AMERICAN ARBITRATION ASSOCIATION

In the Matter of the Arbitration Between

CAMBRIDGE HEALTH ALLIANCE

And

SEIU, UNITED HEALTHCARE WORKERS EAST, LOCAL 1199

AAA Case No: 01-18-0003-1047 Date Issued: July 19, 2019
Gr: [redacted]

Arbitrator: Sharon Henderson Ellis

Appearances:
Anthony D. Rizzotti
Hilary K. Detmold Counsel for the Hospital

Jillian M. Ryan Counsel for the Union

ARBITRATOR'S DECISION AND AWARD

Pursuant to the parties' collective bargaining agreement, an arbitration in the above matter was held on February 7 and March 11, 2019 at the Alliance's Somerville Hospital location. Both parties were provided a full and fair opportunity to call witnesses and submit evidence. The parties' written arguments were received by the Arbitrator on May 22, 2019. At the Arbitrator's request, the due date for the Award was extended to the above date.

The Issues

1. Did just cause exist for the Hospital to terminate the Grievant, [redacted]
2. If not, what shall be the remedy?

SUMMARY OF THE EVIDENCE

The Grievant, [redacted] was employed as a Certified Nursing Assistant (CNA) by the Hospital for thirty-one years prior to her discharge on May 1, 2018. The issue in this arbitration is whether the discharge was supported by the contractual requirement of just cause.

Background

The Grievant worked at Everett Hospital for her entire career of thirty-one years. The Hospital is part of the Cambridge Health Alliance, serving Cambridge, Somerville, and Boston's Metro-North communities. The Grievant was a member of the float pool, being assigned to whatever unit needed her on any particular shift. In the preceding four years and likely more, [redacted] had incurred no discipline.[1]

[redacted] immediate supervisor was Nurse Manager [redacted] One of the Nurse Manager's responsibilities is approving the monthly schedules and approving or denying vacation requests. Also relevant in this case is Clinical Manager [redacted][2] a nurse at the Hospital since 2006 and in charge of education and professional development since 2015. A third witness for the Hospital was Staffing Coordinator [redacted]

[redacted] issued the notice of termination on May 1, 2018. In summary, the disciplinary action was based on the following two alleged violations of policy:

> [Y]ou had absences without notification from work on April 5, 2018, and April 6, 2018. You had requested these dates off but were denied the time off, however you did not call or report to work. Your attendance [absences] placed a great burden on your fellow workers . . . .
>
> On April 20, 2018, you were assigned to a constant observation of a patient; however, you were found on the opposite side of the room

[1] The parties' agreement stipulates that disciplinary notes are removed from an employee's file after two years for infractions not involving patients and after four years for infractions involving patients. The Hospital and the Union disagreed as to whether the Grievant had been

[2] [redacted] described herself as also the education coordinator.

> using your cell phone. Your failure to follow steps in caring for a patient requiring constant observation for which you received and completed education on December 18, 2016, had the potential of rendering your assigned patient in an unsafe situation with the potential for elopement.[3]

The testimony and documents related to the two stated bases for discharge are discussed separately below.

The Asserted No-Call/No-Show Violation

The Hospital's Attendance Policy contains in part the following provision:

> **C. No Call/No Show – This is a specific type of unscheduled absence.** An employee who is absent and fails to notify their manager will not be paid for any time missed, unless it is approved by their manager for extenuating circumstances.
>
> 1. For a first absence-without-notification, an employee shall receive a three- (3) day suspension.
> 2. The employee will be terminated if within a one-year period of an absence-without-notification an employee is absent without notification a second time. *This includes:*
>   *a. a consecutively scheduled shift following a first absence-without-notification;* or,
>   *b.* for a subsequently scheduled shift that follows either a worked shift or an absence-without-proper-notification.
>
> . . .[4]

The Grievant was born in Vietnam and has family there. After more than twenty years' service with the Hospital, she is entitled to five weeks of annual vacation. In the past on some number of occasions, she has used her vacation time to travel to Vietnam.

