked Kropacek whether she was going to be getting into trouble, and Kropacek told her that she would have to let her supervisor know what happened.

Kropacek next found Sears and asked her about the incident. Sears said that GS had been bothering her during the setup time, so she asked the Grievant if he could have coffee and to help him. Sears denied giving coffee to GS. The food service staff did not pass out beverages, and at that time, they were not trained to serve residents. Kropacek then checked the diet card and beverage sheet which indicated that GS was to have thickened liquids only. She reported to Kujawa that the Grievant had admitted giving GS thin coffee, and that food service worker Cynthia Sears denied giving him anything.

Sears testified that she was setting up trays and things in preparation for the meals on November 21, 2006. GS had frequently come up to the food service people asking for coffee and they told him he would have to wait. He did not have a coffee cup in his hand. Sears asked the Grievant if she had time to get him some coffee. She did not see the Grievant get his coffee. She knew that he was on thickened liquids from looking at the tray cards. However, Sears did not see the tray card on that day because there was no need for her to look at it. She was working when the CNA's asked her how GS got the thin coffee, and she told them that the Grievant served him.

Barbian testified that Sears gave a cup of coffee to GS who was asking for coffee non-stop – coffee, coffee. A little later, a couple of people – Kathy Morgan and Sue Robers – brought up the question of why GS was having thin liquids when he was supposed to have thickened liquids. Barbian said that nobody said anything for awhile, and then Sears said that the Grievant gave him the coffee. Barbian just looked at Sears. She had not seen the Grievant give any coffee. Barbian told a unit nurse that a kitchen person had passed a thin cup of coffee to GS, and then Kropacek came to talk to her about it. Barbian testified that she wrote the incident down on a piece of paper because she knew she was going to the unit supervisor and wanted to repeat the incident exactly. She did not have that piece of paper, and her written statement was dated three days later than the incident.

Kujawa checked GS's physician's orders, his nursing care plan, his CNA summary card and found that he was to have nectar thickened liquids. Kujawa got the Grievant to her office, where the Grievant admitted giving GS thin coffee. The Grievant wanted to know if she was in trouble and if she was going to be fired. Kujawa replied that it was not up to her, that she was trying to find out what had happened, and that she would provide the information to Marie Maguire, the Director of Nursing at that time. Kujawa and the Grievant reviewed the resources to check on liquids, such as the tray card, the CNA summary card, the care plan, and the beverage list. The Grievant acknowledged that she knew all those resources were available to her but that she did not check them. The Grievant told her that she had been in trouble for a similar incident. Kujawa did not have the Grievant's prior disciplinary record because the Grievant was in a float position, going to whatever unit had a need for that day. Kujawa told her that because she was a float moving from unit to unit, she needed to be even more cautious because physician's orders can change day to day or hour to hour. The Grievant did not say that she was refilling a cup of coffee, and Kujawa said that it would not have mattered because anybody serving a liquid is responsible to make sure he or she is giving the correct diet order.

The County's Labor and Employee Relations Director, Susan Hagstrom, was the Human Resources Manager at the time of the incident. She was notified of the incident by the Director of Nursing, Marie Maguire, on November 21, 2006. Hagstrom reviewed the Grievant's personnel file, and when she called Maguire back, both Maguire and the Health Care Center's Administrator, Phyllis Williams, were recommending termination. Maguire had called Williams, who was out of town that day. Hagstrom concurred with their recommendation based upon the past disciplinary record. At that time, all that Hagstrom was told was that the Grievant had given a cup of thin coffee to a resident who was on thickened liquids and that the Grievant had admitted doing it. Hagstrom asked Maguire to have the Grievant come meet with her the next morning.

On November 22, 2006, Union President Mary Price, Maguire, and the Grievant met with Hagstrom. Maguire told the Grievant that the incident was going to lead to her termination. Hagstrom decided that discharge was appropriate rather than a suspension, because the Grievant had been suspended 10 days one month before this incident for the same issue. The Grievant also had a history of resident safety issues.

The Grievant served a 10-day suspension in October of 2006 for putting a pitcher of thin water in a resident's room when that resident required nectar thick liquids. The Grievant also had a three-day suspension in May of 2005 for a resident safety issue when she left a resident unattended in an elevated bed with the foot of the bed sloping down and the door to the room closed. In April of 2004, the Grievant was given a second step discipline for a resident safety issue for leaving a resident sitting on a toilet without a call light. In May of 2002, the Grievant was given a one-day suspension for a resident safety issue for not following a plan of care regarding a walker and a personal alarm.

