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July 18, 2017

Redacted for Publication

OPINION AND AWARD

IN ARBITRATION PROCEEDINGS

PURSUANT TO A

COLLECTIVE BARGAINING AGREEMENT

In the Matter of a Controversy Between	)	
	)	
Santa Rosa Memorial Hospital, Employer	)	
And	)	Lead Nurse Duties
	)	
Staff Nurses Association, Union	)	

APPEARANCES:

For the Employer: Jason W. Kearnaghan, Attorney
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For the Union: Victor C. Thuesen, Attorney
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PROCEDURAL BACKGROUND

The above-referenced matter was processed through the grievance procedure contained in the collective bargaining agreement (CBA) between the parties. Remaining unresolved, it was submitted to final and binding arbitration. The undersigned was selected as the arbitrator by mutual agreement of the parties. The matter was heard on February 27, 28 and April 13, 2017 in Santa Rosa, California.

The parties raised no concerns about whether the matter was properly before the arbitrator or whether all steps of the grievance procedure had been met or waived. The parties were unable to agree on a statement of the issue in this matter.

Both parties were afforded full opportunity to present documentary evidence and to examine and cross-examine witnesses. Both parties were ably represented by their respective representatives. At the conclusion of the hearing, the parties chose to conclude their presentations by written briefs. Briefs were received on June 15, 2017 and the matter was submitted for decision.

ISSUE

The Union formulated the issue as follows:

> Does the hospital violate Article XVI, D.2, of the contract when lead nurses are given patient care assignments in order to satisfy the nurse-to-patient ratios set out in Title 22 of the California Administrative Code; and if so, what shall be the remedy?

The Employer formulated the issue as follows:

> Whether the Union has established that the patient assignments to lead nurses were not due to "unanticipated, incidental, and explainable" reasons and, therefore, violate Article XVI of the CBA and the 2008 arbitration award.

The arbitrator's formulation of the issue is as follows:

> Did the Employer violate the CBA and the arbitration decision of arbitrator John Kagel dated September 15, 2008 when it assigned patient care duties to lead nurses beginning in September 2015? If so, what is the proper remedy?

RELEVANT CONTRACT PROVISIONS

Agreement Between Santa Rosa Memorial Hospital and Staff Nurses Association – September 16, 2015 – September 30, 2017

Article III – Management Rights

The Hospital will retain and have exclusive right to exercise the customary functions of management, including but not limited to…the right to select, hire, promote, suspend, discharge, assign, supervise and discipline employees…to determine and change the size of, composition of and qualification of working forces…to assign duties to employees in accordance with the needs and requirements determined by the Hospital; and to carry out all functions of management – whether or not exercised by the Hospital prior to execution of this Agreement – subject only to provisions expressly specified in this Agreement.

Article VII – Compensation

I. Lead Nurse
   1. The Lead Nurse will be a member of the Association and shall be covered by the terms of this Agreement…
   2. The Lead Nurse will assume responsibility for clinical oversight of the unit where he/she works, consistent with the Lead Nurse job description.
   3. The Lead Nurse will be paid a six percent differential above his / her base rate of pay…

Article XVI – Patient Advocacy

C. Reasonable Belief Regarding Imminent Risks

If the Nurse reasonably believes that a real and imminent risk of injury, health hazard, or death exists to herself/himself, to other employees, or to patients will result if the Nurse carries out an order, direction, or assignment, the Nurse shall immediately contact her/his Manager/Director to explain her/his reasons, and to seek confirmation or modification of the direction, order or assignment.

2. If the Nurse performs the order, direction, or assignment under protest, no disciplinary action will be taken against such Nurse…

4. After the Nurse has explained her/his reasons and concerns, and if the Manager, Director, or Supervisor requires that the Nurse carry out the order, direction, or assignment, the Nurse shall document the pertinent facts leading to the circumstances which were the basis for her/his refusal to perform or performance under protest…The Nurse may use a form prepared by the Association, if she/he desires, but the requirements of this paragraph shall otherwise be met.

D. Issues Pertaining to Nurse Staffing

1. Staffing of Nurse positions in each department, on each shift, will be maintained at a level which enable Nurses to meet California state law and Title 22 patient care requirement regulations with regard to assessing patients and evaluating their plan of care…No questions or disputes of any kind relating to this paragraph shall be subject to the Grievance and Arbitration provisions of Article XX.

2. The Parties agree that SRMH will act in full accordance with California state law and Title 22 regulations regarding the Nurse to Patient ratios and Registered Nurse's role in patient care. When determining the Nurse-to-Patient ratios as specified by the DHS, only licensed Nurses providing direct care who have patient care assignments in each department will be counted in the Nurse-to-Patient ratio. There will be a designated Lead

Nurse for each shift in each department. However, the designated Lead Nurse for each shift in each department shall not be counted in the Nurse-to-Patient ratios/matrix. The designated Lead Nurse shall be considered in addition to the core staffing required to comply with mandated Nurse-to-Patient ratios. Matrices are available to Nurses upon request, and will be provided to SNA…The data, analyses and calculations utilized by the Hospital in creating and implementing its matrices shall not be subject to the grievance and arbitration provisions of this contract.

3. The Lead Nurse shall count in the Nurse-to-Patient ratios/matrix in the following departments: Pediatrics, Electrophysiology, ASC and Endoscopy.

4. There will be a Lead Nurse in the following departments, for designated shifts only, as follows: Angiocardiography (Days only) Operating Room (Days & PMs only) Peri-op (Days and PMs only).

5. Lead Nurse will assume responsibility for the following combined areas for each shift: Nurseries/Labor & Delivery/3 North.

6. When department census falls below 8 (eight) the Lead Nurse may have a patient assignment.

9. When a nursing department is staffed for any particular shift at a level less than specified by the department's ratios/matrix (in terms of staff and/or skill mix), the Lead Nurse, Shift Administrator, and Manager/Director shall, at the request of any one of them, confer at the beginning of the shift concerning:

   a. Setting priorities for patient care;
   b. The mobilization of resources from elsewhere in the Hospital to assist the staff in the department for the shift; and
   c. The ongoing plan for obtaining additional Nurses to meet the staffing matrix criteria for the shift.

