

UNITED STATES OF AMERICA  
**FEDERAL LABOR RELATIONS AUTHORITY**  
Office of Administrative Law Judges  
WASHINGTON, D.C. 20424-0001

<p>INDIAN HEALTH SERVICE, CROW HOSPITAL CROW AGENCY, MONTANA</p> <p style="text-align: center;">Respondent</p> <p>and</p> <p>MARCELLA A. KNAUB, Individual</p> <p style="text-align: center;">Charging Party</p> <p>And</p> <p>INDIAN HEALTH SERVICE, CROW HOSPITAL CROW AGENCY, MONTANA</p> <p style="text-align: center;">Respondent</p> <p>and</p> <p>MILLIE F. STEWART, Individual</p> <p style="text-align: center;">Charging Party</p>	<p>Case Nos. DE-CA-90532 DE-CA-90639</p>

NOTICE OF TRANSMITTAL OF DECISION

The above-entitled case having been heard before the undersigned Administrative Law Judge pursuant to the Statute and the Rules and Regulations of the Authority, the undersigned herein serves his Decision, a copy of which is attached hereto, on all parties to the proceeding on this date and this case is hereby transferred to the Federal Labor Relations Authority pursuant to 5 C.F.R. § 2423.34(b).

PLEASE BE ADVISED that the filing of exceptions to the attached Decision is governed by 5 C.F.R. §§ 2423.40-2423.41, 2429.12, 2429.21-2429.22, 2429.24-2429.25, and 2429.27.

Any such exceptions must be filed on or before **APRIL**  
**24, 2000,** and addressed to:

Federal Labor Relations Authority  
Office of Case Control  
607 14th Street, NW, 4th Floor  
Washington, DC 20424-0001

GARVIN LEE OLIVER  
Administrative Law Judge

Dated: March 21, 2000  
Washington, DC

UNITED STATES OF AMERICA  
**FEDERAL LABOR RELATIONS AUTHORITY**  
Office of Administrative Law Judges  
WASHINGTON, D.C. 20424-0001

MEMORANDUM

DATE: March 21, 2000

TO: The Federal Labor Relations Authority

FROM: GARVIN LEE OLIVER  
Administrative Law Judge

SUBJECT: INDIAN HEALTH SERVICE  
CROW HOSPITAL  
CROW AGENCY, MONTANA

Respondent

and

Case Nos. DE-CA-90532  
DE-CA-90639

MARCELLA A. KNAUB, Individual  
MILLIE F. STEWART, Individual  
Charging Parties

Pursuant to section 2423.34(b) of the Rules and Regulations, 5 C.F.R. § 2423.34(b), I am hereby transferring the above case to the Authority. Enclosed are copies of my Decision, the service sheet, and the transmittal form sent to the parties. Also enclosed are the transcript, exhibits and any briefs filed by the parties.

Enclosures

**FEDERAL LABOR RELATIONS AUTHORITY**

Office of Administrative Law Judges  
Washington, D.C.

OALJ 00-23

INDIAN HEALTH SERVICE, CROW HOSPITAL CROW AGENCY, MONTANA  Respondent  and  MARCELLA A. KNAUB, Individual  Charging Party  And  INDIAN HEALTH SERVICE, CROW HOSPITAL CROW AGENCY, MONTANA  Respondent  and  MILLIE F. STEWART, Individual  Charging Party	Case Nos. DE-CA-90532 DE-CA-90639

Kim Nicholson  
Counsel for the Respondent

Michael Farley  
Counsel for the General Counsel, FLRA

Before: GARVIN LEE OLIVER  
Administrative Law Judge

**DECISION**

Statement of the Case

The consolidated unfair labor practice complaint alleges that Respondent violated section 7116(a)(1) and (2) of the Federal Service Labor-Management Relations Statute (the Statute), 5 U.S.C. § 7116(a)(1) and (2), on or about December 14, 1998, by giving Millie Stewart and Marcella Knaub notices of termination during their trial periods and the option to resign. The complaint alleges that such action was taken because they each engaged in activity protected by the Statute.