When the Grievant met with Kujawa, she did not ask for Union representation and Kujawa did not offer it to her. Since the Grievant admitted she gave GS the cup of coffee, Kujawa did not feel that Sears had a role in the incident. At the third step grievance meeting, the Grievant said that she was refilling a cup of coffee.

When the CNA Registry came into effect in the mid 1990's, Williams sent Union President Mary Price and Chief Steward Donna Busch to a training session regarding reporting abuse and neglect to the State. Price testified that a practice developed as to how the Health Care Center and the Union would work together in investigations of potential disciplinary matters. When there was an allegation of abuse or neglect, the Director of Nursing would have Busch sit in on interviews that were being conducted. If there was no chance for discipline to result from that interview, there was no need for a Union representative to be present. But if discipline could result, a Union representative was always there, according to Price.

Williams has told her managers that if they are just talking to an employee to gather information and they are not going to issue discipline, they may do so without a Union representative. However, if during that process an employee states that he or she would like to have a Union representative there, then they are to provide the employee with a Union representative. According to Williams, Union representation is not necessary where an employee is being counseled, since counselings are not considered to be discipline. If a disciplinary action is being issued, there must be a Union representative present. A Union representative may not necessarily be present during the investigation, but there may have been a representative present in an investigation if an employee asked for one. This is a practice that Williams has followed for 15 years. While Williams was not at the facility on November 21, 2006, she testified that the investigation in this case was their typical practice.

THE PARTIES' POSITIONS

The County

The County asserts that it had just cause to discharge the Grievant based on her own admission that she gave GS an unthickened cup of coffee without checking the resources available to her, and the only remaining question is whether termination was an appropriate response. The County's response was necessary, because resident safety is at the heart of the Health Care Center's business. An employee's failure to abide by policies and procedures in place to keep residents safe puts residents in jeopardy and increases the Center's liability for wrongdoing.

Termination was justifiable given the Grievant's disciplinary record regarding resident safety issues. Only a month prior to the incident leading to her termination, the Grievant was involved in another resident safety issue of an almost identical nature. She was given a ten day

suspension and told about the risk of aspiration to patients who were given unthickened liquids when a thickened liquids order was in place, and she was warned that further incidents of that nature would result in even greater penalties. The Grievant had a three day suspension in 2005 for a resident safety infraction, a second step discipline in 2004 for resident safety, and a one day suspension in 2002 for a safety infraction. The Grievant was on leave between September 2002 and April 2004 and was completely retrained when she returned to work in April 2004.

The County submits that one would think that just coming off a ten day suspension for an infraction concerning thickened liquids would have caused the Grievant to take pause prior to getting GS a cup of coffee, but it didn't. She either did not feel like checking the resources or she was not capable of remembering safety procedures. Either way, she posed a risk of danger to residents. The County does not have to wait for a patient to die or be seriously injured before getting rid of an employee who has ongoing safety problems. There was no reasonable expectation that the Grievant was going to improve. Progressive discipline was not working.

While the Union argued that the termination was procedurally flawed because the Grievant was not provided with Union representation in the investigatory interview, the Grievant never requested Union representation. The Grievant was neither disciplined nor discharged during the meetings with Kropacek and Kujawa, so Section 26.06 of the bargaining agreement was not violated. The Union also tried to establish that a past practice existed where the Health Care Center automatically provided a Union representative to an employee being investigated for matters that could lead to discipline. Williams testified that not only is there no such practice, but that she trains her managers that Union representation of employees during investigations and verbal counseling sessions is not necessary unless the employee asks for it. The Union's only evidence of such a practice came from Price, but she did not have personal knowledge of every investigatory conversation that goes on at the Center. Even if there were such a past practice, it would be insufficient to mitigate the just cause for termination that clearly exists. The lack of Union representation is insufficient to overturn the decision to terminate the Grievant for proven, undeniably egregious conduct. A Union representative would not have changed anything during the investigation.

