THE LABOR RELATIONS CONNECTION

In the Matter of the Arbitration

Grievance #277-19
([redacted] Termination)

Between

Town of Nantucket – Our Island Home

And

1199SEIU, United Healthcare Workers East

I, the UNDERSIGNED ARBTIRATOR, having been designated in accordance with the arbitration agreement entered into by the above-named parties, and having been duly sworn and having heard the proofs and allegations of the parties, AWARD the following

AWARD

The Employer did not terminate the grievant for just cause.

The Employer must offer the grievant reinstatement to her former position.

The Employer must make the grievant whole for lost wages and benefits from the date of her termination to the date of compliance with this Award, less interim earnings.

The arbitrator retains jurisdiction over this matter for ninety days from the date of this Award for the sole purpose of resolving any dispute between the parties concerning the remedy ordered herein.

Sarah Kerr Garraty, Esq.,

Arbitrator

February 17, 2020

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([redacted] Termination)

Before:	Sarah Kerr Garraty, Esq., Neutral Arbitrator
Appearances:	For the Employer: David C. Jenkins, Esq. For the Union: James Hykel, Esq.
Hearing Dates:	September 5, October 24 and December 6, 2019
Briefs Received:	January 17, 2020

ISSUES

The parties stipulated to the following statement of the issues:

Did the Employer terminate the Grievant for just cause?

If not, what shall be the remedy?

RELEVANT CONTRACT PROVISIONS:

The 2017-2020 collective bargaining agreement ("Agreement") between the Town of Nantucket/Our Island Home and 1199SEIU United Healthcare Workers East contains the following relevant provision:

ARTICLE 21 - DISCIPLINE

21.1 JUST CAUSE. The Employer shall have the right to suspend, discharge or otherwise discipline non-probationary employees for just cause only. In the exercise of its rights under this Article, the Employer will not act in violation of the express terms of this agreement.

Also relevant to the dispute are the following policies of Our Island Home:

ADMINISTRATION, STORAGE, AND DESTRUCTION OF
SCHEDULE II CONTROLLED SUBSTANCE MEDICATIONS

I. Policy

* * *

2) Our Island Home will recognize this category of medications as having the potential for diversion and will strictly adhere to all procedures accordingly.

* * *

II. Procedure

1) All Schedule II Controlled Substance medications will be kept on active narcotic count and stored in a "separately locked" and "permanently affixed" drawer/unit(s) with only the nurse performing narcotic count having the keys to this storage unit(s)

2) Narcotic reconciliation or "narcotic count" will be performed with each change of shift or any time the medication nurse relinquishes her narcotic keys. Narcotic count is documented in the "Controlled Substance Register." Discrepancies in count will be reported to the Director of Nursing.

* * *

4) Every Schedule II Controlled Substance medication administered will be recorded on both the Medication Administration Record (MAR) and on the Controlled Substance Register.

* * *

MEDICATION ERRORS POLICY

I. Standards

A medication error is defined as preparation or administration of a drug…not in accordance to physician's order, manufacturer's package insert specifications, or accepted national, state, and professional nursing standards.

II. Policy

1) A Medication Error/Omission Report is completed on all medication administration errors and immediately after error is discovered to ensure proper resident/employee follow up.

* * *

III. Procedures

1) A licensed nurse makes an immediate assessment of the resident in relation to the nature of the error.

2) Notify the Director of Nursing immediately for significant medication errors and as soon as prudent for less significant.

* * *

4) A Medication/Omission report is completed.

* * *

7) The Director of Nursing investigates the error to determine the cause.

8) The nurse is responsible for completing the Medication Error/Omission report.

* * *

MEDICATION ADMINISTRATION POLICY

* * *

II. Procedure

2) The Medication Cart:

* * *

b) Keep the keys with you at all times.
c) The cart and narcotic drawer must always be locked when unattended.

* * *

e) Always keep the cart in sight or locked if out of sight.

* * *

3) The Medication Pass – The Seven R's:
   a) RIGHT RESIDENT …
   b) RIGHT DRUG: Verify <u>three times</u> (drug & labels vs MAR) before administration.
   c) RIGHT DOSE: Verify against the MAR and label.
   d) RIGHT DOSAGE FORM: Verify against the MAR and label.
   e) RIGHT TIME: Administer within the scheduled time frame (1 hour before & after).
   f) RIGHT ROUTE: Verify against the MAR and label.
   g) RIGHTS OF THE RESIDENT…

4) Proper Disposal of Medications during the Pass:
   a) Dispose of medications into the sharps container
   b) Never dispose of a medication where a resident can retrieve it.
   c) Schedule II medications have a separate policy for destruction.

BACKGROUND

Our Island Home

Our Island Home ("OIH") is a forty-five-bed skilled nursing facility, owned and operated by the Town of Nantucket ("Town"). It provides long-term care and ancillary medical services to its primarily elderly residents, many of whom have significant physical and/or mental deficits. 1199SEIU United Healthcare Workers East ("the Union") represents OIC's healthcare workers and nonprofessional staff, excluding clericals. [redacted] has been OIH's administrator since March 12, 2018. Registered Nurse [redacted] became OIH's director of nursing in January 2017, after serving as its quality-control nurse for four years.

OIH operates on three shifts.[1] The day shift, from 7AM to 3PM, is staffed with a charge nurse (an RN or LPN), a medication nurse (the same), and five certified nursing assistants ("CNAs"). The evening shift, from 3 p.m. to 11 p.m. is staffed by a single nurse (RN or LPN), who serves as both charge and medication nurse, and four CNAs. [redacted], [redacted], and a quality assurance nurse work more conventional daytime hours, and [redacted] and [redacted] are always on call.