Respondent's answer denied any violation of the Statute. Respondent asserted that the two probationary employees voluntarily resigned instead of being terminated for committing a medication procedure error involving a controlled substance. Respondent's prehearing motion to dismiss on jurisdictional grounds was denied by the Chief Administrative Law Judge.

For the reasons explained below, I conclude that a preponderance of the evidence does not establish the alleged violations and recommend that the complaint be dismissed.

A hearing was held in Billings, Montana. The Respondent and the General Counsel were represented by counsel and afforded full opportunity to be heard, adduce relevant evidence, examine and cross-examine witnesses, and file post-hearing briefs. The Respondent and General Counsel filed helpful briefs.<sup>1</sup> Based on the entire record, including my observation of the witnesses and their demeanor, I make the following findings of fact, conclusions of law, and recommendations.

### **Findings of Fact**

#### The Charging Parties

Millie Stewart and Marcella Knaub are Indian preference nurses who were recipients of scholarships sponsored by the Indian Health Service. They were previously employed as Registered Nurses at the Crow Hospital, assigned to the Med/Surg ward under the supervision of Nora Hayes.

Millie Stewart began her employment at the Crow Hospital as a probationary employee on August 31, 1998, and her employment continued until her termination/resignation on December 14, 1998.

Marcella Knaub was a probationary employee beginning on approximately December 18, 1997, until her termination/resignation on December 14, 1998.

#### Controlled Substance Procedures

Nurses at the Crow Hospital generally acquire medication, including controlled substances, by making use

1

Counsel for the General Counsel filed a particularly thorough brief. While, based on my examination of the entire record, I am unable to agree with many of Mr. Farley's proposed findings and conclusions, his professional representation in this proceeding was indeed commendable.

of an automatic medication-dispensing machine called a Pyxis machine. The Pyxis machine resembles a chest of drawers. There is a keyboard and computer screen located on the top surface of the machine. Nurses are each assigned access codes. By entering the access code and a patient's name and number, a menu of medications for that patient becomes available on the computer screen.

The nurse's request for a patient's particular medication will trigger the opening of a drawer in the Pyxis machine which contains the medication. The medication comes pre-packaged in a unit dose, which is the minimum amount available in that particular medication. When dispensing controlled substances, the computer screen on the Pyxis machine inquires whether the whole dose will be administered.

Agency policies and procedures require that any narcotic and/or controlled substance remaining after the initial administration of a fractionated dose of the unit dose must be disposed of ("wasted"). Wasting requires that the medication be disposed of in the presence of a witness and that records be annotated regarding the wasting. No fractionated doses of a drug are to be labeled with intended use for a patient during a shift.

#### Medication - Procedural Errors of Nurses Knaub and Stewart

On October 21, 1998<sup>2</sup> Knaub obtained for a patient from the Pyxis machine a one unit dose of Ativan, a mild, low-dose sedative, classified as a low-risk controlled substance. The machine dispensed 1 mg. of Ativan to her. The patient was scheduled to receive only 0.5 mg. during Knaub's shift, so Knaub split the 1 mg. unit dose of Ativan and placed the unused portion back in its original identified package in the patient's drawer in a medication cart maintained near the Pyxis. Knaub also initialed and attached a note, apparently to the patient's Medication Administration Record, indicating that the half-tablet of Ativan for the patient was available in the patient's medication cart drawer.

Millie Stewart was working the next shift. She discovered the note and the half-tablet in the drawer, still in the Ativan packet, confirmed that Ativan was the ordered medication, and administered it to the patient.

#### Notices of Separation

On December 14, Knaub and Stewart received notices of the termination of their employment during the probationary or trial period. The notices each indicated that the medication procedure error on October 21, demonstrated that "your performance has not been maintained at an acceptable level for retention beyond your trial period[.]"

The notice to Knaub indicated that by giving the additional dose of Ativan to another nurse to administer to a patient she failed to follow specific procedures in dispensing and administering this drug.