Historically, employees have requested time off by sending an email to their Nurse Manager. In January 2016 this system was supplemented with a computerized Web Scheduler, wherein time off could be requested and

[3] In this context elopement by a patient is defined as leaving the hospital without having been discharged.
[4] Hosp. Exh. 2, at p. 2.

approved or denied. Part of the staff (Super-Users) were trained on the system and required to pass on what they learned to the remaining employees.[5]

In August 2017 sent an email to her manager, requesting five weeks' vacation time for the period beginning on February 26, 2018. heard nothing in response, so in September she approached in person.[6] Her manager told her to put the request in the computerized Web Scheduler and that she would "look into it."

During October, the Grievant was out for six weeks after a patient broke her thumb. She returned to work in late November, and in December she asked again and, she added the dates of April 5 through April 8. said she was still working on it.

On December 21, 2017, approved the Grievant's time off requests from February 26 through March 2 but took no action on the remaining requests. By the end of January, testified, she was very frustrated, as her planned vacation period was nearing. The Grievant approached again, this time in tears. With all the time that had passed, the price of the airline tickets was increasing—so she also asked for a sixth week because the prices would be lower or, until April 10. asked whether she had that much time available. The Grievant replied that she did. According to stated, "Well, you can have it."

On January 31 or February 22,[7] approved pending time off requests from March 5 through April 4 and April 8 through April 10, but denied requests for April 5-7. testified that after talking to she again went to see in tears. She explained she needed the April dates because the fares were cheaper the second week of April. told her that as long as she had enough time banked, she could have the days off

[5] The Grievant got her training from one of the Super User employees.
[6] At that time, she also extended her request from March 26 to April 4.
[7] The record is unclear as to whether action occurred on January 31 or February 22. Hospital Exh. 6, references both dates related to the request for April 5.

and instructed her to put the dates in the Web Scheduler, again. [redacted] did on February 10.

Between August and the end of January, [redacted] testified, she went to see [redacted] the staffing coordinator, at least five times. Each time, [redacted] told [redacted] she had to talk to [redacted] [redacted] created the monthly schedules, finding coverage when there were sick-day absences, etc. [redacted] testified that just before she left for her trip on February 26, 2018, she asked [redacted] whether her return date was April 10 or 11. [redacted] confirmed that it was April 11 but said nothing further.

It is undisputed that by the time the Grievant left for her trip to Vietnam, the computer's Web Scheduler showed "vacation" for all the relevant dates except for April 5, 6, and 7. On those dates, in small print on the bottom right side was the hyperlink "More". According to the Grievant, she was unfamiliar with the term "more" and did not understand that, had she clicked on it, there would have been a further message stating that the dates of April 5 and 6 had been denied.[8]

The Grievant testified that she never learned that April 5 and 6 were denied until she returned to work on April 11. At that point, [redacted] called her into her office and told her she was a "no call/no show".

Management's testimony on this issue came from Nurse Manager [redacted] and Staffing Coordinator [redacted] On the one hand, [redacted] testified that she saw on the Web Scheduler that April 5 and 6 had been denied and that she told [redacted] She said she believed she told the Grievant to find someone to cover for her and to talk to [redacted].

At the same time, [redacted] testified that when she printed out the April schedule, she filled in "vacation" for [redacted] for April 5 and 6, knowing that the

[8] Although the term "more" also appeared on April 7, that was a regularly scheduled day off for the Grievant, so it did not end up being significant to the issue at hand.

Grievant was in Vietnam and would not be able to report to work.[9] testified that when she changed April 5 and 6 to vacation time, told her to put them back on the schedule as workdays because the vacation request for those dates had been denied. On cross examination, however, testified that told her she changed April 5 and 6 to "vacation" because "she [ ] didn't think knew" the dates were unapproved.

testified that she denied April 5 and 6 because a second employee also wanted those days or that week. acknowledged that the parties' collective bargaining agreement provides that "employees will be given the opportunity to choose vacation time, but final assignments will be based on the department's operating requirements and, in the case of more than one employee requesting the same time off, the employees' length of service."[10] had ample seniority over the other employee. indicated that pursuant to "operating requirements" it essentially seemed unjust to have an employee's vacation time disallowed because another employee is taking such an extended vacation. denied the two April dates on February 22.[11] However, never explained to that she was denying those dates and, why.

testified that asked what her plan was because the Grievant didn't know about the denial of the two dates. At that point, testified, she attempted to telephone the Grievant "on her last day". However, the day Cor called was February 26, the date the Grievant flew to Vietnam. Prior to April 5, testified, she called the Grievant again; however, was of course in Vietnam at that time. conceded that she herself found the extra coverage for April 5 and 6 in advance of those dates because she knew that "probably wouldn't show up."