Most OIH residents take multiple prescription medications, often more than once a day. The medication nurse is responsible for dispensing and documenting these

[1] There was no evidence concerning a third shift, but presumably the facility is staffed overnight.

medications, in accordance with OIH policies and the orders of the resident's doctor. The job description for LPNs describes these duties as:

> Medications: administers medications safely according to policy and procedures while adhering to State and Federal regulations, within clinical scope of practice, and in accordance with physician orders.
>
> - Orders medications…as needed. Prepares and distributes medications and charts medications administered appropriately in the medical record, drug order book, flow sheets, narcotic record log, and all other means of documentation.
> - Ensures all medication and vaccines of the facility are properly stored and secured.
> - Ensures the medication room, carts, refrigerator, and other storage areas are clean, free from items or food, and properly stocked.
> - Review of resident medication orders, sheets, and administration for discrepancies, errors, drug reactions, etc.

As the job description suggests, the medication nurse must complete multiple levels of documentation for each dose. The primary record is the Medication Administration Record ("MAR"), but there are also PRN Medication Reports, a register for documenting the counts of controlled medications, Medication/Documentation Error Reports, and perhaps others.[2] All of these records are in paper form. At the time of the events to be recounted, there was also a handmade, unofficial record of each "med pass," which witnesses called the "cheat sheet," and which ███ subsequently prohibited.[3]

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[2] Under the federal Controlled Substances Act, 21 U.S.C. 13, drugs that have any potential for abuse or harm are "scheduled" according to the level of risk. The schedule ranges from 1 (banned even from medical use, e.g., heroin) to 5 (lowest risk). Medications on the schedule are referred to as "controlled" medication. Many prescription medications non-controlled, that is, not on the schedule at all.

[3]A "med pass" is a distribution of medications to all residents scheduled to take medication at that particular time. There are multiple med passes every day. Based on the single

All medications at OIH are secured in the "med cart," a wheeled cabinet with two columns of four drawers each. One drawer contains over-the-counter medications, five contain prescription medications, and the third drawer down on the right contains controlled substance medications. On the front of the cart is a lock for all eight drawers. Inside the controlled substance medication drawer is a metal lid with a second lock. The cart must remain locked at all times, except when staff are administering medications. Only the medication nurse has the keys.

During every change of shift, the outgoing and oncoming medication nurses must count the controlled medications on hand, reconcile them with those dispensed during the shift, and record the final count in the register. If there is a discrepancy, the nurses must immediately report it to the director of nursing.

The Events of November 2, 2018

The case concerns the termination of the grievant, LPN [redacted] on February 15, 2019. [redacted] worked at Our Island Home for eighteen years. She began as a CNA, was promoted to CNA Mentor, and in 2007 was credentialed as an LPN, the most highly compensated title in the bargaining unit. The grievant's performance evaluations from 2001 to 2007 are in evidence (there have been none since then) and are uniformly positive. Evaluators praised her reliability, work ethic, "clear & accurate reporting," attention to detail, and consistent treatment of residents with "the highest degree of care & compassion." Until 2018, she had never been disciplined.

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example in evidence, the "cheat sheet" was a checklist of residents scheduled to take medication on a shift, and the time to administer that medication to each resident.

The grievant usually worked the day shift. On Friday, November 2, 2018, which was her day off, she volunteered to cover a half-shift as the charge/medication nurse from 3 p.m. to 7PM. Presumably, four CNAs also worked that evening, but the evidence does not disclose their identities, except for one,

LPN was the outgoing day-shift nurse on November 2. When the grievant arrived, and the grievant performed the count and documentation of the controlled medications. One of these was oxycodone, a Schedule 2 controlled substance medication that was prescribed for resident TW. The oxycodone comes packed in blister cards, each of which holds thirty-one 5mg tablets in separate, consecutively numbered blisters. The doses are administered in descending numerical order. Following protocol, the grievant counted the tablets remaining in the blister cards, while checked the MAR for TW. As of 3 p.m., all doses of oxycodone were accounted for and 49 tablets remained.

gave the grievant the keys to the med cart and the cheat sheet of residents who were to receive medication on the evening shift. According to the cheat sheet, TW was scheduled to receive her third dose of oxycodone at 5 p.m.. That was incorrect; in fact, according to TW's MAR, she was scheduled to receive the third dose at 8 p.m..[4]

The grievant began one of the evening's med passes at around 5:30 p.m., in the dining room. OIH has security cameras throughout the facility, including in the dining room, so the med pass was captured on video. The camera seems to be situated in one corner of the ceiling, aiming downward, so that most of the dining room appears in the frame of the video. The video was played at the arbitration and introduced into evidence, but several factors

[4] OIH's Medication Administration Policy provides leeway to administer a medication anywhere from one hour before to one hour after the scheduled time. Thus, TW's 8 p.m. dose could be administered at any time from 7p.m. to 9p.m.

limited its utility: the resolution of the image is low; the grievant and the medication cart were in a distant area from the camera; most of the time the grievant was facing the cart with her back to the camera; and residents and staff frequently blocked the camera's view of the grievant and the med cart. Therefore, the grievant supplemented the video with her testimony, describing what she was doing.