The County argues that the fact that Sears was not disciplined is irrelevant. The Grievant admitted giving GS the thin coffee, and Barbian's testimony would only be relevant if the Grievant denied it and tried to pin it on Sears. Although the Union seemed to argue that the failure to discipline Sears mitigates the Grievant's violation of resident safety, there was no evidence that the Grievant and Sears had similar disciplinary histories. Management's conclusion that Barbian was mistaken in her observation was reasonable where the Grievant admitted giving the coffee and Sears denied doing so. Moreover, the food service workers did not and were told not to serve beverages to residents at the time in question.

The Union

The Union contends that the investigation failed to establish the salient facts necessary to prove that a work rule violation had occurred. The first error arose when Barbian reported to Kujawa that she had seen a food service worker give GS coffee, and that she had never seen the Grievant give GS coffee. Neither Kropacek nor Kujawa gave any credence to Barbian's observations. Both supervisors indicated that after the Grievant admitted giving GS coffee, their search for the truth ended. When Sears denied giving GS coffee, in contradiction to Barbian's credible statement, Kropacek accepted Sears response on its face and dismissed Barbian's claim. Given the conflict between a credible witness statement and the self-serving statement of the potentially accused employee, the Home's failure to pursue the investigation further to determine whether or not Sears had also violated the protocol is contrary to the disparate treatment principle embodied in just cause. There was a lack of diligence in searching for the truth, and the Home demonstrated that it was unwilling to put the Grievant's admission into any kind of mitigating context, and without the benefit of competent Union representation, the Grievant was unable to defend herself.

The Union further asserts that the Home's failure to determine Sears' role in encouraging the Grievant to give GS coffee in violation of his beverage orders was never factored into either the penalty or the determination of the Grievant's liability. The Home's failure to discover that Sears failed to inform the Grievant of GS's status is an extraordinary omission underscoring the Home's perfunctory investigation. After the Grievant admitted giving GS coffee, the Home did not recognize any exculpatory evidence and booted her out the door after 22 years. Moreover, the Grievant was fired for giving unthickened coffee while Sears received no discipline whatsoever.

The Union contends that the Arbitrator should exclude the Grievant's illegally obtained admission. The record evidence reveals that a consistent, mutually acknowledged prevailing practice of the Home requires an employee accused of a serious event to be provided with Union representation whenever any accusation is being investigated that may lead to discharge. Both Price and Williams testified to this. The practice is embedded in the contractual provision of Section 26.06. The parties have continuously, with mutuality of intent, followed this practice. The practice requires the Home to provide a Union representative, even if none is requested.

This case shows why the failure of the County to utilize Union representation in the investigation of the Grievant is so critical. The need for an accused employee to have Union representation becomes most pertinent when the accused employee is unable to represent her own interests effectively. The only evidence against the Grievant is her own admission of guilt. She was unable to offer any defense. She failed to mention in her own defense that Sears had asked her to help provide coffee to a cranky resident. Sears admitted that she knew that GS's coffee should have been thickened, but was too busy to mention it to the Grievant. The Grievant, in all likelihood, was merely refilling GS's coffee cup which was first provided to him by Sears.

The Union believes that the Grievant's admission should be considered to be inadmissible and excluded from the record as having been obtained extra-contractually. Without that admission, the Home has no cause to discipline or discharge the Grievant. But for the illegally conducted investigation, it is possible that the Home would not have been able to conclude independently that the Grievant had violated the thin water protocol.

The Union asserts that the Home's post-termination conduct shows its own failure to properly train employees on the protocol in question. After the Grievant was terminated, the Home initiated several policy shifts. For the first time, it decided to provide CNA's with copies of the beverage list which was previously restricted to food service employees. This is a tacit admission by the Home that its policies had failed in the Grievant's case. Also, Price had her first encounter with the Home's written thin water protocol after the Grievant's termination. The Home also ordered a mandatory in-service for CNA's and other employees on January 25, 2007, after promulgating its thin water protocol 10 days earlier. The evidence suggests that the Home had come to realize that its own workforce was inadequately trained. This should be considered as one mitigating factor in the discharge penalty. It is further likely that the absence of training would have been raised as a mitigating factor by a competent and experienced Union representative.

The Union states that in order for the Home's interest to rise up to a level sufficient to discharge a 22-year employee, there needs to be a nexus drawn between the employee's action and the unfavorable consequences to the resident which flowed from the error. The Grievant did not cause sufficient harm to the Employer as to justify the discharge penalty. Moreover, the Grievant was relying on Sears' custodial relationship with the beverage list. The Employer decided not to submit the Grievant's name to the registry, which is evidence that the Home did not consider the rule violation to rise up to a major disciplinary event such as patient abuse or gross negligence.