The notice to Stewart indicated that by accepting the dose of Ativan from another nurse, instead of directly from the Pyxis system, she had failed to follow specific procedures, thus creating a patient safety issue, as she could not verify that the drug had not been tampered with or contaminated.

### Practice

As noted, Agency procedures require nurses to obtain a unit dose from the Pyxis for each single dose and waste any excess quantity immediately thereafter. The testimony of five nurses of the Respondent reveals that it was a common practice for a nurse to obtain a unit dose of some controlled substances from the Pyxis and dispense the unit dose in multiple doses throughout the shift.<sup>3</sup> On occasion, the Pharmacy at the Crow Service Unit has instructed nurses to save for later administration the medication remaining in tubexes of controlled substances after the initial dose. Pharmacy did this when the supply of the medication was short or Pharmacy did not have time to restock the Pyxis. Janice Sauls, a nurse appointed by supervisor Nora Hayes to provide guidance and orientation for newly assigned nurses, has instructed nurses that the practice of not wasting medication, and preserving doses of medication for later use, including controlled substances, was an acceptable

3

Nurse Olsen also testified as an expert witness regarding documents which were provided by the Agency in response to a subpoena duces tecum. Olsen provided five examples from the documents which reflect nurses maintaining possession of medication throughout their shift without wasting the excess medication after the initial administration. None of the examples cited by Olsen depicts a nurse passing controlled medication from one shift/nurse to another. Olsen testified that she was prepared to present 21 additional examples. Olsen did not provide any testimony that any of the 21 additional examples would show a passing of controlled medication from one shift/nurse to another.

practice at the Crow Hospital because it saves time. I find that the Respondent was aware of this practice since Hayes, the clinical nurse supervisor, also worked alongside the other nurses as a working nurse. Area Chief Pharmacy Officer Albert Fisher also acknowledged that the failure to follow proper wasting procedures "does occur in all facilities."

Although the practice described by the various witnesses is not in compliance with established Agency procedures, it involves a single nurse maintaining exclusive control and possession of medication throughout the shift.

This case involves the situation in which one nurse (Knaub) relinquished possession of a controlled substance to another nurse (Stewart) on another shift who then accepted the substance and administered it to a patient. The record does not establish that the conduct of Nurses Knaub and Stewart was a common practice known to management.<sup>4</sup> Nurse Susan Chase's testimony did not address passing medications from one nurse/shift to another. Nurse Olsen testified that she would "occasionally" pass a controlled substance, Tylenol with codeine elixir, to the next shift, but she did not pass solid controlled substances to other nurses. She stated that dividing doses for the use of her own patients did not compromise patient care, "Not when I didn't pass it to another nurse, I wasn't concerned." Knaub and Nurse Lucy Long cited single examples of passing a tubex of morphine to the next shift.

The record demonstrates that a practice of passing medications from one nurse provider to another could impact on contamination of the substance, infection control, poison prevention, ability to positively identify the substance, and the status of the Drug Enforcement Administration license issued to the facility.

4

Counsel for the General Counsel established that additional subpoenaed information should have been provided by the Respondent. Counsel requested, as a sanction for such conduct, that an adverse inference be drawn that "additional" information in support of this unfair labor practice charge exists. Based on the record, I believe it would be appropriate to find that "additional" information exists in support of nurses maintaining possession of controlled medication throughout their shift without wasting the excess medication after the initial dose, but not that "additional" information exists of one nurse relinquishing possession of a controlled substance to another nurse on another shift who then accepts the substance and administers it to a patient.

Millie Stewart - Employment and Protected Activity

During her employment at the Crow Hospital, Millie Stewart was assigned to the night shift, which was 7:00 p.m. to 7:00 a.m. Within approximately one week of beginning her employment at the Crow Hospital, on September 8, Stewart submitted a memorandum to her supervisor, Nora Hayes, and requested that her days off be scheduled during the months of October, November, and December 1998 to accommodate her need to attend graduate classes at the University of Wyoming.

Supervisor Hayes indicated in response that Stewart would have to use an exchange system, annual leave, or leave without pay since she had not accrued sufficient annual leave for this period of time.