The video shows the grievant entering the dining room with the medication cart at 5:28:17. There is a large container of water on top of the cart, along with other supplies. The grievant places the cart against the wall opposite the camera, underneath a window. There is a corridor leading out of the dining room immediately to the grievant's left. CNAs and dining-room staff circulate among the residents and enter and leave the room throughout the video. Among the residents eating dinner is TW, who was seated in a wheelchair.

The grievant proceeds to review paperwork that is on top of the cart, and to administer medication to various residents in the dining room. She spends at least as much time checking the documentation as she does actually distributing the medication. At 5:36, a woman in street clothes wheels TW away from the dining table and into the corridor to the grievant's left. The grievant, who is at the medication cart, speaks to the woman, and the woman parks TW's wheelchair in the corridor, a few feet away from the grievant, with TW's back to the camera.

At 5:40:49, another resident in a wheelchair, with her back to the camera, approaches the grievant. The grievant gives this resident a cup, and the resident backs away and moves to the grievant's right.

At 5:41:52, the grievant opens the drawer containing the controlled medications, opens the locked lid inside, and appears to take something out. At 5:42:02, with the drawer still open, she checks the documentation. The grievant testified that at this point, she was comparing the cheat sheet to TW's MAR, and discovered that TW was not supposed to receive the dose of oxycodone until 8PM. She therefore returned the blister card to the controlled-medication drawer, without removing the tablet. At 5:42:10, the grievant is seen closing the controlled-medication drawer. The video is not clear enough to show whether she placed anything back in the drawer before closing it.

The grievant testified that at that point, she turned her attention to the medication for another resident who is standing nearby, with a walker. On the video, the grievant is seen standing at the medication cart with her back to the camera, checking documentation. At 5:42:22, she opens one of the non-controlled medication drawers, closes it, checks documentation, re-opens the drawer, and closes it again. Again, it is not possible to see whether she took anything from the drawer, but the grievant testified that she did remove a medication and began crushing it. At 5:43:15, with her back to the camera, the grievant moves her right arm in a manner consistent with crushing a pill. The grievant testified that she dumped that medication into the trash container on the cart (although she did not explain why); on the video, she can be seen throwing something away.

The grievant testified that while she was crushing the pill, TW was coughing and asking her for a drink of water. At 5:43:40, the grievant takes a cup to TW. Standing to the left of TW's wheelchair, the grievant bends over TW; she testified that she was giving TW the water "a little bit at a time," and that TW then took the cup and drank it herself. The grievant

is then seen straightening up and standing next to TW. Two dining-hall workers are nearby, cleaning up. The resident with a walker is also standing nearby.

At 5:44:49, the grievant takes the cup from TW, returns to the medication cart, and throws it away. At 5:45:25, a CNA wheels TW away. By this time, almost everyone has left the dining hall.

The grievant opens and closes two non-controlled medication drawers and looks through them. It is not clear whether she takes anything out of them. She testified that she was looking for the medication for the resident with the walker but could not find it. At 5:46:30, the grievant turns to face the resident with the walker and hands her a cup. The resident appears to drink or consume whatever is in the cup, and then leaves the dining room. At 5:48:29, the grievant wheeled the medication cart out of the dining room.

The grievant testified that she gave the oxycodone to TW at around 7PM. She did not recall where she administered that dose. The grievant signed off on the dose at 8PM on the MAP, and at 7PM in the register.[5] The grievant testified that at around the same time, she learned that a resident was missing. She was "at the med cart with some [blister] cards in my hand," and "dropped the cards." The "lid of the cart" (apparently a reference to the inner lid of the controlled-medication drawer) fell down on the cards, and after "rearranging" the cards, the grievant put them back in the drawers. She then went off to look for the resident. The grievant testified that within less than five minutes, the resident was found in the shower room.

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[5] The 8 p.m. time for the dose was pre-printed in the MAP. The grievant hand-wrote the actual time, 7 p.m., which was at the beginning of the permissible two-hour window.

The grievant testified that her relief, LPN [redacted] arrived at around 7:10PM, after the resident was located. The grievant gave [redacted] the keys to the medication cart, and the two nurses began counting the oxycodone. They found only forty-seven tablets, which meant that one was unaccounted for. The grievant called [redacted] and told her the count of oxycodone was "off by one," and the two nurses began searching for the missing tablet.

[redacted] immediately drove to OIH. She testified that when she arrived, she found the medication cart in the nurses' station, unlocked, with neither nurse in the vicinity. Both nurses soon appeared, and [redacted] said, "No wonder drugs go missing. The cart is unlocked."[6] [redacted] asked the grievant how many pills had been "in the cup" when she gave TW the 7 p.m. dose.[7] The grievant did not remember, but told [redacted] she was sure she had not given TW a double dose of oxycodone. She also told [redacted] that at one point, the lid in the controlled-medication drawer fell on the oxycodone blister pack and could have popped out one of the tablets onto the floor. According to [redacted], the grievant could not recall when the lid fell, or where the cart had been.

[redacted] signed off on TW's oxycodone count in the register, so that the count for November 2 looked like this:

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[6] [redacted] testified that at that point, she did not know which nurse had the keys to the cart. However, [redacted] who also arrived at OIH that night shortly after [redacted] testified that [redacted] told him that [redacted] had the keys. During a subsequent interview, [redacted] stated that she had the keys when [redacted] arrived.

[7] More than one of TW's nine medications were scheduled to be administered at 8PM. [redacted] question was aimed at determining whether the grievant could inadvertently have included an extra oxycodone tablet with the others.

