ARBITRATION DECISION NO.:
316

UNION:
OCSEA, Local 11, AFSCME, AFL-CIO

EMPLOYER:
Department of Mental Retardation
and Developmental Disabilities
Mount Vernon Developmental Center

DATE OF ARBITRATION:
December 14, 1990

DATE OF DECISION:
January 15, 1991

GRIEVANT:
Barbara Anderson

OCB GRIEVANCE NO.:
24-09-(89-03-03)-0183-01-04

ARBITRATOR:
Hyman Cohen

FOR THE UNION:
Brenda Goheen

FOR THE EMPLOYER:
Roger Coe

KEY WORDS:
Patient Abuse/Neglect
Improper Restraint
Removal

ARTICLES:
Article 24-Discipline
§24.01-Standard

FACTS:

The grievant is a Therapeutic Program Worker (TPW) for the Mount Vernon Developmental Center and works in a cottage which houses sixteen clients. The grievant had worked for the Center for twenty-four years. A Licensed Practical Nurse (LPN) claims that the grievant neglected a patient. The LPN claimed that while she noticed that a client was striking her head repeatedly against a table the grievant allegedly said, “ignore her and she will stop that."

The grievant denies the LPN's version of the event. The client was screaming and the grievant told the LPN to ignore her and she would settle down. The client at that time was not self-abusive. When the grievant or another TPW told the client to stop screaming the client reacted by hitting her head against the

table. The client's behavior got worse with her hitting her hand on the table, upsetting her chair, scrambling towards a door and hitting her head on the door. The grievant and the second TPW attempted to get a hold on the client, the other TPW tried to put her hand between the grievant's head and the floor. The client's head started to bleed which the grievant thought was caused by her head hitting the ring on the other TPW's hand. The grievant claims that the LPN did not assist in restraining the client but just stood by a table until the client was under control again.

The grievant was charged with improperly restraining the client. Based on the LPN's claims the grievant was suspended for twenty days for patient neglect in failing to respond to the patient's self-abusive behavior.

EMPLOYER'S POSITION:

There is no reason for the LPN to lie. She saw the incident and reported it, and the employer had just cause to suspend the grievant. The grievant did not respond to repeated severe self-abusive behavior with the callous statement of "ignore her." The client was also later injured by the grievant's further negligence. Restraining techniques were also ignored and caused the client to reopen a cut on her head. These are serious incidents and the employer must be allowed to discipline the grievant in this case. The grievant did not minimize the injury to the client.

UNION'S POSITION:

The LPN's story is uncorroborated and false. The grievant and another TPW claimed that the client was only hitting her hand on the table, not her head. From the client's history it was known that the client would stop in a few seconds. Both TPW's also testified that they were too far from the client when it later became necessary to restrain the grievant. The LPN's testimony had several inconsistencies. The most serious variance was that the LPN contradicted whether she attempted to restrain the client herself. She even said that she could have "confused two different situations." Her testimony was not credible and it was confused at best.

The grievant should be allowed to use her best judgment to restrain the client. She knew the behavior patterns of the client and how to best stop the self-abusive behavior. It was also impossible to apply what the employer now claims is the correct hold with the client hitting her head against the floor and lashing out. The injury to the client was most likely caused by the other TPW's ring hitting the client's head; the grievant can not be responsible for this injury. There is no just cause for the discipline. The grievant should be commended for his appropriate response to the situation, not disciplined.

ARBITRATOR'S OPINION:

Further testimony indicated that the grievant had to use his own judgment in restraining the client; the client's history and present behavior precluded a specific restraint. The inconsistencies in the LPN's testimony also destroys that rationale for disciplining the grievant. Even the client's injury was not proven to be caused by the grievant's alleged negligence. The client may have reopened her cut on the other TPW's ring while the other TPW tried to place his hands between the client's head and the floor. The State failed to show just cause for the grievant's removal.

AWARD:

The grievance is upheld. Grievant is to be made whole for the 20 day suspension.

