

IN THE MATTER OF ARBITRATION BETWEEN

STATE OF MINNESOTA)	
	“Employer”) RN Discharge
AND)	
)	BMS Case No. 12-PA-1296
MINNESOTA NURSES ASSOCIATION)	State of MN Case No. 12-254
	“Union”)

NAME OF ARBITRATOR: John J. Flagler

DATE AND PLACE OF HEARING: September 28, 2012; Rochester, MN

DATE OF RECEIPT OF POST-HEARING BRIEFS: 3 Briefs Received; November 28, 2012

APPEARANCES

FOR THE EMPLOYER:	Rebecca Wodziak Minnesota Management & Budget 400 Centennial Building 658 Cedar Street St. Paul, MN 55155
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THE ISSUE

Did the Employer have just cause to dismiss the Grievant?

If not, what shall be the remedy?

BACKGROUND

The Grievant is a long-term employee with almost 25 years of experience. Employer witness Paul Ploog noted that she was a kind nurse and very appropriate with patients. This comment is confirmed by her consistent evaluations in the last 25 years (MNA Exhibit No. 9).

On November 15, 2011, she was assigned to Unit 800. Unit 800 is not her home unit and it houses some of the most dangerous patients in the entire state hospital system. One of the most dangerous patients was Patient X, who has been diagnosed as bipolar and has a history of self-injurious behavior and of exploding quite quickly and who has threatened to injure not only himself but also other patients and staff.

These behaviors are not unique to Patient X. Workers at the St. Peter Security Hospital are often subject to verbal and physical assault. Nurses themselves have been yelled at, spit at, and patients have threatened at times to kill or rape nurses or members of the nurses' families. Even in the world of Minnesota Security Hospital-St. Peter, the night of November 15, 2011, was an unusual one.

Although the Grievant was not working in her regular unit, she was on an evening shift until 10:30 that night. Patient X became enraged when he was not allowed to go to the canteen after it had closed. Patient X exhibited his anger by swinging a chair against the wall and plexiglas. The staff decided to put him into seclusion in his own room. It took a call out of the guards' SWAT team to put him there. Once in the room, the Grievant asked fellow staff if he should be allowed to have his MP3 player. While to some, the MP3 player may be seen to be a coping mechanism, to others, such as Patient X, it could be used as a means to commit self-injury with its sharp edges and cord. At that time, staff decided to keep his MP3 player. Still, Patient X became further enraged and started trashing his unit. That included tearing up his pillow, spilling liquid, and beginning to write on his arms with a magic marker: "Kill her," on one arm, "Rape her," on the other.

The Grievant, by this time, began viewing Patient X through the observation window as she was required to do for 30 continuous minutes. However, the Patient started taking his mattress and putting it against the observation window so he could not be observed. As the patient had a history of self-injurious behavior, this was unacceptable. After calling in Dr. Harlow, he now decided to remove the mattress from his room, so Patient X could continue to be monitored. Another SWAT team was called in and approximately eight guards behind a plastic shield made their way in through the trash ridden room where they found he had been cutting his arms. When the patient noticed that they were taking out his mattress, he responded by yelling more obscenities and threats against staff and said he was going to kill them all. He said that even if they took his mattress, he would cover the window with his clothing. This was approximately at 9:40 p.m.

Dr. Harlow then decided to remove the clothing to prevent him from blocking the window. Members of the SWAT team then proceeded to handcuff Patient X and cut off his clothing where he again threatened to kill staff and in particular the Grievant and Luke Frederichs. The Grievant was not in the room at this time but was observing from outside the

hall in what was a chaotic scene with trash strewn with a small area of movement available for the SWAT team. The Grievant did not wish to upset the patient further, but could observe him through the doorway. His respiration was not a concern as he was yelling obscenities and bellowing quite loudly.

Staff left the seclusion room and removed all the items including the MP3 player as per Dr. Harlow so Patient X could not injure himself. All of the staff involved thought the takedown was a success in that neither the patient nor any staff members were hurt. The Grievant and Paul Ploog looked for a tear-proof gown but were not able to find one on the unit. However, as the patient would not stand away from the door, the gown could not be given to him for some period of time. It was later determined that the patient was without clothing for approximately one hour. The fact that the staff did not attempt to pass the clothing through the meal slot was, in retrospect, a good thing, in that the same patient later injured a nurse by attempting to pull her through the meal slot and is currently being prosecuted for that felony assault.

The Grievant left the unit at 10:00 p.m. and was unaware that the gown had not been immediately passed to him as she was writing up her supplemental incident report. She was advised to write it up for the Office of Special Investigation to Jerry Yousta so that Patient X might be prosecuted and that no other nurse would be subject to the behavior that he ultimately committed on yet another nurse. After she completed her paperwork, she left work at 10:30 p.m., as did Paul Ploog.

The patient continued to be without clothing until approximately 11:00 p.m. and was not provided with a mattress until 12:40 a.m. His MP3 player was not returned until 9:00 a.m. the next morning and he was not released from seclusion until 5:00 p.m. the following day as he was still threatening yet other staff (see investigation and licensing report, MNA Exhibit 6A). When senior hospital management started reviewing the supplemental reports of all of the staff involved, including the Grievant, Paul Ploog, and Justin Nelson among others, management decided they needed to launch an investigation.

Senior management at the Security Hospital would launch an investigation as to what had occurred in this seclusion as they were already under scrutiny from the MN Department of Health – Licensing Division which was already conducting a licensing investigation as to St. Peter's use of seclusion in addition to the continuing issues of the leadership team of St. Peter Hospital and Director Paul Proffitt in particular. Proffitt had been hired to replace yet an earlier head of the hospital and was allegedly an expert in the use of seclusion, yet had been found only after he had been hired that he had a history of aggressive behavior and had lied about his background. Thus, St. Peter Security Hospital was already under a great deal of pressure even before this incident. Especially with the pending licensure determination from St. Peter's earlier use of seclusion that among other things included a patient who was left without a mattress for 25 straight days for which, out of the many employees that participated in his care, no one was disciplined (see licensing investigation MNA Exhibit 6B).

While the Grievant and others continued to work with no restrictions or limitations on their assignments, the State called in two investigators to deal with alleged employment issues.