Appendix H – Lead Nurse Job Description

Job Summary: Acts to promote the quality of patient care in the department/unit and serves as a role model for professional nursing practice. Utilizes direct patient care experiences to lead staff in providing safe, effective delivery of care. Coordinates clinical activities of staff to contribute to regulatory compliance and continuity of patient care.

Essential Functions:

1. Organizes clinical delivery of care
2. Effectively monitors expected clinical outcomes
3. Acts as a role model for team approach to deliver patient care
4. Assumes responsibility for personal professional development and practice
5. Delegates shift tasks to appropriate personnel
6. Responds to others in a timely manner and maintains accessibility
7. Attends bed control meetings
8. Ensures that patient acuity data is collected and forwarded appropriately
9. Anticipates and plans for admissions
10. Works with case managers in planning discharge/transfer

11. Determines patient care assignments based on clinical competencies, patient acuity and Title 22 regulations
12. Assesses competency of float, traveler and registry nurses
13. Utilizes chain of command to resolve issues
14. In collaboration with manager/shift administrator assures adherence to staffing criteria per Title 22 regulations, acuity data and matrix for current shift and anticipates/plans for next shift(s) as applicable

FACTS

The Employer, Affiliated with the St. Joseph Health System, is a General Acute Care Facility: Santa Rosa Memorial Hospital (SRMH) is staffed for approximately 270 beds. It is the only Level 2 Trauma Center from Sonoma County, California, north to the Oregon border. The hospital has sixteen patient care centers, including an operating room and an emergency room. SRMH is not allowed to divert patients arriving in ambulances "unless there is a facility failure," according to Chief Nursing Officer Vicki White.

The Association Represents Staff Nurses, Relief Nurses, Casuals, and Lead Nurses: The 680-member bargaining unit is composed of all licensed registered nurses in the facility below the manager level. Lead nurses, in some other facilities known as charge nurses, are in the bargaining unit. Traveler nurses are not in the unit, and are limited by the CBA to covering leaves of absence, temporary vacancies, and mandatory education absences of bargaining unit nurses.

Nurse shifts are typically twelve hours, although some units are staffed with eight-hour shifts. Nurses may volunteer to work overtime, but mandatory overtime is effectively banned by the CBA.

The hospital has faced staffing challenges in recent years. The parties differ in their explanations of the difficulty of recruiting and retaining qualified nursing staff. Sue Gadbois has been president of the Union since 1983. She testified that the major acute care competitors in the region are Kaiser, Sutter Santa Rosa, and Marin General. "Our wages are lower than [those hospitals]. And our benefit package is significantly lower than those other hospitals as well," she testified.

Jessica Jauregui is the hospital's director of human resources. She acknowledged that the hospital has experienced difficulty in recruiting nurses. "…We are competing for a select group of individuals with many hospitals and health care organizations in California and nationally, so it can be an issue of supply and demand overall," she testified. She also stated that it can be more difficult to recruit nurses in certain specialties, such as electrophysiology.

Ms. Jauregui also testified that a change in retiree benefits in the last contract negotiations caused many bargaining unit members to leave before the effective date of the change. Ms. Gadbois agreed with this assessment.

The parties' collective bargaining relationship has been tumultuous. The parties went without a signed agreement for three years, from 2012 - 2015. During that three-year period, the Union conducted five strikes of one or two-days duration each.

Lead Nurses Primarily Direct and Check the Work of Other Staff, But Also Perform Some Direct Patient Care: Lead nurses are charged with myriad responsibilities in this complex medical environment. [Employee A] has been a lead nurse in the labor and delivery unit since 2007. She is "responsible for the flow of traffic in and out of that unit," from 7:00 p.m. to 7:00 a.m., she testified. She added:

> Patients that come in to labor and delivery to have their babies, they need to be triaged. Whether they stay with us or whether they can return home. And then from there manage, with the nurses, their labor, and then moving them to postpartum…if the babies require higher-level care than normal newborn nursery, ICN [intensive care nursery].

She testified that, in labor and delivery, the staffing is supposed to consist of a lead and two staff nurses. When staffing is short, she is required to take a patient care assignment and still perform lead duties.

[Employee A] testified that, prior to August 2016, they had an on-call nurse ready to come in to work if needed. "If the census increased through the night to where I would need to take a patient," she testified, "I would at least take the patient, get the patient started, and then have that on-call person in in 30 minutes. And they…would take over the assignment for me."

She testified how having a patient impacts the remainder of her work:

> When I have to take a patient, I'm not readily available to my other staff nurses to resource them, if they need help. If things changed where I'm supposed to be the second nurse in a delivery room and sometimes I can't be there because I'm having to take care of my patient…I'm also the person that's responsible to make sure that 3 North has everything that they need to do what they need to do, and I can't resource 3 North as well because I can't be [verbatim] labor and delivery area.

Lead nurses regularly and routinely provide break relief for staff nurses working under them. They take care of the staff nurse's patients when he / she is on break.

Lead nurse [Employee A] also testified that she participates in efforts to get additional nurse staffing when needed. "I'll put calls out to co-workers to see if I can try and get somebody to come in," she stated, adding that "I have had discussions with my manager before I've made those telephone calls to make sure that…we're all on the same page…"

[Employee B] has been a lead nurse at SRMH since 2004. As of the date of her testimony, she was assigned to the oncology unit, 3 East. As part of her lead duties, she makes assignments and delegates duties. She assists staff on other floors when chemotherapy and transfusions are administered. The patient-to-nurse ratio on her floor is four-to-one, and patient census is typically 24 or 25. This translates into six or seven staff nurses and her, as the lead.

She testified that, in late 2016, she had direct patient care assignments about twice a month. When she did, she continued to perform her lead duties – "but my priority's to my patients," she testified.