TEXT OF THE OPINION:

VOLUNTARY LABOR ARBITRATION

In the Matter of the Arbitration

-between-

STATE OF OHIO, DEPARTMENT OF MENTAL RETARDATION AND DEVELOPMENTAL

DISABILITIES, MOUNT VERNON DEVELOPMENTAL CENTER, MOUNT VERNON, OHIO

-and-

OHIO CIVIL SERVICE EMPLOYEES ASSOCIATION, LOCAL 11, AFSCME, AFL-CIO

ARBITRATOR'S OPINION

Grievant:
Barbara Anderson

FOR THE STATE:
R0GER COE, Esq.
Ohio Department of
Administrative Services
Office of Collective Bargaining
65 East State Street
Columbus, Ohio 43215

FOR THE UNION:
BRENDA GOHEEN
Advocate
Ohio Civil Service Employees
Association, Local 11, AFSCME,
AFL-CIO
1600 Watermark Drive
Columbus, Ohio 45246

DATE OF THE HEARING:
December 14, 1990

PLACE OF THE HEARING:
State of Ohio
Office of Collective Bargaining
Columbus, Ohio

ARBITRATOR:
HYMAN COHEN, Esq.
Impartial Arbitrator
Office and P.O. Address:
Post Office Box 22360
Beachwood, Ohio 44122
Telephone: 216-442-9295

*** * * * ***

The hearing was held on December 14, 1990 at the State of Ohio, Office of Collective Bargaining, Columbus, Ohio before HYMAN COHEN, Esq., the Impartial Arbitrator selected by the parties.

The hearing began at 9:00 a.m. and was concluded at 4:05 p.m.

*** * * * ***

On or about March 3, 1989 **BARBARA ANDERSON** filed a grievance with the **MOUNT VERNON DEVELOPMENTAL CENTER, OHIO DEPARTMENT OF MENTAL RETARDATION AND DEVELOPMENTAL DISABILITIES**, the "**State**", in which she protested her disciplinary suspension for twenty (20) working days because of "resident neglect--failure to act".

The State denied the grievance after which it was processed at the appropriate steps of the Grievance Procedure contained in the Agreement between the State and **OHIO CIVIL SERVICE EMPLOYEES ASSOCIATION, Local 112, AFSCME, AFL-CIO**., the "**Union**". Since the parties were unable to resolve the grievance, it was carried to arbitration.

FACTUAL DISCUSSION

The Grievant has been employed as a Therapeutic Program Worker, TPW, by the State for twenty-four (24) years at the Mount Vernon Developmental Center, Mount Vernon, Ohio. Since January 3, 1988 the Grievant and Margaret Hoar, another TPW, have worked the first shift in Washington Cottage, which houses sixteen (16) clients. The Grievant's primary responsibilities were eight (8) male clients and Hoar's responsibilities involved the primary care of eight (8) female clients. In light of the events which unfolded on November 5,1988, the testimony of the Grievant, Hoar and Ann Crouse, a licensed practical nurse, LPN, are critical in resolving the dispute between the parties. Since Crouse's testimony is relied upon by the State, in its effort to prove the charge of resident neglect--failure to act, against the Grievant, I believe it is useful to set forth her testimony first with regard to the relevant events of November 5,1988.

Crouse had been employed by the Mount Vernon Developmental Center for twenty-five (25) years, the last twenty (20) of which she had served as an LPN. During the morning of November 5,1988, at approximately 8:40 am. Crouse was in the nurse's office in Washington Cottage when she heard a commotion in the dining room. She left the nurse's office and went to the dining room where she observed V., a client, sitting at a table and banging her head at least two (2) times against the table. According to Crouse V. stopped banging her head when she saw Crouse "coming". Crouse testified that she asked both the Grievant and Hoar who were present in the dining room "what was the matter with V?" According to Crouse, the Grievant said, "ignore her and she will stop that". Crouse said that the Grievant made the statement after she (Crouse) saw V. hitting her head against the table.

Crouse said that she turned around and headed back to her office to get a pair of white mittens to place on V.'s hands. Crouse added that V. had a habit of biting herself; and if the white mittens were placed on her hands they would prevent V. from injuring herself. Crouse went on to state that in the past, V. has stopped her "behavior" when she saw the white mittens.