While some of the involved staff were investigated, others were not interviewed at all until after the Grievant had been terminated. Staff, such as Shift Commander Leads Justin Nelson and Paul Platzgraf were never interviewed, and staff members Lori Halverson and John Kennedy were not interviewed until the termination. After being allowed to work or over a month after this incident without restriction or concern as to what the Grievant had faced, she was called into a meeting on December 21, 2011 and summarily fired as was Dr. Harlow a day earlier. The firings were done just in time as the licensing report was issued only one day later on December 22, 2011.

Of all the staff that were involved in the treatment and take down of the patient, only Dr. Harlow and the Grievant were terminated. Even though the patient still could not have a tear-proof gown for about half an hour after the Grievant left and the mattress for over two hours after she left, it is uncontested that no other nurse or guard was disciplined.

Both staff and psychiatrists expressed anger as to how the Grievant was made scapegoat in this matter. All of the psychiatrists assigned to the St. Peter Security Hospital resigned. Even the Governor later toured the facility. Staff were confused about when it was safe to put somebody in seclusion (again see testimony of Tammy Hughes). The State, in turn, only completed their investigation by interviewing several more witnesses including Lori Halverson and John Kennedy after the Grievant had been fired from three weeks after her termination date. State investigator, Becca Kennedy, admitted it was the first time she completed an investigation after the firing.

The grievance was filed and proceeded through the grievance process. Some two weeks prior to the actual hearing, the State yet again failed industrial due process by revising the termination letter and rationale for the termination of the Grievant. The Employer removed the charge of withholding the MP3 player and added the charge of causing the patient's behavior to become "escalated significantly." At the hearing the parties stipulated that this matter was properly before the arbitrator who was empowered to render the decision as the sole neutral. Because of the complex nature of this case, the parties agreed to waive the 30-day timeframe for issuance of the Award. At the hearing, the parties agreed that the Arbitrator could frame the issue.

POSITION OF THE EMPLOYER

The Grievant, was employed as a Registered Nurse (RN) at the Minnesota Security Hospital (MSH) in St. Peter, MN. The Security Hospital is a maximum security psychiatric facility which serves persons who are civilly committed as mentally ill and dangerous. The MSH is operated by the Minnesota Department of Human Services (DHS) under the State Operated Services (SOS) Forensics Division.

As a Registered Nurse, the Grievant served as a charge nurse providing guidance and leadership to other MSH staff. On November 11, 2011, a patient on Unit 800 (Patient X) required seclusion after he engaged in a violent outburst. Patient X was secluded in his room

beginning at 7:30 p.m.; he was placed under constant, one-to-one observation by nursing staff during the initial 30 minutes of his seclusion.

The Grievant performed the required 30 minute one-to-one observation of Patient X. While conducting his one-to-one observation, she initiated a discussion with Security Counselors, over whether Patient X should retain his MP3 music player, a designated coping mechanism for the patient. She and the staff discussed whether Patient X should be required to "...earn his right to have that."

Patient X overheard this conversation and immediately began to escalate his behavior. Patient X began to "target" the Grievant with violent threats. He wrote threats on the walls and door of his room and on his body. He passed a paper out of his room upon which he had written the words "Dumb Bitch Dies Now She Gets Raped Tortured Slaughtered Dead" and he shouted and pounded on the walls and door.

At 8:00 p.m., the one-to-one constant observation conducted by the Grievant ended. Patient X's symptoms continued to escalate, however, for the next two hours; he also began to injure himself with plastic shards made from broken marker caps. Patient X placed his mattress over the window in his door, obstructing the view and preventing staff from observing him and ensuring his safety.

Security Counselors spoke with Patient X, trying to persuade him to remove the mattress; they were successful and Patient X complied, twice. The third time, Patient X placed his mattress over the window, staff were unable to persuade him to remove it. Staff could no longer observe Patient X or ensure his safety. Shortly before 10:00 p.m., an intervention was ordered; an Incident Command System (ICS) call was made and staff entered Patient's X's room, forced him to the floor, removed all items from the room and forcibly removed his clothing. Throughout this entire seclusion, nursing staff conducted assessments for Patient X at fifteen minute intervals. The Grievant conducted all of the 15 minute nursing assessments for Patient X from the beginning of the seclusion at 7:30 p.m. until after her shift ended at 10:00 p.m..

In her 10:00 p.m. nursing assessment of Patient A, she recorded the ICS call, noting that Patient X's clothing had been removed and his room emptied. At 10:15 p.m., Patient X's assessment was conducted by Registered Nurse C.B. Patient X's behavior was recorded as "Pt standing at window of door requesting 'all my PRNs' agreeable to taking HS medications first." At 10:30 p.m., Patient X's assessment was conducted by Registered Nurse C.B. She recorded his behavior as "Given his meds – cooperative with taking and mouth check." At 10:45 p.m. Patient X was assessed by Registered Nurse R.I. She described Patient X as "Sitting on counter and when he saw nurse came to window requesting to clean marker off self." There were no other violent outbursts recorded in patient X's nursing assessments, after 10:00 p.m., the final assessment was conducted by the Grievant.

During the first two and one-half hours of his seclusion, Patient X made generalized threats of violence. He specifically targeted the Grievant far more than any other staff involved in his care. The Grievant was aware that Patient X was specifically targeting her; she was also aware that her presence agitated the patient.

She described her efforts to minimize the agitation caused by her presence: “She tried not to get him upset during the Q15 minute checks and would just peek (sic) in the window so that he couldn’t see her.” She described the targeting as “stressful” and herself as “I was really scared.”

She provided a written summary of this incident in which she also noted a recent incident with Patient X. According to her summary, on October 18, 2011, Patient X watched her for a period of time and later reported to a therapist that he had considered entering the room, closing the door and sexually assaulting her:

He reported that he went so far as to stand in the doorway watching the nurse, who turned around and noticed him, at which time he backed off. He shared that he was not sure if he would have stopped himself from entering the room had she not noticed him. (Patient X) reported that he had been considering committing an offense, violent or sexual, at the hospital so that he would be sent to jail. I feel (Patient X) has the ability to carry out the threats towards me and I am taking this seriously. This has been stressful for me to be the target of his threats and to have him not only verbally threaten me, but to write it out on paper, the walls, door and on his own body. (Employer Exhibit No. 16L).