Like [Employee A], she stated that she assists in trying to secure additional staffing. "We try to get people to stay over. It's tougher, since now they're 12-hour shifts." And because many nurses work full-time now, she added, "they don't usually want to work full-time plus."

Hospital Staffing Levels are Regulated by the State of California: Title 22 of the State of California's Code of Regulations contains robust requirements for hospital staffing by registered nurses. These detailed regulations set required nurse-to-patient ratios for various hospital units, such as critical care or labor and delivery. In addition, medical entities must establish a patient classification system and provide additional staffing based on patient acuity (the measurement of the intensity of care required by a patient).

The regulation addresses the issue of lead (or charge) nurses in the following paragraph:

> Nurse Administrators, Nurse Supervisors, Nurse Managers, and Charge Nurses, and other licensed nurses shall be included in the calculation of the licensed nurse-to-patient ratio only when those licensed nurses are engaged in providing direct patient care. When a Nurse Administrator, Nurse Supervisor, Nurse Manager, Charge Nurse or other licensed nurse is engaged in activities other than direct patient care, that nurse shall not be included in the ratio. Nurse Administrators, Nurse Supervisors, Nurse Managers, and Charge Nurses who have demonstrated current competence to the hospital in providing care on a particular unit may relieve licensed nurses during breaks, meals, and other routine, expected absences from the unit.

The regulation leaves it up to bargaining parties, in a unionized hospital setting, to determine whether and under what circumstances charge (lead) nurses may perform patient care. When they do

"engage in providing direct patient care," they may be counted in the required nurse-to-patient ratios under the regulation.

The Union Provides "Assignment Under Protest" Forms to Nurses and Lead Nurses Who Wish to Object to Lead Nurses Performing Direct Patient Care: According to association president Gadbois, the Union created an "assignment under protest" (AUP) form prior to 2004 and has been using it continuously ever since. She cited the language in Article XVI C.4 as the basis for the creation and use of the form. The form, with four copies, is made available to Union members who wish to protest their assignment or the conditions on their work unit. It begins with this preamble:

> As a patient advocate, in accordance with the CALIFORNIA NURSE PRACTICE ACT, this is to confirm that I notified you, the hospital or its representative, that in my professional judgment, today's assignment is unsafe and places my patients at risk. As a result, the facility is responsible for any adverse effects on patients or staff. I will, under protest, attempt to carry out the assignment to the best of my ability.

Section II of the form contains this partial sentence: "I/we am/are objecting to the aforementioned assignment on the grounds that." This is followed by a list of grounds. The first "grounds" is "Lead required to take patient assignment. (Please complete Section III)."

Section III of the form pertains to the number of hours the lead nurse had patient care duties, whether or not the unit was "scheduled to core" and "staffed to matrix/ratios."

The Union receives a copy of each form filled out by a nurse, and logs and files them at the union office. The Union also uses them as the basis for discussions with management about staffing concerns, including about the issues in dispute in this grievance. According to Ms. Gadbois, the hospital administration and the Union have been in "general" agreement about the number of occurrences of lead nurses taking patient assignments. But the Union's AUP forms occasionally identify incidents of lead nurse patient care that the hospital did not record.

Ms. Gadbois testified that, when she receives an AUP form reporting lead patient care of an hour or less, she does not record it.

Management witnesses confirmed that they receive AUPs from the Union documenting lead nurses performing patient care. They check those through department management, and revise their own data on lead nurse duties when appropriate.

The Union introduced a set of completed AUPs alleging "Lead required to take patient assignments." No testimony from any nurses or lead nurses who filled out these forms was offered.

In 2008, the Union Grieved the Use of Lead Nurses for Direct Patient Care and the Matter Was Decided by Arbitrator John Kagel: In 2007, the same or a similar issue was grieved by the Union and decided in a 2008 arbitration decision by arbitrator John Kagel.[1]

The issue in that case was identified by arbitrator Kagel as follows:

> Did the Hospital Violate Article XVI, Part D2, page 62, including Nurses designated as Lead Nurses in the ratio required by Title 22 of the California Code of Regulations; if so, what should be the remedy.

He wrote that the "remedy sought is Lead Nurses not be so counted."

The award cites contract provisions and summarizes the parties' positions. However, it does not recount the facts upon which the award is based.

Arbitrator Kagel finds, in his Discussion section, that the Hospital is required to "schedule its staffing so that they [lead nurses] are not included [in the Nurse-to-Patient ratio] and, implicitly, it is to have a scheduling system for its matrices and core staffing that reasonably does not do so." He goes on to write that the Union has conceded that "there are times when a Lead Nurse can, under the Agreement, have a patient assignment."

He adds that "there can be census or staff changes during a shift, or at the beginning of one if the provisions of Article XVI, D.11 do not resolve a staffing issue, and in such instances the Agreement does not bar a Lead Nurse from having a patient assignment if alternative staffing is unavailable."

The contract language, Arbitrator Kagel found, "is not plain, as [the Union] contends, as simply stating that a Lead Nurse will not have a patient assignment."

Arbitrator Kagel further outlines his thinking on the matter by stating that "the Hospital is barred from having either staffing matrices or core staffing which do not reasonably allow for Lead Nurses to be excluded from such staffing on other than an infrequent, incidental basis which can be explained due to an unanticipated fluctuation in census or available staff in a given situation."

Finally, in his Decision section, arbitrator Kagel finds the following:

[1] The Union cited the Kagel award in its grievance in the instant case, and both parties referred to it in their opening and closing statements. The award itself was in evidence. However, no testimony was in the record pertaining to the circumstances that led to the filing of that original grievance.

> The Employer does not violate Article XVI Part D.2 of the Agreement when a Lead Nurse is given a patient assignment to comply with California State mandated Nurse-to-Patient ratios provided that the Lead Nurse not be included in the Nurse-to-Patient ratio/matrix or core staffing and, provided, that the Nurse-to-Patient ratio/matrix or core staffing in a given unit allow for the exclusion of Lead Nurses from taking such patient assignments except on an unanticipated, incidental and explainable basis.