As Crouse approached the door to her office, she heard V. "just throw herself out of the chair". By Crouse's account, she thought that V. was going towards the outside door. As a result, Crouse went into her office but could not find the white mittens. She quickly went to the medical room to get 4 x 4's or "bandages". As Crouse indicated, she "has a habit of picking up the bandages because there was a chance that if [V.] strikes the back of her head", she would cause bleeding. Crouse testified that she proceeded to the T.V. room because she could hear the noise in there. When she entered the room, she observed that the Grievant and Hoar had V. on the floor and V. was bleeding from a wound in the back of her head. She indicated that V. was then taken to the couch close to a window where she (Crouse) treated her.

Elaborating on the incident, Crouse said that she had just walked into the dining room when the Grievant told her not to interfere with V. She added that this occurred before V. knocked the chair down and "scooted away". Crouse then went on to say that she walked away when she saw V. go towards the wall and that is when she went for the white mittens. Crouse also said that she did not observe the Grievant's conduct after she told her (Crouse) not to interfere.

I turn to the Grievant's account of the events of November 5, 1988. During the morning of November 5 the Grievant indicated that she was in the kitchen setting up for breakfast when she heard V. screaming in

the dining room. She and Hoar went to the dining room to see what was wrong. While V. was screaming Crouse entered the dining room from the nurse's station to ask what was going on. The Grievant told Crouse to ignore her and that V. settles down on her own. At the time that she made the statement to Crouse, the Grievant said that V. was not doing anything abusive at the time. The Grievant went on to state that while V. was screaming, she or Hoar told her to stop it, after which V. hit her head against the table. Again she was told to stop it. According to the Grievant, V. upset the chair that she was sitting on by pushing the chair backward and while she was on the floor she started “scooting” towards the door. The Grievant and Hoar followed her towards the door when according to the Grievant, V then jumped up and ran towards the living room. The Grievant added that when V. approached the door she hit her head against the door. While running out of the room, the Grievant and Hoar were directly behind her and V. entered the T.V. room. She jumped onto the couch, and banged her head against the wall. V. then threw herself on the floor. At this point, the Grievant and Hoar tried to get V. into a hold. The Grievant said that this is the first time that she and Hoar could apply a hold to her because they were close enough to her. Since she and Hoar knew that V would try to hit her head against the floor, Hoar put her hands behind her head as the Grievant got hold of V.'s shoulders and hands. The Grievant then saw V.'s head bleeding. She believed that the bleeding was caused by hitting her head on Hoar's ring as Hoar had her hands behind V.'s head. At this point, V. ceased her aggressive behavior. The Grievant indicated that it was not unusual for V. to stop her aggressive behavior when she saw blood.

According to the Grievant, Crouse came into the T.V. room after V. was on the floor and under control. The Grievant added that Crouse then walked with V. to the window and they did not see any abrasions or any marks on V.'s forehead. However, a pre-existing wound to V.'s head resulting from an episode which took place when she banged her head against a bus window causing the window to crack, had re-opened on November 5. The bleeding came from the wound.

The Grievant said that Crouse was at the corner of the table in the dining room until V. went by her towards the T.V. room. After V. went by Crouse, Crouse went back to the nurse's station. At no time did Crouse assist the Grievant and Hoar until V. was under control in the T.V. room.

Hoar's account of events was similar to the version provided by the Grievant. Hoar indicated that they were setting up breakfast on November 5 when she heard V. yelling. When Hoar and the Grievant walked into the dining room, they observed V. screaming while holding onto her chair which she moved up and down. Hoar testified that when Crouse appeared in the dining room, the Grievant told her to stay out of it until V. calms down “which she usually does”. Hoar also indicated that while sitting at the table, she observed V. slapping her hand on the table. Hoar said when the Grievant banged her head on the table, she and the Grievant, started for her. V. turned her chair over and then scooted over to the wall and banged her head lightly against the wall. As V. was hitting her head lightly against the wall, she scooted towards the door, as Hoar got closer to her. Hoar continued her testimony by indicating that V. kept swinging her hands and kicking her feet as she scooted through the two doors and ran to the T.V. room. Hoar said that she and the Grievant intervened when V. was in the T.V. room on the floor. Hoar's version of the events that occurred in the T. V. room essentially tracks the Grievant's testimony. Hoar said that her hand was under her head and the Grievant had her in a hold on the floor. Hoar added that V.'s head might have hit her ring at the time which caused her pre-existing wound to open and bleed.