Finally, the Union finds that the Home's failure to investigate similar instances of thin water protocol violations indicates disparate treatment. Between December 8 and 12, 2006, the orders for another resident failed to mention that YM was on a nectar thick protocol. Price brought it to the attention of her unit supervisor, but there was no investigation and no discipline applied. The Grievant was fired while other violations were not even noted. Nursing notes were altered to correct the violation without any attempt to see who had recorded the incorrect documentation. Resident YM was at risk for 5 days and 15 meals but nothing was done about it.

In Reply, the County

The County responds first by noting that the access to the beverage list was not a factor in the Grievant's failure to check GS's restrictions. There was an October 27, 2006 in-service telling all CNA's that they were to use the beverage list during the meal service. The Grievant knew that before serving any resident a beverage, she was to find and use the beverage list. The Grievant could also have checked the dietary tray card or other sources.

The Union argues that the training on thin water protocol is an enlightening post-termination development. This case concerns thickened liquids, not thin water. There is no claim that the Grievant was not trained in thickened liquids orders or that she did not understand them. She was retrained in thickened liquids when she returned from a leave of absence in April of 2004.

The County notes that even if Barbian saw Sears give GS a cup of coffee, it does not mitigate the Grievant's termination. There is no evidence that even if Sears gave GS a cup of coffee, it was unthickened. The Grievant still committed the offense and termination would still be appropriate because of her work record and failure to respond to progressive discipline. Management reasonably determined that Sears did not serve GS coffee and that Barbian was incorrect.

The fact that Sears requested the Grievant to help GS does not excuse the Grievant's failure to do her job. Sears was merely informing the Grievant that a resident needed a beverage. Food service workers were told not to serve beverages. She had no authority to order the Grievant to do anything. Also, it is the responsibility of the person serving a beverage to a resident to first determine whether there is a thickened liquids order in effect for that resident. That responsibly was heightened by the fact that the Grievant was a float employee. While the Union argued that the Grievant may have reasonably concluded that it was safe to give GS a thin cup of coffee, the Union cannot argue that she may have reasonably concluded anything, absent her testimony. Having just come off a ten day suspension for failing to follow a thickened liquids order, the Grievant should have known that she had to be very careful about serving beverages. She was not careful, and nothing in the situation serves to mitigate her failure to be careful.

The County states that the Union has failed to establish any set practice relating to Union representation. The Union argued that the Home would provide a Union representative to an employee accused of a serious event during an investigation in which one may reasonably assume that discharge may ensue. However, Kropacek and Kujawa had no idea whether they were investigating a dischargeable event. A large part of the decision to terminate the Grievant was based on her previous disciplinary record of resident safety violations and her failure to respond to progressive discipline. Neither of the supervisors knew of her past work record. They had no authority to make any decision regarding her employment status.

Further, the Union failed to establish the existence of an unequivocal, clearly enunciated, readily ascertainable, fixed and established practice by both parties. Price testified that Williams "sometimes" asks the Union to sit in on interviews. Beyond that, Price stated that Union representation was always offered at the point at which the discipline was applied. That is what the contract requires and that is what the County does. Williams testified that Union representatives are not automatically provided during investigatory interviews.

The County finds the Union's reference to this case as one involving the thin water protocol as baffling. There was no thin water order in place for GS. And the Union's allegations of similar instances are anything but similar. The lack of evidence makes any comparison impossible. Regarding Exhibit #29, there is no indication who wrote the entry in the communications log, no indication of how the resident got the thin coffee, no evidence that there wasn't an investigation, or that an employee was counseled. Regarding Exhibit #30, Price admitted that she had no idea who was involved in the alleged incident. The employee could have been counseled without Price knowing about it. Price was not sure if there was any violation, as the liquids order could have changed. Moreover, there is no indication that any employees who engaged in the alleged wrongdoings in these incidents were similarly situated to the Grievant. There is no showing of disparate treatment.