During her investigatory interview, the Grievant truthfully relayed her actions during Patient X’s seclusion. The facts she provided are not disputed by the Union. The Grievant acknowledged that shortly into Patient X’s seclusion, she initiated a discussion about removing Patient X’s MP3 music player and whether or not he should be required to “...earn his right to have that.” She admitted that she held this discussion within Patient X’s hearing. The Grievant described how the patient overheard this discussion and then immediately began to escalate his behavior and target her with violent threats. The Grievant’s decision to hold this conversation within hearing of the patient as not appropriate, not professional and clearly, it was not therapeutic for Patient X. The Grievant then compounded her inappropriate decision. As patient X’s symptoms worsened, he began to react adversely to her presence and continued to target her specifically; nevertheless, the Grievant continued to assess and treat him, despite his escalated targeting.

The Grievant admitted that she knew Patient X began to target her immediately after the discussion about removing his MP3 music player. The Grievant also knew that her presence agitated Patient X and caused his symptoms to escalate. She described her efforts to mitigate the agitation that her presence caused to Patient X. She stated that she tried not to upset him and chose to “just peek” in the window during her nursing assessments, so that he could not see her. (Employer Exhibit No. 6, p. 21). The Employer contends that this was a poor clinical decision. Clearly, a caregiver, whose presence agitates a patient so severely that she finds it necessary to “peek” at him when conducting required nursing assessments, should remove herself from that patient’s care. The Grievant should have removed herself, so Patient X could be assessed and treated by a caregiver who was able to perform their job without having to hide from the patient.

The Grievant continued to assess and treat him for two more hours, a poor clinical decision. The Grievant's actions were inconsistent with the Employer's policies and with reasonable expectations for appropriate patient care.

The Grievant was not dismissed because she engaged in maltreatment of Patient X; but because her nursing decisions were not therapeutic. By her actions, she failed to properly advocate for Patient A's best care.

The Grievant had a disciplinary record for inappropriate conduct that included a five day suspension in 2008 and a disciplinary demotion in 2009, both for violations of the State Operated Services Workplace Relations Policy. Discharge was the appropriate level of discipline, in light of the Grievant's disciplinary record.

The Union failed to demonstrate that the Grievant was subject to disparate disciplinary treatment. The Union did not present any cases with facts comparable to this grievance. Two RNs testified that they had been targeted by patients in the past and had not removed themselves from those situations. Nether testified that they had experienced targeting incidents that can be compared to this case.

The Grievant herself distinguished the instant case from all others. When describing the incident, she indicated that she is not a stranger to threatening behavior. She state that she had never known Patient X to be as threatening as that night. "This was new. I was really scared."

Neither nurse described any situations in which, knowing that their actions aggravated a patient's symptoms, they continued to assess and treat them, for hours nor had they spent two hours "peeking" at a patient because their participation in the patient's care was so obviously exacerbating the patient.

The Grievant described the events that triggered Patient X's targeting symptoms: "He began targeting me after being placed in seclusion when he overheard discussion of him having his MP3 player with him in seclusion." She admitted that she had not observed any dangerous behavior with Patient X's MP3 player. Nevertheless, she initiated a discussion that was audible to Patient X, about whether he should retain his MP3 player, a designated coping mechanism. She and the other staff then debated whether Patient X should have to "earn" back his coping mechanism. This entire discussion was held within hearing of the patient, while the Grievant was conducting the initial 30 minute nursing observation. The patient was secluded at approximately 7:30 p.m. and by 8:00 p.m., he had written the threatening note targeting the Grievant. It was inappropriate for her to hold this discussion within the patient's hearing. The results of her actions were an escalation of the patient's symptoms and his aggressive targeting. And despite Patient X's aggressive targeting directed specifically at her, the Grievant chose to continue treating him for two more hours. Neither of the other nurses who testified on behalf of the Union described any similar situations in their experiences.

The Employer presented testimony from three Psychiatric RNs, each of whom testified that a psychiatric nurse should remove himself or herself from a targeting incident of this magnitude. The two RN's who conducted the employment investigation (Becca Kennedy and

Becky Kern) both testified that nurses should not remain in a care-giving position when a patient is targeting them as specifically, as aggressively, and for as long as Patient X targeted the Grievant. Both nurses testified that it is necessary to remove oneself if their presence agitates the patient and causes his symptoms to escalate significantly. Both nurses testified that the therapeutic action is to remove oneself from direct care, when possible. It was possible and appropriate for the Grievant to remove herself from this patient's care.

Colleen Ryan, MSH Director of Nursing with 26 years of psychiatric nursing experience, also testified that the Grievant's discussion, regarding the Patient's MP3 music player, was inappropriate to hold within Patient X's hearing. Ryan also testified that the Grievant should have removed herself from Patient's X's care, because of his escalated targeting symptoms. In her testimony, Ryan specifically reviewed the nursing schedules for the evening shift and identified two other RNs on duty in the Grievant's work area who could have exchanged places with her. All three psychiatric nurses who testified for the Employer indicated that it was necessary for the Grievant to remove herself from the situation, because care is too easily compromised in circumstances such as these.

The Employer must be permitted to set reasonable standards for patient care. The Security Hospital has been placed on a conditional license status because of inappropriate care related to patient seclusion and restraint. The specific incidents that prompted the finding of maltreatment and conditional license status occurred in July and October of 2010. The conditional license finding was issued December 22, 2011, one day after the Grievant was dismissed. –No MSH staff were disciplined for these incidents. The Union itself noted the truthful explanation for why no staff were disciplined as a result of these cases: Human Services Commissioner Lucinda Jesson, quoted in the Minneapolis Star Tribune stated "I cannot undo the decisions that were made in 2010 under different hospital leadership." Commissioner Jesson further stated "If it happened today, I'd hold them very accountable." The Employer has the right and in this case, the duty, to set higher care standards than those used by the previous administration in the 2010 cases.