Effective March 3,1989, the Grievant was suspended for twenty (20) working days for “resident neglect -- failure to act”. In an order of suspension issued by the State to the Grievant on or about February 24, 1989 the disciplinary suspension of twenty (20) days was based upon the following:

“On November 5, 1988 at approximately 8:40 a.m. you observed a resident exhibiting self-abusive behavior and failed to intervened as required and by such failure, permitted the resident to injure herself. In addition, you instructed another employee, Ann Crouse, LPN, to ignore the self-abusive behavior of the resident * *.”

It should also be noted that Hoar received a twenty (20) day disciplinary suspension for the same charge of "resident neglect -- failure to act". Hoar filed a grievance protesting the disciplinary suspension which was carried to arbitration, where the Arbitrator issued a "directed verdict of not guilty”. It should be noted there

was no ruling on the merits by the Arbitrator.

DISCUSSION

The issue to be resolved by this arbitration is whether the Grievant has been suspended for just cause; if not, what should the remedy be?

EVENTS OF NOVEMBER 5,1988

The initial inquiry concerns a determination of the events of November 5,1988. The testimony of Crouse is at variance with the testimony of the Grievant and Hoar with regard to whether the Grievant told Crouse to “ignore” V. or “to stay out of it until V. calms down”, after or before V. hit her head against the table in the dining room. Crouse testified that upon entering the dining room she was told by the Grievant to “ignore” V “and she will stop that” after she observed V. hit her head against the table.

I am persuaded by the testimony of the Grievant and Hoar that Crouse was told by the Grievant to "stay out of it” until V. “calms down” before V. hit her head against the table. I have concluded that the testimony of Crouse is unreliable. At the pre-disciplinary hearing of Hoar, Crouse said that she attempted to restrain V. when V. scooted to the door and began hitting the back of her head. No such testimony was provided by Crouse at the Grievant's pre-disciplinary hearing which took place the day after Hoar's pre-disciplinary hearing, namely, February 10, 1989.

At the arbitration hearing Crouse acknowledged that she did not attempt to restrain V.; she said "I did not do it that day”. Moreover, Crouse went on to state that at the time she gave the statement she “confused two (2) different situations”. I find it extraordinary that Crouse could have confused two (2) different situations” in providing testimony at the pre-disciplinary hearing of Hoar that she attempted to restrain V. There is nothing in the evidentiary record to indicate that there was an episode involving V. that was similar to the episode that occurred on November 5,1988. Indeed, the events of November 5 are unique inasmuch as the events led to twenty (20) days disciplinary suspensions of the Grievant and Hoar. Moreover, Crouse acknowledged that she has never physically. restrained “V”. I find it nothing less than astonishing that Crouse indicated at Hoar's pre-disciplinary hearing that she attempted to restrain V. Even though Crouse recanted her earlier statements, I find her testimony unreliable and not credible.

Furthermore, Crouse said that she observed V. bang her head against the table, at least two (2) times. She further acknowledged that at Hoar's pre-disciplinary hearing she might have said that V. banged her head “at least one time”. In light of Crouse's statements at Hoar's pre-disciplinary hearing, I do not find the testimony of Crouse trustworthy as to the events that occurred on November 5, 1988.

I have therefore determined that the events of November 5, 1988 are based upon the testimony of the Grievant and Hoar which I find persuasive. In this connection, both the Grievant and Hoar were in the kitchen during the morning of November 5,1988. Upon hearing a commotion and notice coming from the dining room, they left the kitchen to see what was going on. Upon entering the dining room where they observed V. screaming. When V. was not banging her hands on the table she was holding on to her chair and “going up and down” with it. While V. was screaming, Crouse appeared in the dining room. She asked what was going on, to which the Grievant replied that she should ignore her since she would calm down or settle down as she (V.) usually does.

While V. was screaming Hoar told her to stop it. After V. hit her head on the table, she was told to stop it again by Hoar or the Grievant. V. then pushed her chair backward and began scooting on the floor towards the door. Both the Grievant and Hoar immediately pursued V. While scooting to the door V. was kicking her legs and swinging her hands. V. then banged her head lightly on the door several times. As the Grievant and Hoar got closer to V, she then scooted to the T.V. room where she jumped on the couch. While jumping on the couch, V. hit herself against the wall. V. then threw herself on the floor as the Grievant applied a hold on V's shoulders and hands while Hoar placed her hands behind V's head since they anticipated that she would try to hit her head against the floor. The Grievant and Hoar then noticed that V.'s head was bleeding.