Stewart was concerned that Hayes was not supporting her efforts to attend the graduate-level classes, so she contacted a Union representative, Jerome White Hip, and discussed her scheduling conflicts. The Union, through White Hip, requested Stewart to document her complaint by preparing a memorandum so that the Union could then pursue further action with management on her behalf.

On September 25, members of the Med/Surg nursing staff, through a memorandum to Hayes, requested Hayes to meet with them in order to address "several concerns and complaints." The requested meeting took place on September 28, and it was held in a nurses' conference room. In attendance at the meeting were Hayes and most of the nurses assigned to the Med/Surg ward, including Stewart and Knaub. Hayes was the only manager who attended this meeting. Also in attendance at this meeting were Michael LaForge, President of NFFE, Local 224, and White Hip, Union representative. The Union representatives were there in order to represent the employees. Hayes had been the Union president from 1992 to 1995.

At the beginning of this meeting, the employees presented Hayes with a document dated September 27, which set forth "several concerns and complaints" which they believed needed to be addressed immediately. This document was a group grievance under the negotiated grievance procedure. The original document presented to Hayes was signed by most of the nurses assigned to the Med/Surg ward (about twelve). The complaints were categorized under the following headings: unfair scheduling, granting leave unfairly, unprofessional conduct as a supervisor, and supervisor unaccountable for time. The employees also spent

considerable time discussing their problems with a fellow employee.

Within the employees' memorandum to Hayes, under the heading of "Unfair Scheduling," the following complaint was included: "You are uncooperative in arranging the schedule to allow staff members the opportunity to take training or classes to further their nursing skills and/or education, yet your schedule reflects several training/education days."

During the meeting, after reviewing the employees' memorandum, Hayes asked who had problems with scheduling. In response, Stewart stated that she had previously submitted a memorandum to Hayes indicating critical times that she needed to attend classes and had not received a response. Stewart also questioned why a co-worker had been accommodated by Hayes in order to attend classes, but that Stewart was not being given the same opportunity. Stewart also raised a complaint with Hayes over being assigned to the night shift and not being rotated to the day shift along with the other nurses.

Hayes was taking notes during the meeting and did not respond directly to these comments. When the employees mentioned at the end of the meeting that they were dissatisfied with its results, Hayes stated that they could take their concerns to the Union or, through the Director of Nursing, to the administration.

Hayes' demeanor during the meeting was described by Stewart as defensive, as evidenced by Hayes pointing at people and demanding additional details in a loud voice. However, Hayes subsequently recommended one of the employees, Georgia Buckingham, who raised an issue regarding the use of sick leave, for Employee of the Year, and Buckingham received the award.

Hayes subsequently made entries in the "communication book" which is a ledger notebook located at the nurses' station through which Hayes communicates with the nurses and the nurses communicate with each other. With respect to complaints raised by Stewart concerning the scheduling of leave and the rotation of shifts, Hayes made entries in the communication book concerning the method by which employees were to select holiday leave, and she stated that shifts are to be rotated every six weeks.

On or about October 5, Stewart submitted a "Request for Payroll Deductions for Labor Organization Dues" to LaForge, Union President.

On October 20-21, the medication errors occurred involving Stewart and Knaub, as described above.

On or about October 21, Karl Schlepp, a nurse assigned to the Med/Surg ward, prepared a Medication Error Report. The report reflected that it appeared from the records that Stewart had not administered the prescribed Ativan to the patient.

Approximately one week later Stewart was given a copy of the Medication Error Report. A note was attached from Hayes which indicated that the medication had not been given and cautioning Stewart to "check MAR [Medication Administration Record] frequently."

On November 12, Stewart delivered two memoranda to Hayes. The first memorandum was dated November 12, and was entitled "Scheduling Issues." Through this memorandum, Stewart complained about not being rotated from the night shift to the day shift. Stewart pointed out that she had been on the night shift since August 31, and that Hayes had previously promised to rotate nurses from one shift to the other every six weeks. Stewart also complained that the night shift was not adequately staffed, and she requested that an additional nurse be added to the shift. Stewart's memorandum to Hayes indicated that copies of the memorandum were provided to Robert Valandra, the Director of Nursing, and the Union.