Date	Time	Amount on Hand	Amount Used	Method	Amount Left	Nurse's Signature
11/2/18	8A	51	One	PO	50	[initials]
11/2/18	2P	50	One	PO	49	[initials]
11/2/18	7P	49	One	PO	48	[grievant's initials]
11/2	7:30	Count off		PO	47	[initials]

Both and the grievant left within the next ten or fifteen minutes. According to the nurses' notes for the rest of the shift, TW was "acting off baseline," and her pulse was "tachycardia at 110"[8] until 1:00 a.m., when it slowed to 93. testified that this was "consistent with a double dose," but did not necessarily prove it.

The grievant's next workday was Sunday, November 4. In the meantime, discussed the missing oxycodone with When the grievant arrived for her shift, called her into his office and, according to the grievant, told her that "he wanted to talk about the missing pill, but [ ] was not there," so she should go home, and "he would get back to [her] on Monday."

On Monday, November 5, the grievant received a hand-delivered letter from , notifying her that he was placing her on paid administrative leave "pending the outcome of an investigation arising out of your actions as an employee for the Town of Nantucket." She was directed "not to have any contact with any Our Island Home employees regarding Our Island Home business," except for a Union representative.

[8] Tachycardia is characterized by a rapid than normal heart rate. There was witness testimony that a double dose of Oxycodone would, if anything, produce a bradycardia (slower than normal) heard rate.

This was not the first time a dose of a controlled medication has gone missing at OIH. testified that it occurs about once every three to six months. No other employee has been terminated in consequence.

The Investigation

Between November 4 and 15, , and Human Resources Director investigated the disappearance of the oxycodone tablet. They interviewed , , and the grievant, and reviewed the documentation for the evening of November 2, including TW's physician orders, her MAR, the controlled-medication register, the cheat sheet, and the oxycodone blister packs themselves.[9]

, and interviewed the grievant, accompanied by Union Representative on November 14, 2018. The grievant testified that she was extremely nervous, and believed that regardless of what she said, "I would be disciplined no matter what." During the interview, the grievant was unable to recall many of the details of her shift, unless the managers showed her the documentation. She could not recall or estimate the number of residents to whom she gave medications, or when or where she administered the oxycodone to TW (until she was shown the documentation), or whether it was before or after arrived. Asked to describe the lid of the med cart falling, the grievant stated that she was "near the fish tank [i.e., an aquarium] and someone was speaking with her," but could not recall who that was. When the managers told her it was "improbable" that the lid would have popped out the next pill in numerical order, the grievant disagreed.

[9] Neither nor testified at the arbitration.

According to the managers' notes of the interview, they showed the grievant the video and "talked through the timeline of the video footage…how the narcotic [drawer] was opened, pill was popped, placed in a cup and administer[ed] to [TW] at 5:41." The grievant testified that she did not see the video until after the interview was over, when she watched it with [redacted] and [redacted]. According to the grievant, the managers never "talked through the timeline of the video," or questioned her about it at all.

[redacted] prepared a written report on the investigation, which she sent to [redacted] and [redacted] on November 15, 2018. [redacted] conclusions were:

- The unaccounted-for narcotic pill remains unaccounted for.
- [redacted] violated the Medication Administration Policy.
    - The medication cart was unlocked and unattended upon [redacted] arrival …
    - Video surveillance of the dining room shows [redacted] administering medication to resident TW at 5:41 p.m., a violation of the 2 hr administration rule for controlled substances (drug was scheduled for 8 p.m.).
    - [redacted] cannot recall the majority of what occurred during her 4-hour shift and cannot recount when/where she administered medication to resident TW.
- Disciplinary record: written warning July 2018, Performance Improvement Plan 8/15/18-10/3/18.
- Current other medication error/oversight in which a potentially critical discrepancy between the [MAP] and actual medication dosage on hand was overlooked, primarily by [redacted] and one other nurse, for over 4 months, which could have led to over-medication of a critical blood pressure medication, Lisinopril (this is still under investigation but is clear in documentation and report that it was not noticed, which would not have been the case if Medication Administration Policy had been followed).
- Violation of the verbal administrative leave notice on 11/4 6:52 a.m. …
    - [redacted] returned to OIH around 4:13 p.m. to enter a vacation and sick leave request for 23 days.

The Prior Settlement Agreement

Some background is necessary concerning [redacted] observation about the grievant's prior disciplinary record. [redacted] testified that, both before and after she became Director

of Nursing, she had "interactions" with the grievant concerning documentation errors, although they were "not a frequent issue at all." There is no documentation of these interactions. further testified that when she became Director of Nursing in 2017, she had more day-to-day contact with the grievant and was able to "observe her performance," although, as noted earlier, the grievant received no formal performance evaluations. testified that the grievant made "significant documentation and medication errors," although again, there is no documentation of these errors.

testified that she had "educational" meetings with the grievant "at least monthly," but did not document any of these meetings or take any disciplinary action. When came on board in March 2018, discussed her perceptions of the grievant's performance with him at some length.

Thereafter, documented purported errors in the grievant's performance on nine occasions (Town Exh.-9). (The grievant disputed them at the time, sometimes refusing to sign documentation.) In chronological order, the documentation of the purported errors was:

- April 18, 2018: Town Exh. 1, Documentation Error Report, for writing a date of 4/15 with no year,[[10]] and without stating who the nurse and MD were. This report was not brought to the grievant's attention until July 10, 2018.