At some point in time, Crouse entered the T.V. room. After the Grievant and Hoar secured control over V., she stopped resisting. The Grievant, Hoar and Crouse then walked with V. to the window where Crouse

treated the blood coming from V.'s head which apparently resulted from an opening of a pre-existing wound.

INDIVIDUAL BEHAVIOR PROGRAM

Inter-disciplinary teams are created to encourage growth and independence of clients. Such teams develops a formal program which take into account the psychological problems of the client. The plan that is reduced to writing by the inter-disciplinary team is called an Individual Behavior Program or an “IBP”. The IBP for V. consists of “background information” which indicates that V. is a "34 year old female with a medical diagnosis of seizure disorder”. The “predominant problematic behaviors” of V. include “severe temper outbursts marked by throwing self on floor, screaming, kicking, biting self on arms, banging her head and hands on objects and beating her thighs with sufficient intensity to badly bruise herself“.

The IBP also includes a plan of intervention to protect V “from physical aggression to self and objects essentially to protect her from self -abuse and self-injury”. The “procedure” for intervention contained in the IBP, in relevant part, includes:

“Staff will give V. one firm verbal warning to ‘stop’. If V. continues then the staff will apply one-or-more person basket-hold for a maximum of 5 minutes * *.”

A question was raised at the hearing as to whether the Grievant knew of V.'s IBP's procedure for intervention. Although the Grievant had not read V.'s IBP until after the events which led to the filing of her grievance, she had a “general understanding” of the IBP for V. It should be noted that the Grievant's responsibilities in Washington Cottage was the primary care of the male clients; Hoar had primary care of the female clients. The Grievant acknowledged that on the basis of hearsay she was aware of the procedure for intervention for V. She added that when V “becomes self abusive, we were to tell her to stop in a firm” manner, and if she continues her self-abusive behavior, “we were to put her into a two or more man basket-hold". A basket-hold consists of getting two (2) hands leaning against the person so that their arms are immobilized by lifting them upward and propping the client to be subdued on one's hip. There is no question but that the Grievant has been trained in "THAR" (therapeutic handling of aggressive residents) methods which include physical or manual holds. In order to avoid and deter self-abusive behavior by clients and to impose control over "disruptive situations”, TPW's are trained in THAR methods.

The State contends that the Grievant failed to comply with V’s IBP; the State also contends that the Grievant failed to intervene to stop V's self-abusive behavior in a timely manner.

The Grievant acknowledged that at her pre-disciplinary hearing, she disagreed with the IBP because it was not working. Hoar shared a similar view of V’s IBP. Hoar, in fact stated that Ranju Kapahi, PhD, who submitted V.'s IBP for approval, indicated that the IBP “was not working” for V. In any event, irrespective of whether the Grievant agreed with V.'s IBP, the relevant query is whether she followed the IBP on November 5. Hoar acknowledged that even though she felt the IBP did not work for V., she was required to comply with the IBP. Similarly, the Grievant was required to follow V's IBP on November 5.

Based upon the evidentiary record, I have concluded that the Grievant did not comply with V.'s IBP on November 5 because she was unable to do so by V.'s behavior. Thus she was excused from complying with V.'s IBP. As she testified, she followed V.'s IBP “the best that [she] could". The Grievant never got a basket-hold on V. on November 5. When the Grievant left the kitchen and went into the dining room on November 5, she found V. screaming and told her to stop. Screaming is a “usual occurrence”, the Grievant said and was not considered self-abuse. After V. hit her head on the table, the Grievant told her to stop. Immediately after the Grievant told V. to stop, V “upset the chair” by pushing it backward and began scooting on the floor towards the door. It should be noted that Hoar said that they started to intervene when she (Hoar) walked towards V. after she “upset her chair”.