During the arbitration hearing, the Union repeatedly cited these cases of maltreatment in which no discipline was issued. The Employer does not dispute these facts. However, the Employer asserts that these cases should not serve as a conduct standard for any future discipline at the MSH. These cases cannot be used as the appropriate threshold, below which employees are not disciplined for inappropriate actions with patients. If all actions of MSH patient care are judged against the standard used in these 2010 cases, the Employer will never be able to improve employee conduct, provide appropriate care or meet its license standards. Such an outcome would be untenable; it would be highly destructive to the MSH and will be detrimental to mental health care throughout Minnesota.

Carol Olson, the MSH's Chief Administrative Officer was appointed March 28, 2012, after the facility was placed under conditional licensure and after the requested resignation of her predecessor. The decision to dismiss the Grievant was made by Ms. Olson's predecessor, David Profit! Mr. Profit was asked to resign on March 27, 2012, for reasons unrelated to the Grievant's dismissal. Although Ms. Olson did not make the decision to dismiss the Grievant, she did hear the Union's third step grievance. Ms. Olson did not overturn the dismissal.

Ms. Olson testified as to her reasons for sustaining the dismissal. Ms. Olson testified that the Grievant's actions: the conversation over the MP3 player and her continued observation of Patient A amidst his targeting symptoms were "poor clinical decisions." Ms. Olson also cited the Grievant's previous disciplines in her decision to sustain dismissal. Ms. Olson faces a difficult challenge in her efforts to lead the MSH during this period of conditional licensure. The Employer and Ms. Olson should be permitted to set, apply and enforce reasonable standards for employee conduct and those standards must be higher than the patient care standards that resulted in a conditional license penalty against the entire facility.

The Minnesota Security Hospital must be allowed to move beyond the unfortunate patient care mistakes that were made in 2010. If the events of 2010 are used as the acceptable disciplinary standards for patient care and staff conduct, there is no hope that the facility can improve patient care and correct our employees' conduct.

The Employer's disciplinary standards, as applied in the instant case, are reasonable. The Grievant has two prior disciplinary actions in her record: a five day suspension and a disciplinary demotion. (Employer Exhibits # 5 and # 6, p. 27.) Each of these disciplines is for inappropriate interactions with co-workers, in violation of the State Operated Services Workplace Relations Policy. (Employer Exhibit #8.) The Workplace Relations Policy also covers relations with MSH clients. It specifically requires that interaction and communication with clients be respectful, therapeutic and supportive. The Employer asserts that the Grievant's conversation regarding removal of Patient A's MP3 player was not therapeutic or respectful. It should not have happened within Patient A's hearing; it provoked the patient, whose symptoms then worsened.

The Employer also asserts that the Grievant's decision to remain in close proximity to Patient A, directing his care and conducting the nursing assessments while he specifically targeted her, was not therapeutic or supportive. The Employer is not alone in its negative assessment of the Grievant's actions. The DHS Licensing Division conducted an independent review of the MSH's treatment activities in this incident. That review, in which the Grievant is identified as HCP1 and Patient A is identified as the VA, described the Grievant's actions:

Although there was another health care professional that responded to the incident, HCP1 did not remove him/herself from the situation and HCP1's presence was not conducive to calming the VA. Despite the VA targeting HCP1, HCP1 remained at the VA's door, provided continuous observation of the VA from 7:30-8 p.m., and provided visual checks on the VA every fifteen minutes from 8-10 p.m. HCP1's interactions with the VA were inconsistent with the role of a caregiver in a DHS licensed facility. However, it was not determined that his/her actions met the definition of maltreatment. (Employer Exhibit #14, p. 14.)

The Employer asserts that dismissal was appropriate, in light of the facts of this incident and the Grievant's past disciplinary record. As a long-term employee, the Grievant was issued progressive discipline twice in the three years preceding her dismissal. The Grievant was specifically advised that any additional transgressions would result in dismissal. (Employer Exhibit #5.)

The Grievant is an experienced psychiatric nurse. As a Registered Nurse, the Grievant was expected to provide leadership and guidance to other staff and to serve as an advocate for patients. (Union Exhibit # 9, p. 2.) In the instant case, the Grievant failed in these expectations. The Grievant clearly recognized that her actions were an additional catalyst for Patient A's escalating symptoms. (Employer Exhibit # 6, pp. 20-21, 25, 31, 38.) Nevertheless, she continued to treat Patient A as if her actions had no detrimental effects upon him. These were poor clinical decisions that were not therapeutic or supportive. The Grievant's actions were unacceptable; in light of her previous disciplinary action, dismissal was the appropriate response to her clinical errors. For all of these reasons, the Employer respectfully requests that the grievance be denied.

POSITION OF THE UNION

Contrary to the second-guessing of Employer witnesses such as new MHS head Carol Olsen who was not employed at St. Peter until months after the incident, everyone – both Union and Employer witnesses – who were involved in the incident that night believe that the Grievant acted appropriately. Paul Ploog testified she did nothing wrong, as did registered nurse Cindy Bue. The supplemental interviews of the other nurse working alongside of her, Laurie Halverson, also show that she had done nothing wrong. Indeed, the State in essence recognizes this by belatedly changing their termination letter after the fact.

The Grievant was faced with an impossible situation with a patient who was out of control. Indeed, this patient required two separate incident responses, the second of which required six to eight guards utilizing a plastic riot shield to get him into his room. Patient X had a history of self-injurious behavior and had to be observed through the window and that is why the mattress was removed. The supervising doctor later ordered a removal of his clothing when the patient threatened to use them in front of the window so he could not be seen to injure himself. The patient, by this time, in addition to bellowing threats had written threats on his arms and was scratching himself to the point of bleeding.

While it is easy for the Employer to belatedly find that the Grievant should have removed herself from the one-to-one observation, there was no one ready to replace her. Halverson was in the middle of a medication pass and Bue also did not consider it necessary to replace the Grievant. Contrary to the Employer's contention, there is no policy or training as to how and when a nurse should and can remove themselves from a care giving situation (see testimony of the Grievant and Cindy Bue). Tammy Hughes, in addition to Cindy Bue, also testified that there was no written policy nor was there any training on when a nurse should remove themselves. As noted by the testimony of Cindy Bue and the Grievant, that night was a hectic evening. No nurse who testified at the hearing could think of an incident when a nurse had removed themselves in the heat of the moment (see testimony of Cindy Bue, the Grievant, and Tammy Hughes). Tammy Hughes testified to the fact that when she and members of her family were threatened to be killed and or raped by a patient, that her supervisor, while standing right bedside her, did not make any suggestions that Tammy Hughes should remove herself.