The Employer Proposed Changes to the Lead Nurse Patient Care Provisions in 2012 Negotiations, But Ultimately Agreed to the Union's Proposal of Continuing Current Language: In its opening proposal for changes to the "Patient Advocacy" article in the Agreement, the Employer proposed to modify Article XVI D.2. The proposed change to the agreement is underlined in the following excerpt:

> The designated Lead Nurse shall be considered in addition to the core staffing required to comply with mandated Nurse-to-Patient ratios, except that Lead Nurses may take a temporary patient assignment to facilitate patient flow due to unanticipated changes in patient census.

The Union rejected this proposal. On November 4, 2012, the Hospital modified its prior proposal, as follows:

> The designated Lead Nurse shall be considered in addition to the core staffing required to comply with mandated Nurse-to-Patient ratios, except that Lead Nurses may take a temporary patient assignment up to four (4) hours to facilitate patient flow due to unanticipated changes in patient census.

Association President Gadbois was at the bargaining table when the Employer presented these proposals. She recalled that the Employer's negotiator stated that they were offering this proposal to "deal with situations where either the census had increased or they did not have the staff." The Union rejected the proposal, according to Ms. Gadbois, "[b]ecause we considered that it essentially negated the language indicating that the lead nurse was to be in addition to the nurses required to meet the ratio requirements."

No one who represented the Employer at the bargaining table for the above-noted interaction testified at the hearing. However, Ms. Jauregui, the human resources director, stated that she was involved in behind-the-scenes meetings with the management bargaining team. The rationale of the proposal, according to her, was to "take the language in the arbitrator's decision and put it into the collective bargaining agreement." She recalled that the management proposals were ultimately withdrawn because "it wasn't necessary because it was already in the arbitrator's decision."

During the Period Before a New Contract Was Signed, The Union Filed an Unfair Labor Practice Charge About the Hospital's Use of Lead Nurses to Provide Patient Care: The charge was

filed on February 11, 2014 with the National Labor Relations Board (NLRB) Region 20. Among other claims, the charge claimed that the Hospital "significantly increased the frequency with which it assigned patients to Lead Nurses."

On April 30, 2014, the NLRB Regional Director issued a complaint and scheduled a hearing for August 12, 2014. The Hospital denied the allegation made by the Union. On September 30, 2014, the matter was settled. As part of the settlement, the Employer agreed to "return to the status quo frequency with which lead nurses are assigned patients as defined by the October 1, 2010 to September 20, 2012 collective-bargaining agreement, and as interpreted by the arbitration award dated September 15, 2008." The settlement goes on in relevant part, as follows:

> We will not assign lead nurses patients except on an infrequent, incidental basis due to an unanticipated fluctuation in census or available staff in a given situation, as interpreted by the arbitration award dated September 15, 2008 and as defined in the October 1, 2010 to September 20, 2012 collective-bargaining agreement.

The Incidences of Lead Nurses Providing Direct Patient Care Under Non-Excepted Circumstances Has Fluctuated Under the Current Agreement, But Has Generally Increased: Both parties have spent hundreds of hours documenting, analyzing, emailing, and meeting over the incidences of lead nurses performing patient care. While some differences arise in the actual data, the Hospital and the Union generally agree on how many times this has occurred. General agreement even exists on the proximate causes of each incident, although the parties differ on the underlying explanation for the documented events.

The following is the arbitrator's attempt to summarize vast quantities of data presented at the arbitration hearing on this issue. This summary emphasizes those factors the undersigned believes are relevant in reaching a finding in this case. To put the following figures in context, a management witness postulated that approximately 6500 shifts per month are worked by nurses at SRMH. Note that this is 6500 total shifts, not shifts worked by lead nurses. The number of shifts worked by lead nurses per month was not in evidence at the hearing.

The following table includes information for the period January 2016 through December 2016 only, since less information was presented for the period before and after that calendar year. It includes both the Employer's and the Union's estimates of the number of occurrences. It includes the average number of hours worked by the lead nurse performing patient care, based on data from the Employer. All data refer to patient care assignments outside of the allowed exceptions under the CBA.

Incidences of Lead Nurses Performing Patient Care	**Employer's #**	**Union's #**	**Average # of Hours Worked Per Incident (per Employer)**
January 2016	12	13	4.29
February 2016	12	15	5.83
March 2016	33	38	4.63
April 2016	28	34	4.91
May 2016	21	23	4.75
June 2016	34	41	5.81
July 2016	37	51	6.52
August 2016	27	27	5.64
September 2016	31	33	5.59
October 2016	34	36	5.22
November 2016	8	8	5.12
December 2016	21	24	3.29
Monthly Average 2016	24.83	28.58	5.13

The Union Filed a Grievance: On June 20, 2016, the Union filed a grievance, alleging a violation of the CBA, the Kagel award of 2008, and the settlement agreement of 2014. The grievance alleges that "the Hospital does not staff in such a way to permit it to consistently satisfy the Nurse-to-Patient ratio spelled out in Article XVI Part D.2." The grievance goes on as follows:

> The dispute addressed by this grievance has to do with the frequency with which the Hospital has included the Lead Nurse in the ratio since September 16, 2015…

As remedy, the Union sought a "monetary remedy for each occasion beginning September 16, 2015 on which the Hospital has breached the arbitrator's award or exceeded the historical average."

On July 29, 2016, the Employer denied the grievance. The denial letter cites steps the Employer was taking to eliminate instances of lead nurses being assigned to patient care duty.

On October 10, 2016, the Union appealed the grievance to binding arbitration. The appeal letter adds to the original grievance in demanding "an award of damages" on behalf of the Association and its members. It also states that the Association will ask the arbitrator to order the Hospital to "cease and desist from hiring, scheduling and other practices that result in violations of Article XVI Part D.2 of the CBA." It is that grievance that is currently before the arbitrator.

UNION'S POSITION

The burden is on the Hospital, the Union argues, to establish that it has complied with the Kagel award. It is for the Hospital to establish that each of the lead nurse patient assignments was "unanticipated, incidental, and explainable."