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[9] It was who testified that told her she changed the two days in April to vacation because she knew that the Grievant did not know they had been denied.

[10] Jt. Exh. 1 at Art. 11, Vacations, Sec. 7, Scheduling.

[11] also testified that could have found coverage for April 5 and 6—"We have lots of staff"—and that would not have incurred overtime.

At the Investigative conference she conducted after the Grievant returned from Vietnam, [redacted] testified, she rejected [redacted] explanation that she did not understand what "more" meant in the Web Scheduler. [redacted] testified that in previous years she had denied [redacted] vacation request via this same feature of the Web Scheduler. During the meeting [redacted] said that she needed to consider what [redacted] discipline would be, [redacted] testified, however, that the second incident involving the Grievant occurred before she had made that determination,.

The Alleged Constant Observation Violation

Within eight days of [redacted] return to work, an incident occurred that, taken together with the asserted No Call/No Show infraction, resulted in the Grievant's termination. On April 19 [redacted] was assigned to do a "constant observation" of a patient who was described as an elopement risk. Patients are described as an elopement risks if they might attempt to leave the hospital, unaware of potential danger to themselves.

To be clear, there are two types of intermittent and constant observations. Some observations are for patients who may be suicidal and some are for patients who pose an elopement risk. In elopement cases, one CNA is sometimes assigned to be in a room with two such patients, but the Hospital has recently attempted to have just one-on-one observations in all cases.

While there was some disagreement about the precise policy or rule, for the most part during a constant observation the CNA is assigned to sit near, i.e., within arm's length of the patient. [redacted] was often asked to do these observations, and the patients liked her.

The Hospital claims that the Grievant put the patient's safety at risk when she stood near a wall far from the patient's bed and allegedly read her texts or otherwise used her cell phone. The parties agree that having a cell phone on one's person is not restricted. They agree, however, that a cell phone cannot be used during a constant observation. As the Grievant's and the

Hospital's versions of the incident vary in some particulars, they are summarized separately.

Testimony from Management

Clinical Manager [redacted] testified that on the morning at issue, as she walked past Room 100, she observed that no one was sitting beside the patient's bedside as is typical when there is a constant observation. There was, however, an open computer laptop on the portable table near the patient's bed. The patient was asleep and lying on his side. The room was dimly lit, if not somewhat dark, but [redacted] could see the patient lying asleep on his side in the first bed and facing the door. The room also included a bathroom and a vacant bed near the opposite wall, which held a window and a wall-mounted computer that swiveled.

[redacted] entered the room at about 7:30 A.M.[12], looked in the bathroom and then observed that [redacted] was on the far side of the room, on the other side of the vacant bed. According to [redacted], [redacted] was looking downward upon the vacant bed and did not see her enter. There were extra linens folded at the bottom end of the bed, near [redacted]. Also near [redacted] was the permanent computer that was mounted on the wall.

[redacted] testified, "I don't remember what I said to get her attention. She [redacted] lifted her head. But when she saw me, her arm moved forward as though sliding something under the stack of linen at the foot of the vacant bed." According to [redacted], [redacted] then started walking toward the middle of the room. [redacted] walked toward the second bed. [redacted] testified that from the foot of the second bed, "I could see what looked like some type of electronic device partially sticking out from underneath the linen."

At that point, [redacted] asked the Grievant whether she was on her phone. [redacted] replied that she was not. [redacted] said something

[12] The parties agree that [redacted] probably entered the room at about this time.

to the effect that she knew whether a person was telling the truth. According to [redacted], [redacted] then reached over and took the cell phone out from underneath the linen and responded, "Yeah."