The Grievant also did nothing wrong in regards to the issue of the MP3 player. She was merely asking other staff what the policy was regarding whether he could keep the MP3 player in seclusion. If something as simple as a watch or a magic marker could be used as a weapon to

injure oneself as in the Patient's case, it is clear that an MP3 player with sharp edges and a cord could cause harm to a patient who showed self-injurious behavior. The Grievant did not remove the MP3 player, but rather asked the guard whether that was an appropriate thing to do. Ultimately, the MP3 player was only removed upon Dr. Harlow's order. That occurred approximate 9:45 p.m. It is uncontested that the MP3 player was not returned to the patient until 9:00 a.m. the next morning. In addition to the Employer changing that nature of the charges in her termination letter months later, management alleges that the Grievant was guilty of being "non-therapeutic." Again, every witness who was present at the incident both Employer and Union alike believe that the Grievant did nothing to cause any harm to the patient. This was a situation that quickly escalated, much like Patient X's behavior later escalated when he sought to injure a nurse by attempting to pull her through a meal slot in the door. Ploog testified that the Grievant was being therapeutic, as did Cindy Bue, RN. A review of all her evaluation details that the Grievants' nursing patient care has never been at issue at the institution. Simply put, whether one reviews the reasons in the first termination letter of December 2011 or the second termination letter that appeared in September of 2012, the Grievant did nothing wrong and did her best under the trying circumstances.

The manner in which the Employer acted and failed in other regards in this investigation was a denial of industrial due process. The grounds written in the initial termination letter were changed to different charges after the fact. Arbitrators have long taken a dim view for employers who attempt to change the rationale of terminations after the fact.¹ The above is because it has long been held that industrial relations will only work if people know what they are being disciplined for and why. The instant case serves as an instructive reminder as to why that is needed. The Employer only realized after the fact that the original grounds for termination were not appropriate, but then sought to expand them, only months after the fact, utilizing the efforts of some who were not even involved in the initial determination, such as Olson who was not in office at the time of the critical events.

While the Employer's rationale may have changed as this arbitration approached, it was quite clear to the State licensing division the concerns it had about the Hospital. Indeed, in the fall of 2011, David Proffitt and others knew that the Hospital was under investigation for, among other things, the use of seclusion and the denial of mattresses to other patients. In one case, a patient was denied a mattress for approximately 25 days. Indeed, Proffitt had been brought to St. Peter's to replace the previous director who had not been meeting the requirements of seclusion. Coincidentally, the first licensure results placed St. Peter Hospital on a conditional license for two years and fined them \$2200 for their violations. This licensing investigation was issued one day after the firing of the Grievant and Dr. Harlow for their alleged activities in the treatment of Patient X, again involving seclusion issues and mattress covering.

Perhaps the lack of a full and fair investigation can be understood under which the hasty manner under which it was conducted. Some witnesses were not even interviewed until after the Grievant was fired on December 21, 2011. Subpoenaed information of supplemental incident

¹ It is a well-settled arbitration principle that employers cannot change their rationale for firing after the termination. "It is well settled that the discharge must stand or fail upon the reasons given at time of discharge." See Exxon 129 LA 1734 [Eisenmenger 2004]. The reason for such a principle is simple: how can an employee defend himself from an unjust discharge if it is subject to change?

reports. Some witnesses were never interviewed at all, including security counselor Justin Nelson, who also filed a subpoenaed supplemental incident report and Robert Ratzlaff, who also had filed a report.

The fact that this employer used changing rationale for termination and completed its investigation after the termination would be grounds for some arbitrators to reverse this for these reasons alone. Industrial due process means a full and fair investigation and a consistent decision as to why the Employer imposed discipline. Further arbitral authority holds that the employer should not be free to revise and refine their rationale for termination. The MNA believes discipline against the Grievant should be reversed for those reasons alone.

However, this Employer was not satisfied with a flawed investigation but also relied upon a new decision review process being used for the first time to review the discipline imposed against the Grievant. This decision review process was called the WIRC, which stands for Work Incident Review Committee. It is unclear who attended this meeting because no minutes or other records were kept, nor was it clear if there was any sort of training or rationale or both prior to the use of this process.

The Employer provided no other witnesses other than Colleen Ryan and Melissa Gresczyk who participated in this program. Their lack of minutes or records makes it impossible to determine what grounds was based on for this action. Arbitrators take a dim view on employers who hold disciplinary reviews and do not keep records.

Of those involved in the unfortunate incident of November 15th, only Dr. Harlow and the Grievant were disciplined. While other guards removed the mattress and clothing for significant periods of time after the Grievant had left from work, no one else was disciplined.² While other nurses, including Bue, continued to work that shift after the Grievant left, no one else was disciplined for the removal of the mattress or clothing. The mattress was not given back to the patient until 12:40 a.m. and indeed, requested blankets were also provided late. The tear-proof gown also was not provided until the Grievant left.

Although the State now claims that in their revised discharge letter, that they were terminating her for failure to provide one-to-one guidance and a non-therapeutic environment, what the State licensing division was concerned about was the denial of clothing for one hour and the denial of the mattress for at least 2.5 hours (see MNA Exhibit 6A, which did not substantiate any alleged mistreatment of Patient X). All of these things occurred long after the Grievant had left her shift, yet no one else had been disciplined in this matter.

Indeed, the Employer's actions should be contrasted in terms of how the licensing division treated this present and previous infractions.