The County notes that the Union argued that the Grievant relied on Sears' custodial relationship with the beverage list and that she was refilling a cup of coffee. The Grievant never testified, so there is no evidence in the record that she relied on Sears at all. And there was no testimony that she was refilling a cup of coffee. Finally, the fact that Maguire decided not to turn the Grievant over to the State is irrelevant and in no way mitigates the seriousness of the Grievant's failure. The County has the right to discipline employees for safety violations, irrespective of whether those violations would rise to the level of patient abuse or gross neglect.

In Reply, the Union

The Union notes that in the arbitration cases cited by the County, the Arbitrators determined that the evidence of wrongdoing on the part of the grievants was sufficiently shown by an independent investigation. By way of contrast in the instant matter, the procedural errors do have a deleterious effect on the fundamental due process rights of the Grievant. After her admission of giving GS unthickened coffee, Kujawa and Kropacek discontinued any further fact finding, even though they were contemporaneously aware of Sear's involvement in the incident. Kropacek's summary dismissal of Barbian's credible report, claiming that it would only be Barbian's word against Sears, even before Kropacek interviewed Sears, speaks to the fundamentally biased nature of the investigation.

The Union states that for the Employer to simply dismiss Barbian's report about Sears while discharging another employee, solely on that second employee's out of context utterance, is violative of the Employer's due process obligations. The supervisors failed to see or determine the exonerating or mitigating context of the Grievant's actions, and thus failed to uncover the truth. Sears admitted that she knew GS was on a nectar thick regimen when she asked the Grievant to give GS coffee, yet failed to inform her of that. That fact should have emerged in a fair and thorough investigation.

Moreover, the Union contends that there was disparate treatment of the Grievant. Sears did not receive any discipline, despite the eyewitness observation of an impartial and credible witness – Barbian. And an error involving another resident, YM, was never

investigated. These two instances provide ample proof that the Employer treated the Grievant's admission of error in a disparate fashion. The fundamental unfairness of the investigation in this case is easily distinguished from the other cases referenced by the Employer. In none of those cases was the offer of Union representation in question. In none of those cases was there evidence of disparate treatment in the imposition of discipline. In none of those cases was there obvious bias in the decisions made by the primary investigators. And in none of those cases did the Employers fail to determine the essential elements of the case.

The Union contends that there was no work rule violation, because on November 21, 2006, there was no work rule regarding thin/thickened liquids. After the Grievant's discharge, the Home set forth a work rule regarding the appropriate distribution of thick and thin liquids to residents. The Home failed to communicate with sufficient clarity the protocol prior to November 21, 2006. The Employer promulgated a work rule *ex post facto* and mandated all CNA's to participate in training regarding the thin water protocol after November 21, 2006. The Employer also expanded the distributional scope of the beverage list to include CNA's. The Employer's post-termination conduct constitutes a tacit admission that at the time of the termination, the Home did not provide CNA's with sufficient information on the protocol. Moreover, the Home made no assessment on the risk for aspiration for GS. He was taken off the protocol on the day following the incident and released from the Home shortly thereafter. The Employer's case rests on the supposition that a bacterial infection may occur because unthickened coffee may cause aspiration. However, there was no probative evidence introduced that the Grievant's action put GS at any meaningful degree of risk. Absent a viable work rule which places employees on formal notice of the possible consequences of its violation, the Employer lacks a viable interest in disciplining the Grievant.

The Union asserts that one may reasonably conclude that the Grievant had a good faith belief in Sears' authority prior to acting, that she could reasonably conclude that when Sears asked her to refill the cup with coffee, that Sears' access to the beverage list invested her with knowledge of GS's status. Thus, the Grievant could reasonably conclude that it would be safe for GS to have regular coffee. The Union also states that the lack of many meaningful investigations resulted in the Home's failure to discover that Sears knew when she asked the Grievant to give GS coffee that she was not warning her about his status. The Home never determined whether Sears was asking the Grievant to give GS a new cup of coffee or to refill his cup. The Union points out that no one else has ever been discharged without the assistance of Union representation, and no one else was disciplined for violating the thin water protocol.