The Union contends that the Hospital is attempting to achieve through arbitration what it was unable to achieve through negotiations. The Employer's attempt to change the language at issue in this grievance, and their failure to do so, must be held against them in interpreting the language.

Every occasion on which a lead nurse was assigned patient duties because "core not scheduled" violates the Kagel award unless it meets the three Kagel tests. Leaves by nurses, such as those associated with pregnancy, illness or kin care should be "anticipated" by the Employer.

The Association's nurse witnesses established that the units are understaffed and that lead nurses are required to take patients on a regular basis. Management's own testimony confirms short staffing. Management's proposals during the last negotiations that were put into effect – such as a change in the retirement benefits and reduction in compensation for extra shifts – have contributed to the staffing shortage.

The Union asserts that the Management Rights clause does not override the explicit language on staffing and patient assignments in the CBA. The Hospital has breached XVI D2 and the Kagel award by making patient care assignments for lead nurses that are not "unanticipated, incidental, and explainable."

The Union requests that its grievance be granted.

EMPLOYER'S POSITION

The Employer contends that the assignments of patient care to lead nurses are in fact "unanticipated, incidental, and explainable." The Union has failed to identify what they consider to be too many occurrences. There is no numerical cap.

The Hospital argues that the number of occurrences must be placed in the context of the total number of shifts. Less than .7% of shifts include the assignment of a lead nurse to patient care duties.

All of the incidents identified by the Union resulted from unanticipated nurse absences and fluctuating patient census and acuity, the Employer asserts. Lead nurses are not included in staffing matrices and they are not taken into consideration when the Hospital makes core staffing decisions. Thus, the Hospital has complied with the CBA.

The Employer argues that lead nurses are assigned patient duties only as a last resort, and the Hospital has implemented measures to improve recruitment and retention.

The Employer contends that the Union's grievance completely lacks merit and should be dismissed.

DISCUSSION

The NLRB Settlement and Order of May 2014 Bear Little Relevance for the Instant Dispute: The Union appealed to the NLRB in 2014 with its claim that the status quo on lead nurse patient care had been violated by the Employer. Presumably, it chose that forum since the contract had expired, no new agreement had been reached, and the Employer declined to arbitrate grievances during that period. That is the Employer's presumptive right. The Board filed a complaint, and the parties settled the matter by requiring the Employer to return to the "status quo" in terms of the number of lead nurse patient assignments.

The Board and its regions derive authority from the enabling statute and precedent-setting Board decisions, not the parties' CBAs. The NLRB process focused on the number of occurrences as being the

relevant factor in defining the status quo. That may or may not be the relevant factor in a grievance arbitration on this issue.

The responsibility and authority of the grievance arbitrator is quite different from that of the NLRB. It is to evaluate the factual record through the lens of the parties' CBA and, in this case, a related earlier arbitration decision. As such, the unfair labor practice and subsequent settlement agreement have only marginal impact on this grievance arbitration.

Arbitrator Kagel's Award Has Binding Effect as an Interpretation of the Nurse Staffing Section of the Agreement: The issue presented to arbitrator Kagel in 2008 was, on its face, similar to the one presented in the instant case. However, it is difficult to compare the two cases. Arbitrator Kagel did not summarize the factual record in his award. He explained his thinking on the broader issues, but we do not know the fact pattern on which those thoughts were based.

The defined issue in the Kagel case was slightly different, but closely related, to the current one. In that case, the issue was defined as whether the Hospital violated the CBA by including lead nurses in the nurse-to-patient ratio set by the state statute. In the instant case, the issue is whether the Hospital violated the CBA by working lead nurses in patient assignments.

Despite this difference in the issues, arbitrator Kagel's findings and decision are highly relevant to this proceeding. The Kagel award is viewed by this arbitrator as controlling. Both sides here have acknowledged that the Employer is, since the Kagel award was issued, obliged to follow it. Both sides have focused on the three words – "unanticipated," "incidental," and "explainable" as being the key to the decision. Lead nurse patient care assignments are only allowed if they conform to these three conditions.

Arbitrator Kagel did not define these terms, or give examples of what type of circumstances would fit this definition. He left it to the parties to interpret his dictates. A primary reason why the matter, or a closely related matter, is back in arbitration is that the parties have not reached agreement on how to interpret or implement the Kagel award.

In this arbitrators' view, arbitrator Kagel has established a three-pronged test. In order to comply with it, and hence with the CBA, the Employer must assure that each instance of lead nurse patient care assignments meets all three criteria. My view, articulated in further detail below, is that the Employer has complied with the order to limit lead nurse patient care assignments to ones that are "unanticipated" and "explainable." Where it has not met arbitrator Kagel's test is in assuring that such assignments are "incidental."

Arbitrator Kagel did not define "incidental." He did note that the Union acknowledged some circumstances exist under which a lead nurse patient assignment is appropriate. In the instant case, that same acknowledgement was offered in Association testimony. That Union acknowledgment will help define "incidental" and impact the remedy ordered in the instant case.

It is the view of the present arbitrator that, at this juncture, the parties need a more directive award than the one issued by arbitrator Kagel nine years ago. This award will follow Kagel, but will be more detailed. It will define "incidental" and it will order an ongoing monetary remedy for future violations. It will also order steps intended to reduce the constant skirmishing over this issue and allow the parties to move on.

The reason that this award will build from, but go further than, the Kagel award is threefold. One, the undersigned reads the contract language as being unambiguous as to when lead nurses may perform patient care duties. Two, the Employer's bargaining proposals in 2012 are an important new development since 2008. And three, the Employer did not respond to arbitrator Kagel's 2008 award in a manner that would suggest that another award giving general guidance would be effective in resolving this dispute and allowing the parties to move on.

The CBA, Read as a Whole, Does Not Allow for the Assignment of Patients to Lead Nurses Except Under Certain Prescribed Circumstances: The management rights article does give the employer the right to "assign duties to employees in accordance with the needs and requirements as determined by the Hospital." This clause is relevant to the assignment of lead nurses to patient care duties. Under management rights, management also reserves the right to "determine and change the size of, composition of and qualification of working forces."