Contrast where the patient was allowed to sleep on a concrete slab without a mattress for 25 days. The Grievant was terminated for following a doctor's order in removing a mattress and no one else again as noted above was disciplined in regards to their actions on the night in

² As noted by Dobry in Montgomery Ward, 80 LA 321, 324 (1983), "It is incomprehensible that one breach warranted discharge while the other did not receive so much as an oral reprimand.

question of November 15 of the mattress. Both state licensing investigations detailed in MNA 6A and 6B detail how seriously the State viewed this in the first one that came out one day after she was fired and put the State on a two year conditional license and fined them \$2200. In regards to the second licensing investigation that occurred as a result of the actions on November 15, the State found both the institution and Dr. Harlow guilty of licensing violations and imposed a further \$1000 fine. Still, the Grievant who was not found at fault, was the only employee disciplined, and indeed, she was fired.

Disparate treatment could also be seen in how she was treated versus other employees employed in the State in both the current seclusion incident and the previous incident where no one was disciplined.³ The Grievant's previous disciplines have never involved patient treatment. What the previous disciplines and previous evaluations detail clearly is that she provides appropriate patient safe care and had never been accused of being "non-therapeutic."

The Grievant was suddenly called to the administration office after working several weeks without incident or limitation on her activities. It is clear that the office of special investigations investigator Jerry Yousta thought that the Grievant was a victim and encouraged her to fill out a supplemental report which she did. The Employer has compounded the emotional trauma already suffered by this nurse by firing her and leaving her unable to support herself and her family. It is for these reasons that the Minnesota Nurses Association urges that the Arbitrator return her to work with full back pay and benefits and all mention of this discipline removed from her file. Given the Employer's action to date, MNA also requests that the Arbitrator retain jurisdiction for one year to ensure that there is compliance with the award.

DISCUSSION AND OPINION

The just cause for termination standard in arbitration has been defined variously as "good and sufficient cause," and/or as "reasonable and appropriate cause." By either definition the Employer says the Hospital has failed its burden by a wide margin in this matter.

Arbitral review of termination grievances covers both procedural and substantive aspects of just cause. Procedural standards of review simply reflect universally recognized principles of reasonableness and fairness. These principles of fairness and reasonableness have been aptly stated by Arbitrator Carroll R. Daugherty in his oft-quoted Whirlpool Corp. decision, 58 LA 421 (1972).

Daugherty's arbitration decision has been amplified with extensive commentary by Arbitrators Adolph K. Loven and Susan L. Smith in their Bureau of National Affairs publication, Just Cause: The Seven Tests, BNA Series on Arbitration, Washington, DC, 1992.

Obviously, not every test of just cause applies to the facts of any particular case. Further, some tests logically overlap and combine so that fewer than seven tests may be appropriate to accomplish a thorough analysis and review. In the present matter the first three of these

³ As noted by one arbitrator, "Disparate treatment arises when the grievant has been treated unequally with respect to notice, application of a rule, investigatory proof or penalty." Lewis County, 118 LA 685, 689 (Ables, 2003).

commonly applied procedural standards all address the issue of clear and timely notice – a sine qua non of just cause.

These three fundamental standards require in the first instant that the conduct that is expected of employees must be reasonably related to the safe and efficient operation of the Employer's business. Certainly a rule of nursing practice conduct prohibiting discussion of removal of a coping mechanism within the hearing of an agitated patient falls well within the range of reasonable standards and guidelines of this Hospital's mission.

To be enforceable, however, a rule of conduct and practice must be clearly enunciated and effectively promulgated. The Hospital's attempt to justify its termination of the Grievant for violating a rule that nowhere appears in any writing or specifically articulated oral announcement the Employer could point to must surely fail. It is an elemental truth that employees cannot be expected to observe any rule of conduct of which they may be unaware.

Neither can the Employer successfully claim that the nurse should have known that it violated good medical practice to have mentioned the possibility of moderating Patient X's tantrum by making his use of the MP3 conditional upon his good behavior within his hearing. There are behaviors which medical personnel understand to be inappropriate or flat out wrong without being told, of course, including mention of frightening prognoses, guiltig comments, demeaning, insulting slurs and the like.

Control of behavior, however, in any context from Montessori classes to military stockades, is accomplished by a system of rewards and punishment. In enlightened applications, of course, the rewards for desired behaviors in institutional settings may include greater access to pleasurable activities – canteens, recreational areas, game rooms, libraries, movies and the like, while punishment often means restrictions or denials of these privileges. Physical and emotional abuse are never acceptable.

On its face, therefore, it cannot be said that the Grievant should have necessarily known without being told that it was a violation of practice to discuss the possibility of removing Patient X's MP3 as a means of encouraging him to discontinue his violent rant. Such denial of a privilege was a common behavior control means used in the Hospital. If the Employer wanted to curb the discussion of routine means of rewards and punishment the proper way of doing so was to issue a clearly enunciated rule to that effect and to ensure its broad distribution through established communication channels to those affected. This was never done in regard to the action for which the Grievant was penalized.

Part and parcel of managing employee conduct is the procedural test of just cause which advises that fair enforcement of reasonableness work rules require that those affected be forewarned of the consequences of non-compliance. It should be abundantly clear that the Grievant would hardly have discussed using the removal of Patient X's MP3 within his hearing if she knew that it would cost her her job after 25 years of service, unblemished by any misconduct relating to patient care.

Before moving this review to further considerations of due just cause substance and process, a final response needs be directed to the Employer's argument in its brief that the Grievant had, in fact, been afforded forewarning of its rules. The brief asserts that the Grievant was afforded "clear and specific policies...to treat patients in a conscientious manner at all times" and a policy on workplace relations requiring "interactions with clients to be professional, respectful, therapeutic and supportive."

None of these listed expectations and requirements clearly or specifically describe, define, codify, enunciate, or otherwise inform a nurse that she is subject to discharge for a single incident of suggesting the removal of a patient's MP3 within his hearing. It takes an impermissible stretch of the imagination for MHS to claim that merely advising employees of the above-mentioned policies in vague and general language constitutes clear and specific warning that discussing a common treatment modality within the hearing of a patient amounts to a capital offense.

This review now turns to the product of the investigation conducted by the Employer – the Investigative Report and the Notification of its conclusions to the Grievant. It is at this point that the case against the Grievant fatally unravels.