The second memorandum, also dated November 12, was a reply to the Medication Error Report which Stewart had received. Stewart stated that she disagreed with the Medication Error Report, understood that the Pyxis could not be used to document medication errors, and asked for documentation to support the report.

On the morning of November 12, at the end of the night shift, Stewart met with Hayes at the work site. During this meeting, Stewart and Hayes discussed Stewart's complaint concerning shift rotation, and Hayes said that she would move Stewart to the day shift during January 1999. Stewart and Hayes also discussed the medication error. Stewart explained that she *had* administered the prescribed medication to the patient and had used the Ativan located in the patient's drawer.

Following this meeting, Stewart met with Oliver Half, Union Vice-President, and further discussed her complaint concerning scheduling. Around this same time, during mid-November 1998, LaForge spoke to Stewart concerning

management not rotating her to the day shift. Following this discussion, LaForge contacted Valandra and discussed Stewart's complaint that she was not being rotated to the day shift. Valandra advised LaForge that Stewart would be rotated to the day shift at the next schedule change.

On November 13, Hayes delivered a detailed memorandum to Stewart, with copies to the Union, in response to Stewart's complaint concerning shift rotation, and she also delivered a detailed memorandum to Stewart in response to the alleged medication error of October 21. In response to Stewart's complaint concerning staffing, Hayes stated that the floor was not short of staff and that "[t]here WILL NOT be another nurse added to the night shift schedule" for some time. With respect to Stewart's scheduling, Hayes stated that Stewart had been informed when interviewed for the position that it would primarily be on nights; that "I informed you that I DO the scheduling. This means that I have decided NOT to rotate as I had written in the memo book. I had initially agreed to do the rotation, but have reviewed the issues and have decided that this would not be in the best interests of the floor. I will be rotating you to a six week period of days . . . . in excess of what others receive. You are the newest hire. . . . [A] GS 9-1 is expected to be an experienced nurse . . . . If you feel you do not qualify as a GS 9-1, please contact me immediately. I will inform the DON and the personnel specialist and see what we can do to get you into an appropriate level of nursing." (Emphasis in the original.)

With respect to the medication error, Hayes stated, in part, that the Pyxis can be used to document medication errors, that Stewart's reply was not timely, but "an angry rebuttal . . . that did not state what was done that night." Hayes stated that based on the information she had received, the error "was inappropriate and a violation of policy and procedure."

Stewart's scheduling came up again near the Thanksgiving holiday. Initially, she was not scheduled to work on Thursday, November 26, the Thanksgiving holiday. Pursuant to the supervisor's procedures, Stewart had requested the Thanksgiving holiday off, and her request had been granted. On November 24, however, Hayes provided Stewart with a memorandum directing her to work on Thanksgiving night.

Stewart met with Hayes that same day, November 24, in order to discuss this scheduling change. During this meeting, which was held in Hayes' office, Stewart was accompanied by Lucy Long, Union steward. Valandra, Director

of Nursing, was also in attendance at this meeting. During this meeting, Stewart attempted to persuade Hayes to abide by the original schedule, and that Stewart not be required to work on Thanksgiving. Stewart presented Hayes with a copy of Article 21, Hours of Work and Tours of Duty from the collective bargaining agreement. Stewart argued that, pursuant to this contract provision, Hayes should have provided advance written notice of at least 10 work days prior to changing the Thanksgiving holiday schedule. Stewart stated that there was no emergency to justify the schedule change. In response, Valandra and Hayes stated that the contract provision did not apply to nurses, that Stewart had to work on Thanksgiving, and that if she did not work that day, she would be AWOL. Long inquired who the contract provision applied to if not to nurses. Valandra responded that he did not know, but it did not apply to nurses. Stewart subsequently worked on Thanksgiving as directed by management.