However, these management rights provisions clauses are modified by the all-important caveat – "subject only to the provisions expressly specified in this Agreement."

Beginning with the latter clause concerning the size and composition of the workforce, the Union was unable to point to any explicit provisions in the CBA that overrides or modifies this right. The Union, in its grievance, asks for a modification of the Employer's "hiring" practices. Much of the Union's presentation in arbitration called attention to what it considered understaffing. Yet the CBA, in Article XVI D.1, specifically excludes issues of staffing levels from the grievance procedure. The Union's role in expressing concerns about staffing levels is confined to advisory councils.

Moreover, the CBA Article XVI D.2 discusses staffing matrices, but clearly states that the "data, analyses and calculations utilized by the Hospital in creating and implementing its matrices shall not be subject to the grievance and arbitration provisions of this contract."

As a result, this arbitration award will not reach a finding on staffing levels and will not order any changes in the Hospital's staffing practices. It will also not analyze matrices and schedules or order changes in the way the Hospital creates and deploys staffing matrices.

The management rights article also includes the right to "assign duties to employees." But on this topic, the parties have agreed to explicit language about lead nurse duties elsewhere in the agreement. That language makes such assignments subject to the grievance procedure. While the management rights clause bestows a general right on the Employer to make assignments, Article XVI D.2 explicitly and in great detail modifies that right.

An analysis of XVI D.2 begins with the requirement for a "designated Lead Nurse for each shift in each department" that is not to "be counted in the Nurse/Patient ratios/matrix." Later sections make explicit exceptions in some departments altogether and in additional departments on certain shifts. Those "excepted" departments and shifts are not in dispute in this grievance. Another key exception is made for low patient census. A careful examination of the wording of section D.6 is critical to understanding the overall agreement on lead nurse duties.

Article XVI D.6 reads:

> When department census falls below 8 (eight) the Lead Nurse may have a patient assignment.

The Employer has argued in this grievance that the contract language creates, in essence, a lead nurse duty goal the Employer must strive for. It must create staffing matrices and schedules that arguably relieve the lead nurse of patient care duties, except under certain contractual exemptions. As long as a reasonable effort is made, the Employer contends, the CBA has not been violated, regardless of the outcome for the lead nurse. This argument, and the contention that all lead nurse assignments have met the Kagel criteria, is the heart of the Employer's case.

But the key to understanding the general rule (lead nurses should not provide direct patient care) is to examine the wording of the exceptions. In particular, the above-quoted section XVI D.6 makes clear that the lead nurse having "a patient assignment" is the issue here. To adhere to the CBA, both the initial staffing plan and the resulting lead nurse assignment must conform to the contract. The exception

described in XVI D.6 defines the general rule: except under the specific contractual exemptions, lead nurses are not to have patient assignments.

The Union Has Acknowledged, and the Kagel Award Affirms, that Exceptions Exist in Practice to the General Rule of No Direct Patient Care Assignments for Lead Nurses: Deviations from this contractual rule are conveyed by the tacitly and mutually agreed-to practices of the parties. The Union conceded several situations in which lead nurse direct patient care is permitted. Relieving staff nurses on their breaks is one such practice. The lead nurse job description identifies another area: "Acts as a role model for team approach to deliver patient care." The inclusion of this job duty strongly suggests that it is appropriate for lead nurses to provide some direct patient care as a way of modeling best practices for staff nurses.

Additionally, the Association president, in her testimony, conceded that she does not consider a lead nurse performing direct patient care for less than an hour to be a violation. When she receives a complaint from a union member about a lead nurse patient care assignment of less than an hour she does not even record it. Given Ms. Gadbois' long tenure in this role, and obvious authority to state the Union's position, I credit these statements as a recognition of a mutual practice.

The Kagel award follows along these same lines. It identifies exceptions to the rule of no direct patient care for lead nurses. Those exceptions are when the assignments are "unanticipated," "incidental," and "explainable." As noted in the above section analyzing the Kagel award, these guidelines were quite general and open to varying interpretations by the parties.

The Hospital's Bargaining Proposals of 2012 Must Be Construed Against the Employer's Interpretation of Current Language: The Union established with direct documentary evidence and direct testimony of a participant that the Employer attempted to modify the disputed Article XVI D.2 language at the bargaining table in 2012. The Employer has countered with hearsay testimony about what occurred in negotiations. The Employer did not offer a challenge to the legitimacy of the documents offered by the Union that record the Employer's 2012 proposals.

Both Employer proposals attempted to loosen, or provide further exceptions to, the contractual rules regarding lead nurse patient care duties. The wording in both proposals merely reinforces the above interpretation that the existing requirement concerns actual lead nurse duties, not just schedules or matrices. Proposal number one uses the phrase that a lead nurse "may take a temporary patient assignment" under certain additional circumstances. And proposal number two adds the clause "up to four hours" to further specify management's right to assign patient care duties to lead nurses.

Human resources director Jauregui, who met with the management bargaining team during the 2012 negotiations, characterized the Hospital's proposals as merely clarifying the Kagel award and inserting that clarification into the CBA. This characterization does not withstand scrutiny. The Kagel award, notably, did not put a time limit on lead nurse patient care assignments. It merely directed that they be "incidental." If Management had merely been attempting to put the Kagel award in the CBA, they would have proposed the insertion of the three key words.

Management attempted in 2012 bargaining, in its second and final proposal, to define "incidental" as equivalent to "four hours." The Union proposed to keep the current language in 2012. As part of the negotiations, Management withdrew its proposals to modify Article XVI D.2. The Employer's actions at the bargaining table indicated that it believed that the current language was too restrictive on management and that a more liberal provision should be inserted. The bargaining history from 2012 reinforces the arbitrator's view that the current language prohibits lead nurses from performing patient care except under carefully proscribed circumstances.