While V. scooted on the floor towards the door, I have concluded that the Grievant and Hoar were unable to get a basket-hold on her. Moreover, they were unable to get a basket-hold on V when she reached the door and banged her head lightly against the door, inasmuch as V. continued to swing her hands and kick her feet. The only time that both the Grievant and Hoar were able to secure control over V. was in the T.V.

room after she threw herself on the floor and the Grievant applied a hold on her shoulders and hands and Hoar placed her hand behind V.'s head.

The Grievant indicated that she had not been trained to put a client in a basket-hold when a client is running. In her many years of service at the Mount Vernon Developmental Center, the Grievant has never had the occasion to place a client in a basket-hold. The Grievant admitted that by herself she was unable to place V. in a basket-hold position.

The testimony of Laurie Hankins, Unit Manager of the Mount Vernon Developmental Center is useful at this juncture. On cross-examination, Hankins was shown the Center's Policy and Procedure, effective January 26, 1988 on Restraint of Residents", Section 5.0 through 5.1.1.2 of the Policy and Procedure, which provides as follows:

"* * 5.0 PROCEDURE

5.1 General procedures applicable for all crisis, medical, and b al restraints.

5.1 1. Restraining techniques:

5.1.1.1. Shall not be used as punishment or for the convenience of personnel; and

5.1.1.2. shall be applied with concern for good body alignment and comfort of the resident when possible. * *"

Hankins said that the meaning of Sections 5.0 through 5.1.1.1. is that if a THAR hold is applied to a client, it is required to be performed with the least injury and least discomfort to a client as possible. If an employee applies a THAR hold improperly the possible consequences to the client are "bruising, wrenching a client's back"--in other words the basket-hold could result in "injury to a client". Injuries to a client could occur, Hankins added, if a client is kicking or resisting". Hankins "did not know" whether a basket-hold is to be applied to a client on the floor, or in a prone position. If a client is running away, Hankins said that the use of a basket-hold on the client "depends upon the position of the client". If the employee "catches up" to the client, Hankins "advocates" grabbing the client's arm rather than the client's hair; she added that force is not to be used. Hankins added that "the intent is to minimize injury and gain control of the client".

Hankins provided testimony on when an employee is to intervene with the use of THAR methods. She said that "any employee working has a good idea when self-abuse should be stopped". When Hankins was asked how does an employee recognize self-abuse, she replied "it is self-explanatory". She said that it is up to the judgment of the employee who observes a client slapping her hands on the table to determine whether such conduct is abusive. Hankins indicated that the judgment might be influenced by whether the client's conduct is "historically known" or whether there is knowledge that the client's "conduct will escalate". Asked specifically about whether a basket-hold should have been placed on V. when she slapped her hands on the table, Hankins said that the employee has "to know V--she smiles or vocalizes--it is an overall thing". Hankins then stated that "common sense" dictates when the client is self-abusive and must resort to a basket-hold.

In light of Hankins' testimony and the events that occurred on November 5, I have concluded that the Grievant exercised a proper judgment and "common sense" in attempting to intervene after V. banged her head against the table in the dining room. The Grievant was unable to intervene immediately after V. banged her head against the table because V. scooted along the floor and went towards the door where she continued to kick her legs and swing her hands. There was no training for employees to place a client in a basket-hold position when a client is scooting or running away from an employee. Furthermore, V.'s aggressive resistance at the door when she banged her head lightly several times while she kicked her legs and was swinging her hands made it impractical for the Grievant to place a basket-hold position on V. Indeed, to do so would not be consistent with "good body alignment and comfort of the resident", as provided in Section 5.1.1.2 of the Developmental Center's Policy and Procedure on "Restraint of Residents". An

attempt by the Grievant to apply a THAR method including a basket-hold could have caused a serious injury not only to V. but to herself, as well. Such an attempt by the Grievant would be inconsistent with the policy of minimizing injury and gaining control of the client. Based upon the evidentiary record I have concluded that the only time when the Grievant was able to exercise a manual hold on V. was in the T.V. room when both the Grievant and Hoar were able to gain control of V.

As I have already indicated, when the Grievant told Crouse to ignore V.'s behavior, V. was screaming. Inasmuch as the Grievant has contact with V. every day in Washington Cottage there is no need to intervene when V. is merely screaming. Such conduct does not constitute self-abuse.