According to [redacted], [redacted] put the cell phone in the pocket of her scrubs and said something about her mother and her children. At that point, [redacted] informed [redacted] that she would be replacing her in that assignment. [redacted] left the room and returned later with a replacement CNA.

During cross examination, [redacted] indicated that she had not seen a light coming from the cell phone and that she did not recall seeing a screen. At the arbitration, the Grievant proffered her cell phone for observation. It was enclosed in a leather-like case.

Nurse [redacted] testified about the risk to patient safety when a constant observer is distracted from observing the patient or is not sitting nearby. That morning she contacted Nurse Manager [redacted] and also wrote the following incident report:

> This morning I was passing by room 100-A. I was made aware that this patient had a constant observer assigned to him. When I went by the room—the room was very dark and the observer was not in the chair that previous observers had been using. . I entered the room and saw that [redacted] was standing on the far side of the room—on the far side of B bed—very close to the window. She was looking down as if she was focusing on something on the bed mattress. I noticed that there was linen stacked on B bed. As I entered the room and saw her I said—oh there you are. She looked up and I saw her hand/arm make a sliding motion towards the linen. Afterwards she started walking towards me as I walked closer to B bed. When I was standing at the foot of bed B—[redacted] had since moved into a position between A bed and B bed—I asked her if she had been using her cell phone.
>
> I asked this question because I had visualized once I arrived at the foot of the bed—what appeared to be an electronic device partially obscured by the linen stacked on the bed. Her response to my inquiry was no, I asked again[redacted], were you on your cell phone,

> she responded no again. I then stated that I can detect when someone is lying to me and I see her cell phone hidden under the linen and I saw her slide something under the linen as I entered the room.
>
> I then said—I will ask you again—were you using your cell phone. She then stated yes she was and retrieved the cell phone from under the linen and placed it in her pocket. I asked her if she was aware that using a cell phone while doing a one to one was not allowed and she stated yes.
>
> . . . She continued to make attempts to explain that she was checking on the status of her mother who was dying. I again stated that this is not an appropriate time to discuss this in front of the patient.
> . . . .

The Grievant's Testimony

[redacted] testified that on April 19, the date of the alleged violation, she entered the patient's room between 7:05 and 7:08 A.M. She testified that she first took the patient's vial signs and also picked up the area and cleaned the patient's tray table to make it ready for breakfast.

According to [redacted], after she took the patient's vital signs, she wrote them on a scrap of paper and put it in the same pocket of her scrubs that held her cell phone.

After the patient fell asleep, [redacted] started to enter the vital signs information into the laptop computer. However, according to [redacted], the cord to the laptop was only half plugged in and so the computer was "dead". For that reason she opted to go to the computer on the opposite wall and enter the vitals information there.

When she reached the wall-mounted computer, she did what was required to wake it up and placed her cell phone and the note with the vital signs on top of the empty bed. At that point, [redacted] entered the room and addressed her, saying, "[redacted] were you using your phone?" According to the Grievant, she answered no. Then [redacted] said, "You were using your phone weren't you?" The Grievant testified that she again said

no. According to the Grievant, she was going to show the nurse she was not using her phone but [redacted], who was very loud and aggressively standing near her, said, "You are lying. I have children and I know when people are lying."

[redacted] testified that by then the patient had awakened and she was so scared that she said yes to [redacted], "just to get her off of me." She added that her children were at home and her mother was ill.[13] When the patient awoke, [redacted] apologized to him.

The Access Logging Report

It was part of the Grievant's testimony at the arbitration that she went to the far wall to use the computer there because the laptop near the patient was partly unplugged and was therefore dead when she attempted to enter the patient's vital signs.[14] To counter this aspect of the Grievant's testimony, the Hospital entered into evidence a computerized access logging report.[15] The Union objected strenuously to entry of the document because it was not used or relied upon to terminate the Grievant and its existence was unknown to the Union prior to the second day of arbitration.

In any event, the Hospital now relies upon the document to assert that contrary to [redacted] testimony that the laptop was dead, she had actually used the laptop to view or access the patient's medical record—suggesting that there was no reason for her to be standing near the computer on the far wall. Importantly, according to the Hospital, the data report demonstrates that the Grievant's testimony about the laptop's condition was false.