The Employer Has Established That Its Assignment of Patients to Lead Nurses is "Unanticipated" and "Explainable:" The record in this case is replete with extensive and sustained efforts by the Employer to secure adequate nurse staffing to meet its state-mandated ratios. Each incident of a lead nurse being assigned to perform patient care to satisfy mandated ratios was well-documented. Each one was explained, first to the Union and then to the arbitrator at hearing. In some cases, hundreds of phone calls were made to off-duty nurses in an effort to find a last-minute substitute. The Employer also made extensive use of non-represented traveler nurses, a practice that is allowed under the CBA on a limited basis.

Based on this record, the undersigned concludes that each of the lead nurse patient assignments was "explainable" in compliance with the Kagel award.

The Union made an extensive effort to challenge the Employer's practices on the basis that lead nurse patient care assignments were not "unanticipated." The Employer sets staffing levels based on historical trends of patient census, patient acuity, and expected nurse rates of absenteeism. The Union argued that the Employer should have planned more conservatively and scheduled more staff or placed more staff on-call in order to deal with all contingencies.

Management witnesses testified that the Hospital has a staffing plan that eliminates the need for lead nurses to take patient care assignments except under unanticipated circumstances. That testimony was credible and was supported by robust documentation.

The Union faults management's staffing plan. The Union has a right to do so. It was in the record that the Union's suggestions and input have been helpful to management in this regard. Union members have sometimes backed up their words with actions, such as lead nurses making phone calls to find replacement nurses. In the final analysis, however, it is management's right and responsibility to make hiring and staffing decisions. Nothing in the record indicated that the Employer abused that right to the degree that it rises to the level of a contract violation. The Employer has complied with arbitrator Kagel's requirement that lead nurses performing patient care be the result of "unanticipated" circumstances.

The CBA and the Kagel Award Have Been Violated Because the Employer Has Not Established that the Assignment of Patients to Lead Nurses is "Incidental:" The final Kagel test is that occasions when lead nurses perform patient care must be "incidental." The parties have primarily focused their debate in this area on the number of incidences per month. The Union sees an unacceptable rise in the number of such assignments. The Employer views this increase as a miniscule proportion of total shifts worked and therefore characterizes it as still "incidental."

The undersigned views the "incidental" criteria through the lens of the individual lead nurse. From that vantage point, this grievance is primarily a dispute about individual employee workload, not about overall hospital staffing.

The Union offered lead nurses who testified to the challenges of having a direct patient care assignment while at the same time continuing to perform lead nurse duties. Indeed, the lead nurse job description contains fourteen "essential functions," only one of which involves direct patient care. The witnesses indicated that those lead duties do not cease when their unit has a nurse shortage. Those duties become more difficult to carry out, they indicated, but they are still responsible for performing as a lead.

Management, in its testimony, made no effort to discredit this lead nurse testimony or debunk the general characterization that the lead nurse continues her lead duties even when assigned a patient load. No evidence was in the record that he or she is relieved of any responsibilities when so assigned.

A long- established practice exists of lead nurses taking patients for "incidental" periods of time. Staff nurse break relief and time to get a replacement nurse to the facility are notable examples of that. Beyond one hour, such an assignment is no longer "incidental." Inevitably, a longer assignment with primary patient care duties takes a lead nurse away from his or her other responsibilities. In essence, it requires her to do two jobs over an extended period.

As noted in the arbitrator's chart above, the average time for a lead nurse with a direct patient care assignment at SRMH in 2016 was 5.13 hours per incident. This goes well beyond "incidental," regardless of how often it happens or for what reasons. A typical lead nurse shift is twelve hours. The average per incident is almost half a shift. The Employer has violated the CBA and the Kagel award by assigning lead nurses direct patient care duties for one hour or more, except when explicitly allowed by the CBA.

The Remedy in the Instant Case Must Go Beyond the General Instructions Given by Arbitrator Kagel, without Retroactivity: Arbitrator Kagel, for whatever reason, chose to issue a decision that laid out certain general criteria. He did not order a monetary remedy. His award provided the Employer with an opportunity to correct its practices without incurring financial liability.

Arbitrator Kagel's award has not been a sufficient deterrent to the Hospital's contract-violating practices. This is due, perhaps, to the very general nature of his arbitral directions. It may also be due, in part, to the fact that no monetary remedy was awarded.

The instant award follows in the wake of the Kagel award. It follows many years and months of lead nurses continuing to perform direct patient care in violation of the CBA, despite the Kagel award. It comes after a bargaining round in which the Employer attempted to loosen the relevant contract language, only to settle for existing language. For all these reasons, this award will escalate the consequences of the continuing contract violation. It will impose a financial remedy for any future violations.

Despite all these aggravating factors, no retroactive remedy is in order, for two reasons.[2] One, the Union has not specified a retroactive remedy. The Union, in its grievance, asked for unspecified "damages" to be awarded to the Association and its members. It is not clear who, exactly, the Union believes has been damaged. Without a specific remedy request to evaluate and decide on, the arbitrator is reluctant to go down that path.

Second, the Employer is correct in arguing that the Union has focused on the frequency of lead nurse assignments, rather than the duration of those assignments. The Union has never articulated what it considers to be an acceptable number of lead nurse assignments per month. Because of this lack of specificity in the Union's demands, the arbitrator is unwilling to levy a back penalty on the Employer.

[2] Even had there been a calling for a retroactive remedy, it would not have extended any earlier than the filing of the grievance in June 2016. It would not have gone back to September 2015, as the Union requested. The CBA requires that a grievance be filed within twenty days of the event. Any remedy would begin twenty days prior to the grievance filing and go forward from there.

A "Make Whole" Prospective Remedy in this Case Requires that the Lead Nurse be Compensated an Additional Amount for Non-Incidental Patient Care Assignments: This decision orders a prospective remedy targeted for the lead nurses who perform the direct patient care duties in contravention of the CBA.[3]

Management has argued that it is already doing everything in its power to attempt to relieve lead nurses of patient care duties. Witnesses have credibly testified that management's goal is to reduce the incidences to zero. Nonetheless, the Hospital is a large and complex organization with many layers of management. While upper management may be directing certain behavior and practices, that does not mean that department managers are necessarily conforming. The arbitral requirement to pay a premium rate will focus management at all levels on making an even greater effort to avoid working lead nurses outside of contractual boundaries. Another way to view this is that paying the lead nurse what would have been paid to a fill-in staff nurse, in addition to the lead nurse's regular pay, will remove any financial incentive to violate the contract.