It should be underscored that except for the opening in the pre-existing wound in V.'s head which occurred in the T.V. room, there is no evidence of abrasions or any mark whatsoever on V.'s forehead which she banged against the table and the door. The Grievant did not intervene when V. slapped her hands against the table in the dining room. As Hankins said, it is an "overall thing" and the employee "has to knew" V. I have concluded that the Grievant's failure to intervene at the time was motivated by "common sense". It did not constitute an abuse of the exercise of judgment.

These conclusions are supported by several other factors that are found in the record. Deborah Cox, an Activity Therapy Specialist II, has known V. "for years". She indicated that an employee must be very careful on how to approach V. with directions. In order to do so, an employee "must wear kid gloves". Pursuant to a request from an employee, V "will flip a table, or get under a table, bang her body and hands". Cox said three (3) persons are required to get a basket-hold on her. To avoid the basket-hold, V. gets under a table and makes an attempt to bang her head against an object.

The origin of the wound on V.'s head was caused by V. deliberately banging her head against the window of a bus. The window cracked caused an injury to her head, which was injured again on November 5, causing the wound to bleed. When V. injured her head in the bus, Cox said it took two (2) persons about one (1) or two (2) minutes to place her in a basket-hold position. Since V. resists being placed in a basket-hold, it usually takes two (2) or three (3) persons to place her in a basket-hold. Cox added that if a client is in a prone position, the employee should try to get the client into a sitting position. Cox also indicated that training on the application of the basket-hold position does not include applying the hold when a client is running. Cox's testimony merely reinforces the conclusion that in light of V.'s "predominant problematic behaviors", which were exhibited on November 5, 1988, the Grievant could not apply the basket-hold position on V. without the likelihood of causing injury to V. and/or herself until she did so in the T.V. room.

Furthermore, it is undisputed that on one occasion the Grievant observed Hankins' attempt to apply the basket-hold on V. but she was unsuccessful. At the time V. went under the table after which Hankins' walked away, according to the Grievant.

PRE-DISCIPLINARY HEARING

At the arbitration hearing the Grievant stated on cross-examination that she could have said at Hoar's pre-disciplinary hearing that "[she] was wrong for not intervening any sooner".

Carl R. Mackie, Labor Relations Officer at the Developmental Center, was the "pre-disciplinary hearing officer designee" for both Hoar and the Grievant on February 9 and 10, 1989, respectively. In his written report of what occurred at Hoar's pre-disciplinary hearing, in relevant part, he indicated:

"Ms. Anderson [the Grievant] stated that, maybe ignoring the residents behavior was wrong, but that in her opinion this approach was working and she didn't see anything wrong with it, as long as there wasn't any harm done * *."

I cannot conclude that the Grievant's statement at Hoar's pre-disciplinary hearing that "maybe ignoring the resident's behavior was wrong" or that she "could have said" at the pre-disciplinary hearing that she was wrong for not intervening sooner" constitutes an admission of guilt of the offense "Failure to Act/Client Neglect".

Based upon a close examination of the record established at the arbitration hearing, I have concluded that the Grievant first attempted to intervene after V. hit her head against the dining table. When V. did so,

the Grievant and Hoar began to walk towards V. and V. turned the chair over and scooted towards the door. The appropriate context for the Grievant's admission at the arbitration hearing was Mackie's written report which indicated that "maybe ignoring" V's behavior was wrong, but that in her opinion the approach was working and she didn't see anything wrong with it, as long as there wasn't any harm done". Emphasis added. Mackie's report goes on to state the following:

"Ms. Hoar's representative then asked Ms. Anderson why she thought it was best to ignore the resident's behavior. Ms. Anderson indicated she didn't want to see the resident get hurt, but one can not give her (resident) a direct command, because she (resident) will only increase her activity, and if left alone, the resident will many times stop what she is doing and so something else."

Thus, ignoring V's behavior when she was screaming, and banging her hands on the table is a matter for the exercise of judgment by the Grievant. The record warrants the conclusion that the Grievant's judgment was reasonable.