Remarkably, the investigation results in a written notice of termination to the Grievant which states that the decision was based on the finding that "You failed to follow a patient's treatment plan by making that decision not to provide the patient with his MP3

that he has as a copying mechanism. Your decision to withhold the coping mechanism caused the patient's behavior to escalate.

When the Union and Grievant called this glaring error to the Employer's attention, this embarrassment was dismissed as a mere misunderstanding by a clerical person who prepared the Notice of Termination. Accordingly, a second Notice of Termination was issued to the Grievant which stated:

December 21, 2011

Grievant
40481 US Highway 14
North Mankato. MN 56003

REVISED/CORRECTED

Dear Grievant:

This letter is to notify you of our intent to discharge you from employment with the Department of Human Services effective today, December 21, 2011.

An investigation was conducted regarding an incident that occurred on November 15, 2011. The investigation revealed the following:

- ~~You failed to follow a patient's treatment plan by making the decision not to provide the patient with his MP3 player that he uses as a coping mechanism. Your decision to withhold the coping mechanism caused the patient's behavior to escalate.~~
- You conducted a (30 minute) 1:1 observation on a patient in seclusion. During your 1:1 observation, you initiated a conversation with security counselors, asking them whether the patient should retain his MP3 music player or if he should be required to "earn it back." You engaged in this conversation within the patient's hearing. The MP3 music player is a designated coping mechanism for this patient. Immediately after hearing your comments, the patient's behavior escalated significantly.
- Once you realized the patient was targeting you, you did not remove yourself from the situation.
- Your leadership and approach in dealing with this patient was non-therapeutic: you did not advocate for the patient in the best interest of patient care.

This misconduct is unacceptable and cannot be tolerated. As a nurse you are expected to follow and comply with patient treatment plans, and follow standard practice in dealing with patient situations utilizing a therapeutic approach.

You have had previous discipline for unsatisfactory job performance. You received a five-day suspension on September 24, 2008 for failure to follow workplace relations expectations and you were demoted for Cause on September 17, 2009 for unprofessional behavior and interaction with peers.

Because of this unsatisfactory job performance, we can no longer retain you as an employee.

It must be emphasized at this state of the arbitral review that neither of the investigative reports in evidence describe the Grievant's ranking within the crisis staff who handled the Patient X rampage on November 15, 2011. While she is listed as "charge nurse, providing guidance and leadership to other MSH staff," nowhere in the investigative reports as the Grievant identified as the person in charge of the station staff. This fact is especially important to determination of her responsibility for the events which culminated in the arrival of Dr. Harlow to the scene.

The Union argues in this regard that the Grievant's conduct, at least from the point of Dr. Harlow's arrival on the scene, were entirely subject to his control and discretion. This consideration becomes particularly significant in regard to the second charge MSH cites as grounds for her dismissal, i.e., that she:

- Once you realized the patient was targeting you, you did not remove yourself from the situation.
- Your leadership and approach in dealing with this patient was non-therapeutic; you did not advocate for the patient in the best interest of patient care.

These additional charges against the Grievant must be separately reviewed in light of the same standards of just cause as applied to the charge relating to discussion of removal of Patient X's MP3 player. MHS reliance on the Grievant's prior discipline resulting in a five day

suspension and a disciplinary demotion are slender support for MSH argument that her termination was a proper escalation of penalty for continuing misconduct.

It must be noted in regard to this escalation of penalty contention that neither of these prior penalties involved violations of patient care standards. As earlier noted in this review, both misconduct penalties related to relations with co-workers – an element not involved in the instant charges which relate to allegations of failures in meeting patient care standards. As such the Employer's contention that the Grievant's prior disciplinary incidents should have served as forewarning and as justification for failing to correct a poor performance record are both unfounded.

In the following excerpt from the Notice of Termination, the Employer's error in equating misconduct in relationships to work performance failures can be clearly seen:

- You failed to follow a patient's treatment plan by making the decision not to provide the patient with his MP3 player that he uses as a coping mechanism. Your decision to withhold the coping mechanism caused the patient's behavior to escalate.
- Once you realized the patient was targeting you, you did not remove yourself from the situation.
- Your leadership and approach in dealing with this patient was non-therapeutic; you did not advocate for the patient in the best interest of patient care.

This misconduct is unacceptable and cannot be tolerated. As a nurse you are expected to follow and comply with patient treatment plans, and follow standard practice in dealing with patient situations utilizing a therapeutic approach.

You have had previous discipline for unsatisfactory job performance. You received a five-day suspension September 24, 2008 for failure to follow workplace relations expectations and you were demoted for cause on September 17, 2009 for unprofessional behavior and interaction with peers.

Because of this unsatisfactory job performance, we can no longer retain you as an employee.

The reason why authorities on human resources management counsel against combining performance failures with misconduct is that these present widely different, indeed contrasting personnel strategies. Specifically, misconduct offenses arise from willful violation or disregard of a clearly enunciated and effectively promulgated rule of conduct such as insubordination, harassing a co-worker, falsifying a time card and the like. The personnel strategy calls for a penalty such as the demotion assessed on the Grievant for her misconduct toward a co-worker.

In the instant case, however, the basis for the termination decision as cited in the Notice of Termination had absolutely nothing to do with any willful violation of disregard of any rule of conduct. Instead MSH charges the Grievant with a failure to "...to remove yourself from the situation [once] you realized that the patient was targeting you....Your leadership and approach

in dealing with this patient was non-therapeutic; you did not advocate for the patient in the best interest of patient care.”

This charge cannot accurately be characterized as a willful violation or disregard of a clearly enunciated rule of conduct. Instead, the only permissible reading of this quoted charge can be that it alleges a failure of performance. Again, sound industrial relations practice mandates that performance failures call for corrective, non-punitive measures such as coaching, counseling, re-training, adverse performance evaluations accompanied by performance improvement plans and the like.

In sum, the Employer’s argument that the Grievant warrants termination for her alleged performance failure in the chaos surrounding Patient X’s rampage must be recognized as a severe overreaction to the fact that in her twenty-five years of service she has never before been accused of a single incident of performance failure. Thus, the Employer again fails by the widest of margin to meet a cardinal test of just cause – that requiring that any penalty must be commensurate with the severity of a proven misconduct.