- April 21, 2018: Town Exh. 2, Employee Performance Record (which described as an item that "may lead to discipline"), for writing orders for a resident while off the clock.[11]

[10] It should be noted that herself subsequently made this error on a patient medication record, on November 2, 2018. JX 12 at 9.

[11] The grievant was the health-care proxy for this resident, who was a close relative..

- June 29, 2018: Town Exh. 3, Employee Performance Record, for "multiple errors" on admission paperwork.

- July 11, 2018: Town Exh. 4, Employee Performance Record, for failing to draw labs as ordered by the doctor.

- Written warning, which is not in evidence.

- July 14, 2018: Town Exh. 5, Employee Performance Record, for a "documenting/communication error" concerning ordering a supply of medications for a resident.

- July 17, 2018: Town Exh. 6, Employee Performance Record, for not completing 2PM med pass, and leaving a medication pre-poured in a drawer of the med cart.

- July 24, 2018: Town Exh. 8, [Resident] Grievance/Complaint Action Form, stating that the grievant failed to administer her 12PM medications, which the grievant had documented.

- July 30, 2018: Town Exh. 9, Three-day suspension for acting "out of scope" by administering a dose of medication without contacting the doctor, as required.

- August 21, 2018: Town Exh. 7, Employee Performance Record, for giving 8AM dose of medication at 9:30AM

In the middle of this documentation process, on July 9, 2018, [REDACTED] sent the following email to [REDACTED] the Town's director of human services, with the subject line "[REDACTED] performance":

> Just wanted to bring you up to speed with a disciplinary issue. Since my tenure began, I have (borne) witness to nursing errors, narc count issues, med errors, transcription errors and alike. … In retrospect [REDACTED] has made many, many more than the other nurses, and continues to make the same types of mistakes over and again. [REDACTED] and I agree that it is time for discipline as her continued mistakes are creating inefficiencies in the department by having a lot of persons have to go back and fix the issues, not to mention putting residents at risk.
>
> …[W]hen trying to educate her she seems to have a lax attitude about most if not all issues. She can't seem to see the potential dangers, gets somewhat argumentative and seems to think it's "no big deal." …

During this same period, RN [redacted] was regularly auditing all of the nurses' documentation for all residents. Contrary to [redacted]s assertion, [redacted] found that the grievant committed fewer documentation and medication errors than other members of the nursing staff. According to emails that [redacted] sent to the nurses, her monthly counts of their errors were:

	May, 2018	June, 2018	July, 2018
Grievant	1	1	1
[redacted]	8	16	16
[redacted]	1	--	--
[redacted]	1	--	--
[redacted]	9	10	6
[redacted]	--	2	1
[redacted]	--	11	--

[redacted] candidly agreed that there were "many, many more (errors)" among the nursing staff than "just [the grievant's]. These were daily issues."[12]

The Union filed a timely grievance contesting the grievant's suspension. Eventually, the parties resolved the grievance by entering into a settlement agreement. In this arbitration, the parties stipulated that Town Exh. 1-8 and 10

> were the subject of a settlement agreement between the parties making them non-precedential that reduced these actions to a single non-disciplinary warning. The [settlement] agreement read, in pertinent part:
>
> > The parties agree that Ms. [redacted] progressive disciplinary record will be consolidated to a written counseling. Upon successful completion of the thirty (30) day performance improvement plan, Ms. [redacted] July 30, 2018 suspension will be reduced to a written warning.

[12] One of the listed nurses was suspended and subsequently resigned. [redacted] testified that another unlisted nurse and a CNA were also suspended for performance issues and resigned, but it is not clear when that occurred, or what the circumstances were.

The performance improvement plan ("PIP") identified three performance concerns:

- Medication errors
- Transcription errors and documented communication to other nurses/charge nurse
- Practicing outside of the scope of LPN license

Among other actions, the PIP required the grievant to meet regularly with an assigned mentor, HR, and the administration; to have all of her documentation audited by [redacted] and to review her own job description and all OIH policies.

On October 22, 2018, [redacted] notified the grievant that she had successfully completed the PIP. Her memo stated:

> Pursuant to…the…Memorandum of Understanding dated August 15, 2018, Ms. [redacted] three (3) day unpaid July 30, 2018 suspension will be reduced to a written warning. The unpaid suspension days will be paid in the next available payroll. …

There is no "written counseling" or "written warning" in evidence, and it is not clear whether the employer ever issued one.

The Grievant's Termination

On December 4, 2018, [redacted] notified the grievant by letter that there would be a disciplinary hearing on December 11 "to determine whether or not there is just cause to impose discipline, up to and including termination, upon you." The letter continued:

> On November 2, 2018 you were employed as an LPN…and worked the 3:00 p.m to 7:00 p.m. shift. Your assignment was that of a Charge Nurse. At the beginning of your shift you conducted a medication count with [redacted] and at the end of your shift you conducted a medication count with [redacted]
>
> As of 7:00 p.m.…you were unable to account for a narcotic pill. … When the Director of Nursing arrived the medication cart which was under your control was unlocked and unattended.

In addition, the video of your shift shows you administering medication to a patient at 5:41 p.m.. The medication was scheduled to be administered at 8:00 p.m.. When questioned about the medical decisions made by you during the shift you stated that you had little or no memory of anything you did during the shift.

Your actions as described above constitute a violation of the:

1) Medication Administration Policy;
2) Administration, Storage and Desctruction of Schedule II Controlled Medications Policy; and
3) Medication Error Policy.