Hankins' testimony at the arbitration hearing which was not part of the pre-disciplinary hearing is illuminating on when it is incumbent for an employee to intervene to stop a client's self-abusive behavior. As I have already indicated she stated that "common sense" dictates when a client is self-abusive and when a basket-hold is to be applied. The exercise of "common sense" is influenced by the behavior of a client which is "historically known" and whether "we know it will escalate". Elaborating even further, Hankins said that it is an "overall thing".

Based upon the evidentiary record the Grievant's statements at Hoar's pre-disciplinary hearing were consistent with "common sense" and in light of her knowledge of V. and the type of conduct by an employee that might cause V.'s actions to escalate into self-abusive behavior. Thus, as the Grievant stated, there was no harm done, when the Grievant was screaming and banging her hands at the table. The Grievant also said at Hoar's pre-disciplinary hearing that "many times" if [V.] is left alone, she will stop what she is doing and do something else." I cannot conclude that the Grievant's judgment on November 5 was contrary to common sense or was unreasonable. As Mackie's report stated, in response to a question from Hoar's representative the Grievant said that "* * the first time she thought that the resident [V] might injure herself was when she [resident] jumped up and ran from the Dining Room area." The evidence supports the Grievant's judgment.

CONCLUSION

The dilemma faced by the Grievant on November 5 is only too apparent. The "damned if you do, damned if you don't" approach to intervention is reflected in the Developmental Center's policies. The Center's Policy, dated August 19,1988 on "Unusual Incidents" provides a definition of "Self-abuse" in Section 4.4.: "Deliberate action taken by a resident resulting in harm to himself /herself". Under the policy on "Resident abuse and/or neglect" dated August 19, 1988, "Resident abuse" in part is defined in Section 4.2.2.1 as: "Knowingly causing physical harm or recklessly causing serious physical harm to a person or by the inappropriate use of "physical ** restraint." Section 4.3 of the same policy defines, in part, "Resident neglect" as follows: "Purposeful or negligent disregard of the duty imposed on an employee by law, rule or professional standard and owed to a resident by that employee". Moreover, the policy dated January 26,1988 on "Restraint of Residents" defines Behavior restraints in Section 4.2 as follows:
"A systematic, planned intervention using restraints to reduce or eliminate inappropriate behavior in conjunction with the teaching of appropriate substitute behavior. Behavior restraints include all items or measures used to inhibit, control, or limit the movement or normal function of any portion of a resident's body. (5123-9-06 of the Administrative Code.)"

These definitions are balanced against the Center's Policy dated August 19, 1988 on "Resident Rights" which under Section 4.6 provides as follows:

"Each resident must be treated with consideration, respect and full recognition of his/her dignity and individuality * *."

There is also Section 5.1.1.2 of the policy on Restraint of Residents which I have previously alluded to. The Section sets forth that "restraining techniques * * shall be applied with concern for good body and comfort of the resident when possible.

Along with these considerations Hankins' testimony was useful in stating that "common sense" and the exercise of judgment by an employee determine when a basket-hold or another manual hold is to be applied to a client. I gather from Hankins' testimony that the discretion to be exercised by an employee is to be informed by historical knowledge of the client and knowledge of the of conduct that would provoke or escalate the behavior of a client so that it becomes self-abusive.

In light of the applicable policies, I cannot conclude that the State proved by clear and convincing evidence that the Grievant committed Resident Neglect -- Failure to Act. As I have established, the Grievant acted on the basis of an informed discretion. She did not intervene prematurely, and when V. began her self-abusive behavior, the Grievant followed V.'s IBP in the best possible manner given the circumstances. As I have previously concluded, the Grievant was excused from complying with V.'s IBP due to V.'s aggressive behavior. I have inferred that had the Grievant applied a basket-hold prior to V. entering the T.V. room on November 5, V. and/or the Grievant herself and Hoar could have suffered serious injuries. The evidentiary record warrants the conclusion that V.'s injury to her head occurred by accident and without negligence in the T.V. room.

AWARD

In light of the aforementioned considerations, the State failed to prove by clear and convincing evidence that the Grievant's was disciplined for just cause. The grievance is sustained.

Dated: January 15, 1991
Cuyahoga County
Cleveland, Ohio

HYMAN COHEN, Esq.
Impartial Arbitrator
Office and P.O. Address:
Post Office Box 22360
Beachwood, Ohio 44122
Telephone: 216-442-9295