Management witnesses testified that, each time that a lead nurse takes a patient assignment, the Hospital makes a concerted effort to bring in a staff nurse to take that patient assignment. What follows is that, by its own admission, the Hospital is already prepared in each of those instances to spend the additional compensation dollars to relieve the lead nurse of a patient assignment.

The ordered remedy in this case is based on that understanding. Each time a lead nurse has an improper direct patient care assignment, management is ready to spend an additional nurse salary to remedy it. This arbitral order is that, if the Hospital is unable to find a nurse to relieve the lead nurse within one hour, the Hospital will pay the lead nurse an additional amount equivalent to what it would pay a staff nurse for coming in to work that day. This rate will apply to all hours worked by the lead nurse while she has a patient assignment, including the first hour.

To keep the remedy relatively easy to administer, the amount ordered is step five of a staff nurse II salary. While in some instances, the Hospital may have found a replacement nurse at a lower salary than this, in other cases that replacement pay would have been higher. This order is intended to be a typical salary for a replacement.

[3] If a remedy for staff nurses might also be appropriate, the Union has failed to articulate the basis for such an award. Therefore, this arbitral order will pertain exclusively to lead nurses.

The effect of this remedy on the Hospital is that it will pay no more than it would have paid had it achieved its stated goal of zero incidences of lead nurses taking patient care assignments. The effect on the impacted lead nurse is that he or she will be properly compensated for what is, at its core, working two jobs for an extended period.

The Union Must Modify Its "Assignment Under Protest" Form in Order to Effectuate the Ordered Remedy: The intended effect of this award on the parties is to put the lead nurse patient care issue on a business-like footing. It is intended to reframe this longstanding dispute as a workload issue. The award, if it is implemented in good faith by both sides, has the potential to effect an overall improvement in the relationship of the parties.

A critical component of "re-booting" this relationship is under the control of the Association. The Union's side of the equation is the AUP form and its use.

The Union is using its "Assignment Under Protest" form as a method of pressuring the Employer on staffing and assignment issues on a daily or weekly basis, particularly around lead nurse duties. Each time the form is filed by a staff nurse or lead nurse, it charges the administration with jeopardizing patient or worker safety. The form facilitates union members accusing management of endangering patient safety every time a lead nurse has an assigned patient. It also explicitly purports to absolve the lead nurse and other nurses on the unit of responsibility for anything that might go wrong with patient care on that shift. Use of the AUP form for this purpose creates a constant "cold war" atmosphere between labor and management.

The Employer's advocate indicated during the hearing that management believes that the AUP form is being improperly used for lead nurse patient care situations. The Employer points out that the mention of the form is in a different section of the agreement, not the section concerning nurse staffing and lead nurse duties. The undersigned agrees. The AUP derives from the section of the agreement entitled "Reasonable Belief Regarding Imminent Risks." In very strong and specific language, that section states that if the nurse "reasonably believes that a real and imminent risk of injury, health hazard, or death exists to herself/himself, to other employees, or to patients will result if the Nurse carries out an order, direction, or assignment," the nurse may notify management.

Nurse staffing, and the lead nurse provisions, are in a separate section of the agreement. Yet the AUP form, unilaterally devised by the Association, identifies lead nurses' patient care assignments as *de facto* cause for protest under the "imminent risk" section.

The Union made an evidentiary case for the lead nurse workload concern identified in this opinion and award. However, no evidence was presented indicating that patient safety was jeopardized in any way because of these improper assignments. There may have been some occasions when a lead nurse patient assignment resulted in a patient safety issue, but if so those were not in the record.

The current formulation of the AUP elevates each assignment of a lead nurse to direct patient care into a safety protest. This dynamic, in the opinion of the undersigned, is unhealthy for the parties and prevents them from moving forward to an improved labor-management relationship.

The grievance arbitrator has no authority, when the Union grieves an alleged contract violation by the Employer, to order the Union to take any particular action. However, the arbitrator does have the power to make an ordered remedy contingent on certain actions by the Union. That is the case here. The Union is free to reject the arbitrator's requirement that the Union modify the AUP form. However, by doing so, they would release the Employer from the arbitrator-ordered requirement of paying additional compensation when lead nurses perform patient care duties.

In order for its members to receive the additional compensation, the Association must demonstrate a revised view of the lead nurse patient care issue. By agreeing to modify the form, the Association will acknowledge that the assignment of patient care to lead nurses is fundamentally a workload issue, and not automatically a patient safety issue.

Nothing in this order precludes the Union from continuing to use a revised AUP form for a nurse to report a reasonable belief of imminent risk, including in specific cases of a lead nurse taking a patient assignment. The Union is also free to devise a different, less confrontational, method of reporting lead nurse patient care activity that may have been overlooked by the administration.

AWARD

1. The Employer violated the CBA and the Kagel Award when it assigned lead nurses patient care duties beyond one hour and beyond the contractually-prescribed and mutually agreed exceptions.

2. Prospectively, the Employer shall provide lead nurses additional compensation equal to the staff nurse II pay rate at the fifth step for all hours performing patient care outside of the contractually-allowed exceptions (specified in Article XVI D.3, D.4 and D.6) and mutually-agreed exceptions (such as providing break relief for staff nurses). No additional compensation is required for such assignments of one hour or less. In order for this remedy to be implemented, the Union must agree to # 4 below.

3. No retroactive remedy is ordered.

4. The Union shall modify its "Assignment Under Protest" form to remove "Lead required to take patient assignment" under Section II and remove the entire Section III.

Paul D. Roose, Arbitrator

Date: July 18, 2017