Hospital Exhibit 13a shows that [redacted] accessed the laptop at 7:41:35 or shortly thereafter.[16] The Union argues that this data note does not contradict the Grievant's testimony that the laptop was dead when she first tried to use it, shortly after she entered the patient's room between 7:05 and

[13] [redacted] testimony, she acknowledged that she knew the Grievant's mother was ill.
[14] At no point in her testimony did [redacted] say that she did access the patient's medical record.
[15] Hosp. Exhs. 13A and 13B.
[16] The CNA who was sent in to replace [redacted] first used the laptop at 8:19:58 A.M.

7:08 AM. [redacted] affirmatively testified that at that point she had plugged the laptop in, so by 7:41 A.M. it would have had several minutes to reboot. The Grievant further testified about how upset she was by the interchange with [redacted]. According to the Union, while [redacted] went to find a replacement CNA, [redacted] probably made the entry she had intended to when interrupted by the nurse coordinator or viewed the patient's medical record and simply forgot that she had done so.

Later that afternoon, Manager [redacted] called the Grievant into an investigatory conference. The testimony about what [redacted] said or didn't say during that conference was confusing.[17] Following the conference, however, [redacted] did instruct the Grievant to gather her belongings and go home. The letter of termination followed.

RELEVANT CONTRACT PROVISIONS

ARTICLE 5 – RIGHTS OF THE HOSPITAL

The Unon recognizes the right of the Hospital to operate and manage its departments. Without limiting the generality of the foregoing, the Hospital exclusively reserves to itself through its management officials the rights, power and authority to: direct employees, to hire, promote, require reasonable standards of performance, transfer, assign and retain employees within the bargaining unit covered by this Agreement; and to suspend, demote, discharge, or take other disciplinary action against any employee for just cause, to determine the number and location of departments; to layoff employees from duties because of lack of work or other legitimate reasons, to recall employees, demand reasonable overtime, maintain efficient operations, determine the means, methods, and personnel by which such operations are to be conducted including sub-contracting, to promulgate reasonable rules and regulations pertaining to the employees covered by this Agreement, and to take whatever action may be necessary to carry out the mission of the applicable departments;

[17] Nurse Manager [redacted] testified that during the investigatory conference, the Grievant admitted she had read texts from her phone. The Grievant's testimony was contrariwise – that she asked to bring in her telephone records to prove she was not using her cell phone.

provided the Hospital shall not violate any express and specific provisions of this Agreement . . .

ARTICLE 11 – VACATION
SECTION 7. SCHEDULING. Employees will be given the opportunity to choose vacation time, but final assignments will be based on the department's operating requirements and in the case of more than one (1) employee requesting the same time off, the employees' length of service.

ARTICLE 25 – DISCIPLINE AND DISCHARGE
Section 1. An employee who has completed her/his probationary period will not be formally disciplined (i.e., given a written warning or suspended without pay) or discharged without just cause.
. . .
Section 3. It is understood that, although "progressive discipline" is appropriate in a variety of situations, circumstances may warrant immediate suspension or discharge without prior disciplinary action in certain situations.

ARTICLE 26 – GRIEVANCE PROCEDURE AND ARBITRATION
SECTION 2. GRIEVANCE AND ARBITRATION PROCEDURE. For purposes of this Agreement, a complaint by an employee or by the Union that the Hospital has applied a provision of this Agreement in violation of its terms and that such application has adversely affected one or more employees under this Agreement . . . shall constitute a grievance and shall be subject to resolution in the following manner:
. . .

> **STEP 3.** If the Union is not satisfied with the answer to the grievance given by the CHA Senior Director of Labor Relations or his/her designee in Step 2 . . ., the Union may refer the grievance to arbitration by filing its written demand for arbitration with the American Arbitration Association.

Section 4. Arbitrator's Authority. The function of the arbitrator is to determine the interpretation and application of the provisions of this Agreement. There shall be no right to arbitration of a grievance to obtain, and no arbitrator shall have any authority or power to award or determine, any change in, modification or alteration of, addition to, or detraction from, any of the provisions of this Agreement.