Your actions as described above constitute the following violations:

You did not perform the essential duties/responsibilities/functions set forth in the Job Description as follows:

- Follows and interprets…as well as ensures all existing policies, procedures and performance standards are followed.
- Prepares and maintains residents' clinical records, including medical and nursing treatments and related services provided by the nursing staff.
- Medications: administers medications safely according to policy and procedures while adhering to State and Federal regulations, within clinical scope of practice, in accordance with physician orders.
    - Orders medications…as needed. Prepares and distributes medications and charts medications administered appropriately in the medical record, drug order book, flow sheets, narcotic record log, and all other means of documentation.
    - Ensures all medication and vaccines of the facility are properly stored and secured.
    - Ensures the medication room, carts, refrigerator, and other storage areas are clean, free from items or food, and properly stocked.
    - Review of resident medication orders, sheets, and administration for discrepancies, errors, drug reactions, etc.

Your actions and inactions on November 2, 2018 violated the Personnel Policies, including but not limited to the following:

4.9-1(a) – Incompetence or continuing inefficiency of performing assigned duties.

4.9-1(r) – Any situation or instance of such seriousness or nature that disciplinary action is warranted.

The disciplinary hearing took place on December 11 and 19, 2018, before Assistant Town Manager [redacted] The grievant was represented by counsel and three Union representatives. Among the exhibits considered by the hearing officer were Town Exhs. 2, 4, 5, 6, and 8; an "Employee Performance Record," not identified by date; a "Document Director of Nursing Covering Period April 18 through July 11, 2018," not identified by the date of its preparation; and the settlement agreement, with unspecified "attachments."

On February 8, 2019, Assistant Town Manager [redacted] issued the following decision:

> …Upon review of the video, and the various documents and statements taken in the case, I determined that [redacted] had administered a narcotic to the resident at approximately 5:41 p.m..
>
> The shift in question terminated at 7:00 p.m..... At that time…a pill count was conducted between [redacted] and incoming nurse [redacted] … [I]t is undisputed that the pill count was forty-seven. It is also undisputed that the pill count at that point in time should have been forty-eight. At that time a narcotic pill was missing.
>
> …[A]t approximately 7:17 p.m. [redacted] contacted [redacted] the Director of Nursing to report the inaccurate pill count.
>
> [redacted] arrived at approximately 7:30 p.m. At 7:35 p.m. [redacted] noticed that the medication cart was unlocked and unattended. The practice of the OIH is that the nurse in charge of the medication cart, in this case, [redacted] would remain in control of the medication cart until such time as the pill count was resolved. That was not done in this case.
>
> [redacted] had a conversation with [redacted] at 7:40 p.m.. … [redacted] was unable to give a complete account of the events taking place during her shift, including important details concerning her services provided to residents.
>
> Thereafter, an investigation was conducted. … [redacted] was not able to provide relevant details concerning the events of November 2, 2018.

> … I find that [redacted] actions violated the policies referenced in the Notice of Hearing. The evidence indicates that there have been substantial efforts over an extraordinary long period of time to have [redacted] comply with the medication policies in effect at OIH. Despite repeated attempts over the course of years to motivate [redacted] to comply with medication orders, those efforts have not been successful. … I find that the personal safety of OIH residents is put at risk during shifts worked by [redacted] and that further remedial disciplinary efforts will not put [redacted] in the position of being able to comply with department policies. Accordingly, I recommend that [redacted] be terminated….

On February 15, 2019, [redacted] notified the grievant that she was terminated, attaching a copy of [redacted] decision.

POSITIONS OF THE PARTIES

THE TOWN

The Town insists that it has met its burden of proving that there was just cause for the grievant's termination. The grievant has a long history of medical errors, pre-dating [redacted] arrival at OIH. Although some were undocumented, [redacted] testified in detail about each error, and the grievant never denied them. Far from showing any ill will toward the grievant, OIH managers worked with the Union and grievant to develop a PIP that would allow her to succeed. If managers were predetermined to terminate her, they would have done so in July 2018.

While the Union did not advance its version of what occurred in the dining room on November 2 until the arbitration hearing, the Town's version has been consistent from the beginning. It is clear from the video that the grievant gave a medication to TW between 5 p.m. and 6 p.m., that the grievant lost a narcotic tablet, and that she left the med cart unattended and unlocked while the count remained unresolved. The grievant's memory could not possibly be better thirteen months after the incident than it was in the immediate aftermath.

The Employer argues that Union did not meet its burden to show that the Town treated the grievant differently than other OIH employees. Termination was the only possible response to the events of November 2. OIH provides services to extremely vulnerable residents, who depend on the staff for their daily existence. The grievant's continued employment posed an unacceptable risk. Despite management's long- term efforts at improving her performance, she is simply not capable of performing the duties of her position.

THE UNION

The Union first argues that as his July 9, 2018 email to demonstrates, was predetermined to discharge the grievant. He falsely told that the grievant made "many, many more" mistakes than other nurses, which he disingenuously claimed to have witnessed. In fact, he did not personally observe any errors, and during May, June and July 2018, the grievant had far fewer errors than other nurses. Nevertheless, to meet halfway, the grievant and the Union agreed to a PIP that completely eliminated all errors after August 21, 2018. Even if the Arbitrator finds that the grievant's actions on November 2, 2018 merit some discipline, discharge was not only a grossly disproportionate penalty, it was one that negated the parties' negotiated settlement.