DISCUSSION

The Union has raised a procedural issue about the lack of a Union representative being involved in the investigation of the Grievant's conduct on November 21, 2006. And it has asserted that there is a past practice that Union representation is always provided in

investigations leading to discipline whether or not the employee being investigated asks for a representative. This past practice, the Union believes, bolsters Section 26.06 of the collective bargaining agreement, which states:

> Employees shall comply with all provisions of this Agreement and all reasonable work rules. Employees may be disciplined for violation thereof under the terms of this Agreement, but only for just cause and in a fair and impartial manner. When any employee is being disciplined or discharged there shall be a Union representative present. However, if no meeting is held because the employee and/or Union representative is unavailable, written notice of the discipline may be sent by certified mail (return receipt requested) to an employee's home, provided one (1) copy is sent at the same time to the Union President. When an employee is given a written reprimand, a copy of the reprimand shall be given to the Union President, and the County Human Resources Director.

The County believes it has always complied with the terms of Section 26.06 and did so in this case, by providing a Union representative when discipline was being issued. The contract refers to the phrase "when an employee is being disciplined...." Thus, the County can legitimately state that a Union representative is required by contract at the point where an employee is actually receiving discipline. If the contract language is considered to be ambiguous, a past practice would be helpful in interpreting it. A past practice needs to be unequivocal, clearly enunciated and acted upon, readily ascertainable over a reasonable period of time as a fixed and established practice accepted by both parties.

Assuming for the sake of argument that the language in Section 26.06 is sufficiently ambiguous that it needs the interpretative aid of a past practice, the major elements of a past practice have not been met in this case. Williams – the administrator who is in a position to know how she has administered the contract and discipline for 15 years – stated that she has trained her managers by telling them that a Union representative is not always needed when they are gathering facts and information, including talking to an employee who may be disciplined. She has told them that if the employee asks for a representative, then they are to provide one. And there have been times when investigations into employee conduct issues have occurred without a Union representative present. Williams said that it was only when discipline was being issued that the Union would have to be involved. Price disagreed with Williams, and Price was in a position to know when the Union was asked to be present. However, Price was not always in a position to know when the Union was not asked to be present when investigations were going on. Thus, the Union has not established a past practice that a Union representative is always offered by the Employer when an employee is being investigated and the end result can be discipline.

The Grievant could have asked for a Union representative at any time when she spoke to Kropacek and Kujawa. She knew that she might be in trouble, having been suspended recently for a similar violation. She even asked the supervisors if she was in trouble. Whether or not a Union representative would have made any difference in the development of the facts is simply speculative at this point in time.

The Union also objects to the quality of the investigation and believes that the investigators failed to develop more information about Sears' role in this incident. The Grievant never said that she was refilling GS's cup of coffee until the third step in the grievance procedure. Had she done so immediately, it might have prompted a wider investigation into who had given GS the cup of coffee initially. At the time of the investigation, the investigators had a simple case before them – one person admitted giving GS unthickened coffee and another denied it. It was logical for the supervisors to accept Sears' denial because she was not supposed to be giving anyone beverages. That's why she asked the Grievant to help get the coffee.

Even if one looks at this in the light most favorable to the Grievant – and assumes that Sears gave GS the initial cup of coffee and the Grievant refilled it – that still would not excuse the Grievant from following the protocol for beverages. There is no evidence that the Grievant found that GS had already been served coffee, that some coffee remained in the cup, that said coffee was unthickened, which may have misled the Grievant into believing that he could drink thin coffee. And even if that were the case, the Grievant was not relieved of her obligation to know what kind of liquids the resident could drink. And even if Sears should have been disciplined on some level, the Grievant still did the act for which she was disciplined.

The Employer could have reasonably determined that Sears was not involved in serving GS. First of all, serving a resident was beyond her scope of responsibility. She had not been trained for it. She had not done it before. So when Sears denied doing so, the Employer had no reason to continue to question her. Barbian was a strong witness, but Barbian acknowledged that she was focused on her own job, passing out medications. What else could the Employer do? There was nothing to corroborate Barbian, and no reason for the Employer to not believe Sears.

The fact that Sears asked the Grievant to help GS does not exonerate the Grievant from her duty to see that he could have thin liquids or not, and it does not mitigate anything. There is no evidence that the Grievant relied on Sears for any information about GS's dietary orders. There is no evidence that Sears misled the Grievant into believing that GS could have thin coffee. Sears knew that GS was on a thickened liquids order, but did not tell the Grievant. She did not have a duty to inform the Grievant about how to prepare his drink. The Grievant admitted that she never thought to check. The Grievant knew that she could have checked the beverage list or the tray card or other sources.