ANALYSIS AND CONCLUSION

The issue in this case is whether the Hospital had just cause to terminate the employment of the Grievant, a Certified Nursing Assistant and a thirty-one-year employee. The Hospital alleges that [redacted] within a two-week period, committed two serious rules infractions: she was a No Call/No Show on two dates in April 2018, and she violated the rules governing a CNA's responsibility during a Constant and Intermittent Observation of a patient described as an elopement risk.

The Hospital bears the burden of proving that the violations, as alleged, occurred. If that burden is established, it must show that the level of discipline, here termination, was warranted. Each of the alleged violations is examined below.

The No-Show/No-Call Allegations

The sequence of events regarding the Grievant's proposed vacation time and [redacted] responses is detailed in the Summary of the Evidence, above. Important here is that on February 22, [redacted] approved the Grievant's requests from March 5 through April 4 and then from April 8 through April 10, but, oddly, she denied [redacted] request for April 5–7, even though she knew the leave was for a trip to Vietnam. The calendar on the Web Scheduler for each of those dates included the word "more"—a hyperlink to additional information—in small type in the lower right corner. Had [redacted] clicked on the hyperlinks, she would have seen that the April 5-7 dates had been denied. At the arbitration [redacted] and others testified that they were not familiar with the "more" hyperlink in the Web Scheduler, and according to [redacted], at that point she thought she was all set and confirmed with [redacted] that her return date would be April 11.

At the arbitration, [redacted] explanation for denying the two dates was that another employee also wanted days that week so, she [[redacted]] in effect divided the week up. [redacted] did this despite the contract provision that reads:

> Employees will be given the opportunity to choose vacation time, but final assignments will be based on the department's operating requirements and in the case of more than one (1) employee requesting the same time off, the employees' length of service".[18]

At the Investigatory Conference, [redacted] concluded that she would need time to determine what the level of [redacted] discipline would be.

It's likely that most people are familiar with the term "No Call/No Show": commonly, an employee who is fully expected to show up for a regular shift or day of work does not call or make contact and does not appear at work. In these situations, an employer is caught by surprise and at the last minute must normally find an unscheduled employee to come in for work, often incurring an extra overtime expense. Because No Call/No Show instances are a costly setback for an employer, it is normally treated seriously and may, indeed, result in an employee's discharge.

That, however, is not what occurred in this instance. [redacted] originally asked for time off nearly seven months in advance of her departure. As a longtime employee, she was entitled to an annual five-week leave. Nurse Manager [redacted] was familiar with the fact that over the years, [redacted] often used her earned vacation time to visit her family in Vietnam.

There was no surprise when the Grievant did not report on April 5 and no need to find last-minute coverage. [redacted] provided no explanation whatsoever for why she stalled for months before she approved any of the Grievant's requested leave. [redacted] talked to [redacted] several times during that period, once in tears, but [redacted] never explained to the Grievant either the reasons for her delay or why she ultimately denied her the requested dates of April 5 and 6. Further, the delay ultimately required [redacted] to ask for six weeks instead of the original five because of increasing airline rates.

As it turns out, [redacted] denied two of the days without personally alerting [redacted]. By the time [redacted] attempted to call [redacted] (on February

[18] Article 11, Sec. 7 of the parties' collective bargaining agreement.

26), the Grievant was already in flight. It is incomprehensible why [redacted] was not straightforward with [redacted]. She could have told the Grievant that a fellow employee also wanted time that week and asked the Grievant to find coverage for herself. There is no indication that [redacted] could not have found that coverage; both [redacted] and [redacted] indicated that coverage for the two days was readily scheduled in advance and that there was no need to schedule anyone on overtime. Despite [redacted] statement in her termination notice, there was no surprise and no harm of any kind to the Hospital.

In this instance, there was no carelessness whatsoever on the Grievant's part. She testified credibly that she was not familiar with the hyperlink "more" in small print in the bottom right corner of the date in the Web Scheduler. English not being her first language, she guessed that it related to the fact she had asked for more than the initial five weeks.