In plain truth, since the charges upon which the termination of the Grievant was based do not in any sense constitute misconduct, but instead amount to a minor performance misstep at most, the only permissible personnel action would be corrective, e.g., identifying her errors and providing counseling designed to avoid any future recurrence.

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This review now turns to the other failure of performance charge relied by MSH as just cause for the Grievant’s termination. In this latter instance she is faulted not for something she did but for something she neglected to do, which was according to the Notice of Termination:

Once you realized the patient was targeting you, you did not remove yourself from the situation.

Analysis: Bearing in mind that work rules and performance standards must be clearly enunciated and effectively promulgated, I sought in vain to find any manual statement of how a nurse should respond to targeting through threats and invectives of a patient and found not one word of guidance, neither was any training material on how staff were to handle these issues presented in evidence, nor was any trainer or management person heard to testify that the Grievant or any other staff had been instructed to absent themselves from their duty station and seek a replacement to avoid an unruly patient who targets them.

It cannot be more simply stated – the record is barren of any evidence that the Employer ever communicated to the Grievant in any way that she was to arrange for a replacement on the scene to reduce the misconduct of a patient who targets her. Absent such enlightenment, the Employer cannot penalize her for failing to follow a procedure or protocol which does not exist or at least was never expressed to her.

In the alternative, MSH may seem to argue that an intelligent conscientious nurse should have somehow figured out that she should have abandoned her post during the crisis brought on by the patient's violent rage, to seek out a nurse willing to take over the abuse that she sought to flee from. In this regard, the Employer ignores the fact that the Grievant was not shown to have the authority to order a replacement to take over and no staff person who was her superior in the chain of command saw fit to direct the Grievant to leave the scene. I have no way of knowing whether former staff Doctor Harlow who was heavily criticized for his incompetence in this mêlée took any responsibility for the Grievant remaining on the scene but if she was to have been replaced, it was Harlow's job to have done so.

For the Grievant to be punished for the inaction of the MHS director and/or others superior to her in rank on that riotous occasion, construes a classic example of blaming the victim. On point of fact, the better case could have been made if she had decided in her own to abandon her duty station at such a time of crisis. If the patient or a staff member suffered any unattended injury while a replacement nurse was in transit to the crisis site, this incident might well have become a tragedy.

Perhaps even more distressing would be the inadvertent control lesson sent to Patient X by empowering him to affect the composition of the attending security team by using rage and intimidation to target one of its members and drive her off her assigned duty station. I learned early in my tenure as consultant to the Iowa State Board of Control in Governor Harold Hughes' administration⁴ that members of a secured institutional population were canny students of means to manipulate their caretakers. It makes no sense, therefore, to empower a subject like Patient X to use calculated misconduct to virtually compromise – and in this case – to bring about the discharge of a targeted member of his security detail.

It should be clear that a predictable consequence of rewarding Patient X's misconduct in targeting the Grievant and causing her discharge would be to encourage similar misconduct by other patients who might seek to similarly punish their caregivers by targeting them.

This review ought not close without comment on the untidy handling of the Notice of Termination communicated to the Grievant. The original notification dated December 21, 2011 carried the misinformation that she "...failed to follow a patient's treatment plan by making the decision not to provide the patient with his MP3 player that he uses as a coping mechanism. Your decision to withhold the coping mechanism caused the patient's behavior to escalate."

It was not the Grievant but, rather, the staff Doctor Harlow who ordered the removal of the MP3 music player from Patient A after he was called to the seclusion cell to effect removing the patient's mattress and cutting off his clothing so that the patient could not block the window on the cell door. In fact, the MP3 player remained out of the patient's possession until the next day.

A corrected Notice of Termination was later given to the Grievant but this version also contained errors. These errors include describing her two misconducts as "unsatisfactory job performance." At risk of stating the obvious the term unsatisfactory job performance is reserved

⁴ While serving as the Director of the Labor-Management Center at the University of Iowa.

to describe a substandard utilization of those skills and/or pertinent knowledge of fact and procedures necessary to perform assigned tasks and duties satisfactorily due to lack of adequate training, innate ability, or motivation.

Misconduct, as previously stated, refers to a failure to comply with workplace rules governing behavior. The Grievant's prior disciplinary infractions both involved inappropriate conduct in her relationships with co-workers.

This differentiation is no mere technicality. Indeed in Minnesota State School Law arbitration and in the State Veterans Preference Act this distinction marks separate corrective measures than penalties for non-compliance with rules of conduct. While neither statutes apply in the instant case, these laws underscore the distinction not observed in the letters of discharge to the Grievant.

By far the more critical error in the Termination Notice is the mistaken charge that the Grievant removed the patient's MP3 player. The explanation at the hearing that this gross inaccuracy was merely a clerical error offends logic. When a supervisor signs as important document as a notification to an employee that her twenty-five year service is being terminated for cause, the only sensible assumption must be that that authority will have carefully read the document and approved of its contents before signing over the title of RN Administrative Supervisor.

A mistake of this magnitude can only be logically read to mean that the Employer's chief administrator of nursing practice was not accurately informed about what actually happened during key events giving rise to the decision to discharge the Grievant at the time she approved and effected that action on December 21, 2011. Standing alone this mistake in fact certainly is not fatal and was cured by issuance of the corrected version shortly thereafter. The conclusion remains apparent, however, that the entire decision making process leading to the discharge of this long term employee was marred by confusion and ineptitude.

This criticism does not apply to the Principal Labor Relations Representative of the Minnesota Office of Management who did a masterful job of putting together a cogent case from a chaotic mess of after-the-fact reports replete with the kind of inaccuracies underscored throughout this review. Despite her skilled efforts, the State's Principal Labor Relations Representative, however, was unable to rescue the Employer's fatally flawed case.

DECISION AND AWARD

The grievance is sustained in every particular.

By way of remedy the Grievant will be immediately reinstated to her former rank and position.

Further, the Grievant shall be made whole for all loss of compensation and benefits attributable to her discharge without cause.

The Arbitrator hereby retains jurisdiction for a period of ninety (90) workdays for resolution of any issue solely in relation to the Remedy herein ordered.

December 9, 2012
Date

John J. Flagler, Arbitrator