It is somewhat surprising that the Grievant did not check anything before serving GS, because she had been suspended for ten days within the last month of this incident for giving a resident thin water. Further, the Grievant was working in a float position, and since she would not know the residents as a floater, she was taking a big chance serving GS anything without checking his dietary orders.

The Union has attempted to claim that there has been disparate treatment of the Grievant, but the evidence on the record is slim and unsubstantiated. Exhibit #29 shows that a resident had a thin cup of coffee despite needing thickened liquids, but there is no evidence about who did this, and whether someone was spoken to, counseled, or disciplined. There is no evidence on the record of whether there was any investigation into this matter. There is also Exhibit #30, Price's notes about resident YM. There was no indication noted in the medical administration record that he needed thickened liquids. The unit supervisor is supposed to mark the medical administration record. Price checked the dietary card that showed nectar thick liquids, and reported the incorrect record to the unit supervisor who checked the physician's orders and then wrote nectar thick on top of the record. The problem is that there is no evidence about who did what here. Did a unit supervisor make a mistake, and was it the same supervisor that Price reported it to? Or did the unit supervisor check it out and do something about it with employees who were involved? Or did the resident get the nectar thickened liquids according to the dietary cards that were not in accordance with the medical administration record? Without more information, it is impossible to tell whether or not the Employer turned a blind eye in some instances regarding thickened liquids but jumped on the Grievant with full force. The argument that there has been disparate treatment fails for a lack of record evidence. And there can be no disparate treatment between the Grievant and Sears where the Employer had no proof that Sears did anything wrong.

Next, regarding the Union's concern about the Employer's post-termination conduct, the Union misses the mark. It has noted that the Employer came out with a thin water protocol on January 15, 2007, after the termination, as well as an in-service on the thin water protocol on January 25, 2007. The thin water protocol is somewhat related to thickened liquids in that it deals with liquids and their consistency. However, there was a thickened liquids protocol in effect well before the termination. It was issued in 1994, revised in 1997 and 2005. (See Exhibit #4). In 2004, the Grievant received an orientation in all skills and procedures upon returning from a long leave of absence. Thickened liquids are on the checklist. The object was to demonstrate the ability to identify residents on thickened liquids. Not only had the Grievant been trained in giving thickened liquids, she had been previously disciplined for not doing that job correctly. There was no lack of training or knowledge given to the Grievant before her termination.

In its reply brief, the Union actually contended that there was no work rule violation because there was no work rule regarding thin/thickened liquids on November 21, 2006. This is simply not the case. The thickened liquids protocol was in place before November 21, 2006. The Grievant had been trained and disciplined on the matter. Whether it is called a work rule or a policy or procedure or protocol, the Grievant knew or should have known how to check residents' dietary orders before serving them any beverage.

The Union's claim that the resident did not suffer any unfavorable consequences from the Grievant's error is correctly and easily answered by the County – the County does not have to wait for a resident to be injured or die. The Grievant's failure to abide by measures to

ensure safety gives the County just cause for discipline, whether or not someone was injured or died. The Grievant's conduct did not fall within the parameters of conduct that needs to be reported to the State Registry, but her conduct can still receive a major disciplinary action under all the circumstances, including her prior record.

In conclusion, the Arbitrator has found that the County has just cause to discharge the Grievant based on her conduct on November 21, 2006, as well as her work record. There is no dispute that the Grievant served GS the unthickened coffee. It was her duty to check either the beverage list or the tray card or some source to know whether the resident could have thin coffee or whether it had to be thickened. No one gave her incorrect information. She did this on her own. The Grievant's prior discipline weighs heavily in this case, particularly the ten day suspension in October of 2006. Within one month of coming back from that suspension, the Grievant made the same error by giving a resident a thin liquid instead of a thickened liquid. This is astounding. The County correctly states that progressive discipline is not working, and it no longer wants to take a chance on the safety of residents by having the Grievant continue to work there. The Grievant had other disciplinary actions regarding resident safety issues. But here, there is an identical error within a month of a ten day suspension. Certainly, there is just cause for discipline. Given the Grievant's record, there is just cause for termination. The County's decision is neither excessive nor unreasonable. The grievance is denied.

AWARD

The grievance is denied and dismissed.

Dated at Elkhorn, this 6th day of November, 2007.

Karen J. Mawhinney /s/

Karen J. Mawhinney, Arbitrator

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