The Union contends that the grievant did not engage in any misconduct at all on November 2, 2018. An unaccounted-for narcotic tablet is not, in itself, grounds for discipline, and the Town did not point to any act or omission by the grievant that caused the tablet to go missing. The Town has never specified the basis for its decision to terminate. In the notice of hearing, outlined reasons that were entirely different than HR Director conclusions, and decision did not specify any grounds at all. His observation that OIH had made "substantial efforts over an extraordinarily long period of time" to improve the grievant's performance was simply false.

The Union insists that the grievant did not administer oxycodone to TW at 5:41 p.m. The most that the fuzzy video shows is that the grievant pulled something from the narcotics drawer, engaged in other activities for a minute and a half, and then handed something to TW. The grievant explained, without contrary testimony, that she returned the oxycodone to the drawer when she discovered it was too early to administer it, and later gave TW a cup of water. The MAR documents that the grievant administered the oxycodone at 7PM.

The grievant was not guilty of leaving the med cart unlocked. Under OIH's own policy, ██████ not the grievant, became responsible for the medication cart as soon as the grievant handed her the keys. There is no basis for ██████ conclusion that the grievant remained in control of the cart "until such time as the pill count is resolved." The Medication Administration Policy obligates the nurse to have the keys with her "at all times," which necessarily implies that the responsibility for securing the cart belongs to the possessor of the keys. It is not credible that OIH has an illogical, unwritten "practice" making a nurse responsible for the cart even if she does not have the keys.

As a remedy, the Union asks the arbitrator to order OIH to reinstate the grievant and make her whole in all respects. If the arbitrator finds that some discipline is warranted, the discharge should be reduced to a second written warning.

DISCUSSION

Before analyzing the events that transpired on November 2, 2018, it is important make clear the grievant's status before those events transpired. She was a long-term employee of OIH, who had no disciplinary history at all until April 2018. To the extent that

she had been evaluated, her performance appraisals had been positive. For reasons not explained, however, she had not been evaluated at all since 2007. [13]

[redacted] became OIH Administrator in mid-March 2018, and almost immediately thereafter [redacted] started documenting the grievant's alleged errors between April 18 and August 1, 2018. By June 9, when [redacted] expressed concerns about the grievant's performance to HR Director Day, The documentation errors identified had been: writing a date without including the year and not identifying the nurse or doctor; writing off hour orders for a resident who happened to have been the grievant's father and for whom she was health care proxy; and errors on paperwork associated with a resident admission.

Based on that record, [redacted] reported that he had "witnessed the grievant's nursing errors, narc count issues, med errors, transcription errors" … and that this represented "many, many, more than other nurses." This was not the case. RN [redacted] who had been tracking and reporting on documentation and medication errors throughout the facility, had reported that in the months of May – July the grievant had 3 such errors, while her colleagues had 40, 1, 1, 25, 3, and 11. Moreover, [redacted] acknowledged during his hearing testimony that at this point there had been no "narc count" errors and that he had not actually witnessed any of the grievant's alleged errors because he did not work in the resident areas.

Given this disparity in error and discipline, it is not surprising that when the grievant received a written warning on July 12, 2018, a second written warning six days later, and a suspension less than two weeks after that, the Union grieved. The Union and the Hospital

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[13] Although [redacted] testified that the grievant committed medical errors prior to 2018 and that she discussed her concerns about the grievant's performance with [redacted] when he came on board, these were "educational meetings" that were never documented.

resolved that grievance through a non-precedential settlement agreement that reduced the two written warnings to a non-disciplinary written counseling and suspension to a written warning following the grievant's successful completion of a performance improvement plan.

The fact that the grievant committed fewer errors than other staff, but was repeatedly disciplined, while they were not, supports an inference that for reasons unknown, [redacted] and [redacted] may have had singled the grievant out before the events of November 2, 2018 transpired.

The investigation report concerning the grievant's 3 p.m. to 7 p.m. shift concluded that the grievant had engaged in the following misconduct: First, the unaccounted-for narcotic remained unaccounted for, yet the grievant could not recall the majority of what occurred during her shift and cannot recall when she administered medication to resident TW. A second and related accusation is that the video surveillance of the dining room showed the grievant administering medication to resident TW at 5:41 pm, a violation of the 2-hour administration rule for controlled substances (drug was scheduled for 8 p.m.). Finally, the employer points out that when [redacted] arrived in response to notice that there was a missing narcotic pill, she found the medication cart unlocked and unattended by either the outgoing medication nurse (the grievant) or the incoming medication nurse [redacted]) in violation of the OIH medication administration policy

The unaccounted-for narcotic did indeed remain unaccounted for, and after two days of arbitration testimony and evidence, it remains so. There are any number of possible explanations, but they are all speculative. What we know is that the grievant handed TW a cup at 5:41 p.m. That is all the video reveals in terms of direct evidence that the grievant gave TW something in a medication cup at that time. One theory is that the grievant gave TW a

dose of oxycodone, as the employer concluded. If she administered another one at 7:00 p.m. as she documented she did, that would explain why the count at shift change was one too few. The grievant had a cheat sheet that called for a dose during the earlier time frame, and a narcotic administration schedule that called for a dose within an hour of 8:00 p.m. It Is possible that she mistakenly administered both doses.