The Hospital's decision to characterize this scenario as a "No/Call No Show" is incomprehensible and fairly inexcusable. At no time was any justifiable explanation for Management's action put forward.

Accordingly, there is no basis whatsoever for imposing discipline on [redacted] for an action for which she bore no responsibility.

The Intermittent and Constant Observation Violation

Evaluating the second alleged infraction is as difficult as the evaluation of the first is easy. It is indeed difficult to parse the facts on what exactly occurred on April 19, 2018.

Several facts are in dispute. First is the question of whether an elopement risk and a suicide risk both require the constant observer to be within four feet of the patient at all times. That question aside, however, the testimony and evidence chiefly focused on whether the Grievant used her cell phone in any way and whether she was honest and told the truth when she was confronted with the accusation.

[redacted] appeared to be a credible witness throughout. At the same time, Nurse [redacted] also related a credible version of what allegedly occurred.[19]

In the final analysis, however, I conclude that the Hospital has adequately met its burden of establishing sufficient evidence to support some discipline. It seems clear that, based on [redacted] written report and what occurred at the investigatory conference, [redacted] believed [redacted] had violated the rules, whether by being more than four feet from the patient or by looking at her text messages, or both.

I reach this conclusion on two grounds. First of all, an aspect of [redacted] testimony that I find questionable is that she would falsely admit to [redacted] that she had used her phone, simply to get [redacted] to stop yelling and leave her alone. Also, there was conflicting evidence about what, indeed, [redacted] admitted or did not admit at the investigatory conference.

Second, when [redacted] first asked the Grievant whether she was using her cell phone, it seems that it would have been natural for [redacted] to explain immediately why she was standing at the far wall near the permanent computer—that she was there to enter the patient's vital signs because the laptop computer was dead. Instead, she simply denied that she was using her cell phone.

Accordingly, I conclude that the Hospital's evidence adequately suggests that [redacted] being concerned about her ill mother and her children, took a second to look at the text messages she had received.[20] Out of concern about the distractions created by cell phones, the Hospital's policy strictly bans looking at or using them during a Constant Observation. Additionally, the

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[19] One question, however, was [redacted] assertion that she never yelled or spoke loudly to [redacted] or woke the sleeping patient.

[20] The Union submitted the Grievant's telephone records on her behalf. They do not show that she sent any texts but indicate that there were two texts she received shortly after starting her shift.

Grievant's combination of denials and admissions in this regard weaken her position.

Is a Disciplinary Termination Consistent with Just Cause?

As stated by the Hospital, the discipline imposed on the Grievant is based on two asserted violations of policy. One of those bases fails completely.

Accordingly, we are left with a situation where a longtime employee of thirty-one years left a patient's bedside while he was asleep, apparently to see whether she had texts related to her mother's or children's situation that day.

In her role as a constant observer, [redacted] clearly violated Hospital policy. Two considerations mitigate my ultimate conclusion and award in this case, however. First, [redacted] is not an employee with a lengthy record of discipline. In fact, we don't know whether she had any prior discipline or not. The contract negotiated by and agreed to by both parties wipes out discipline after either two or four years. By contract, then, the Grievant has a discipline-free record.

Further, [redacted] is an employee with an unusually long tenure. And finally, her testimony that she was beloved by patients as a constant observer was not refuted. Given these considerations—in addition to the failure of the no call/no show charge—the serious discipline of termination cannot even be contemplated.

The question therefore is, What level of discipline is appropriate? No evidence was proffered as to whether other employees have violated the constant-observation strictures and what discipline, if any, was imposed. Without that information, it is difficult to know what is appropriate and consistent with the Hospital's practices.

As it is, I will impose a two-week disciplinary suspension. Certainly in terms of the principle of progressive discipline, this is the maximum that should be imposed. That level of discipline, coupled with the amount of work time the

Grievant has lost, will surely alert her to the need to follow the Hospital's strictures at all times.

AWARD

The grievance is sustained in part and denied in part. The termination is reduced to a two-week suspension. The Grievant shall be reinstated to work and made whole for her lost wages and benefits.

Date: July 19, 2019

/s/ Sharon Henderson Ellis
Arbitrator