Another possibility is that the grievant gave TW only water to address a coughing episode, and that the employer misperceived this as a drug administration in this far from high-quality video. It is also possible that the grievant ground up an oxycodone pill around 5:40 p.m., after looking at the cheat sheet, then compared the cheat sheet to the MAR and realized it was too early to administer oxycodone and disposed of it. The video does show the grievant grinding up an unidentified medication for an unidentified resident and then disposing of an unknown item. Another possibility is that the grievant removed a pill, realized that it was too early to administer it, and then lost track of it. [14]

There were several steps that the investigators did not undertake to better identify what took place, though in retrospect, they should have. There were numerous staff members in the area while the grievant was dispensing mediation to several different residents congregated in the area. One of them might have gotten a look at what type of pill the grievant was grinding up, or whether TW was coughing, or whether she had asked for and received plain water, or whether the grievant ever removed a pill from TW's oxycodone medication card in that timeframe. These individuals were not questioned. The

[14] The grievant's suggestion that somehow the cover of the controlled medication med drawer fell on TW's medication and knocked the very pill that was next to be dispensed out does read as far-fetched, but there was evidence that pills do come out of the packages, which is why the grievant and Kennedy were looking in the med cart drawers.

administrators also concluded that it was the grievant who was responsible for the missing pill, but [redacted] was present at the end of the grievant' shift, had been handed the med cart keys, and could also have been responsible. Yet for reasons unexplained, [redacted] was not suspected of any potential wrongdoing.

Significantly, at hearing, the grievant was able to give a cogent explanation of her movements, as depicted on the surveillance video. But she was not asked to do that during the investigatory interview. She asked to view the video and ended up doing that in the company of Union representative [redacted] and [redacted], but by the time that happened, the investigators were done asking questions. It is very plausible that the grievant was fearful of the investigation's consequences and just clammed up. It is equally possible that she dispenses many medications during sifts when she is assigned to that duty and really did forget when she had given a particular resident a particular dose. Under either of those scenarios, viewing the video could easily have triggered her memory.

All of the above described ambiguity leaves too many unanswered questions. The Employer has been unable to meet its burden of proof in establishing that the grievant gave TW a dose of oxycodone at the wrong time, or that TW was double-dosed. It is just as possible that this pill just inexplicably went missing. as reportedly occurs every three to six months or so. When she discovered the wrong count, she reported it immediately and properly.

Turning to the allegation that the grievant left the med cart unattended, the Employer has established this allegation without difficulty. When [redacted] arrived to investigate the unreconciled pill count at the end of the grievant's shift, she found the medication cart unlocked and neither the outgoing nor the incoming medication nurse in the vicinity. That

is a violation of policy. The Union has suggested that because the grievant had turned over the med cart keys to [redacted], she was no longer responsible for the unattended cart. The employer has countered, without citing any written policy, that the grievant remained in control until the low pill count issue was resolved.[15] In either case, it appears that the employer rushed to judgment when it targeted the grievant without even considering [redacted] potential role.[16]

A separate issue of considerable concern is that the Town's designated hearing officer specifically relied on documents introduced as Town exhibits 2, 4, 5, 6 and 8 – all of which had been reduced to the status of non-disciplinary counseling as the result of settlement negotiations between the Town and the Union. There is no single reason that employers opt to settle union disciplinary grievances short of arbitration. One cannot infer from the choice to do so that the employer considered the discipline unwarranted; there can be practical reasons for bypassing conflict. But in the same vein, when an employer reduces discipline to the non-disciplinary level of "written counseling," it foregoes the right to then treat is as discipline after-the-fact. Indeed, the settlement agreement explicitly stated that the incidents underlying the written counseling were to be non-precedential.

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[15] I have reviewed the Medication Administration Policy, the Administration, storage, and destruction of Schedule II controlled substance medications policy and the Medication Errors Policy and have located no language suggesting that in the case of a pill count error the outgoing nurse is responsible until the issue is resolved, as opposed to when her shift ends.

[16] It is unclear exactly when the grievant handed the med cart keys to [redacted], and it therefore cannot be determined whether [redacted] had access to the contents of the med cart before or only after the pill count that revealed that there was a missing pill. [redacted] did not testify, nor was she interviewed, according to [redacted] investigation report.

All that can be said is that the grievant received counseling for medical errors. As noted above, we also know that her errors were at a low to mid-range among the OIH nursing staff. Yet in the summative paragraph of his report recommending that the grievant be terminated, the Town's designated hearing officer wrote: "… Despite repeated efforts over an extraordinarily long period of time to motivate [redacted] to comply with medical orders, those efforts have not been successful…" In fact, the status of her disciplinary history was that she had one written warning that replaced a suspension following her successful completion of a performance improvement plan. And these were not based on alleged errors occurring "over an extraordinarily long period of time;" they occurred between April and August 2018." [17]

For all of the above stated reasons, the employer had been unable to meet its burden of proof in establishing that the grievant was terminated for just cause. Accordingly, she must be offered reinstatement to her former position as an LPN at Our Island Home and must be made whole for her lost wages and benefits.

[17] The grievant did leave the medication cart unattended and unlocked. As did [redacted]. [redacted] testified that this was not a ground for the grievant's termination. It was not specifically referenced as a ground for termination in the Hearing Officer's report, and [redacted] who was clearly equally responsible for this breach of protocol, was not disciplined. Accordingly, I do not reach a conclusion as to that particular breach of protocol.

AWARD

The Employer did not terminate the grievant for just cause.

The Employer must offer the grievant reinstatement to her former position.

The Employer must make the grievant whole for lost wages and benefits from the date of her termination to the date of compliance with this Award, less any interim earnings.

The arbitrator retains jurisdiction over this matter for ninety days from the date of this Award for the sole purpose of resolving any dispute between the parties concerning the remedy ordered herein.

Sarah Kerr Garraty, Esq.
Arbitrator
February 17, 2020