On November 20, Hayes requested the Director of Nursing to "release Millie Stewart . . . due to the judgment, the clinical thinking of giving an unknown substance to a patient." Hayes decided to give Stewart and Knaub a "procedural note" until she received further information from the Area Personnel Office and the Director of Nursing.

On November 30, Hayes approached Stewart who was working the night shift and said that she would like to discuss a "procedural note" with her. Stewart was uncertain what a procedural note was, but believed it involved a performance improvement plan, and refused to talk to Hayes unless she had Union representation. There were no Union representatives available at that time, so Hayes postponed the meeting until the following morning.

The next morning Stewart and Hayes met in Hayes' office. Stewart was accompanied by three Union representatives: LaForge, Union President; Half, Vice-President; and Long, Steward. At the outset of the meeting, Hayes presented Stewart with a procedural note and read the document to her. The document referred to Stewart's administration of 0.5 mg. of Ativan which had been saved for her use by Knaub. Hayes advised Stewart that, as a supervisory follow-up, she would have her shift changed to days and she would meet with a nurse educator concerning medication administration. Hayes also advised Stewart that she was to notify Hayes or the charge nurse when she dispensed any narcotic to a patient from the Pyxis machine. Hayes also advised Stewart that the procedural note would not be made a part of her employment file. Hayes did not suggest that Stewart would receive any form of disciplinary

action based on her administration of the Ativan on October 21. The procedural note stated that "progressive discipline to follow if this type of error occurs."

During the meeting, Half asked Hayes to provide him with a copy of the procedural note, and Hayes said that he would have to submit a written data request in order to get a copy. The Union representatives advised Stewart that the use of procedural notes had been abolished through an agreement between the Service Unit Director and the Union, and Stewart was advised by the Union not to sign the document. Although Stewart subsequently signed the document, the Union representatives who were present refused to sign.

On December 2, Stewart submitted a memorandum to LaForge which outlined her complaints in connection with receipt of the procedural note and other related matters.

Pursuant to the complaints raised with the Union, on December 1, the Union, through LaForge, submitted a data request to management seeking the release of all records generated by the Pyxis machine for the one-year period of December 1, 1997 through December 1, 1998. This request was submitted by LaForge to Tennyson Doney, Service Unit Director. A second data request, also dated December 1, 1998 was submitted by LaForge to Doney at the same time. Through this second request the Union was seeking the release of the procedural notes that were prepared by Hayes and were dated December 1.

In addition to submitting data requests to management, on December 1, Half and LaForge notified Nora Hayes that the Union had a complaint and was requesting data, and they also requested to meet with Doney.

A meeting was subsequently held in Doney's office on December 2, and it was attended by Doney, LaForge, and Half. During this meeting, Doney asked why the Union had three representatives at the meeting on December 1, and why they had "ganged up" on Nora Hayes. LaForge and Half advised Doney that they were considering pursuing an unfair labor practice, and Doney responded that he could pursue an unfair labor practice against the Union, too. Doney stated that he could not release the information requested concerning Pyxis records due to patient confidentiality. LaForge and Half asked if the information could be provided without the patient's name. Doney replied that it was against the law.

On December 14, Hayes asked Stewart to meet with her in a conference room at the work site. In attendance at

this meeting were Hayes, Valandra, Personnel Specialist Lori Old Bear, Stewart, and LaForge. Stewart was presented the letter of termination described above.

Hayes had signed the termination letter. Responsibility for the decision was shared with Valandra, the Director of Nursing. Crow Service Unit Director Tennyson Doney, Area Chief Pharmacy Officer Albert Fisher, and Area Nurse Consultant Rita Harding, were also consulted or engaged in discussions concerning the proper decision.

Stewart was advised that she could either resign or be terminated. Stewart attempted to speak to LaForge, but she was instructed not to speak to him. Stewart stood up to make a telephone call, but she was told by Valandra to sit down and not leave the room. Stewart asked if she could speak to LaForge privately, but her request was denied by Valandra. Stewart was presented with a form which she identified as a resignation form. Stewart turned to LaForge who indicated that she should sign the form. Stewart signed the form.

The next day, December 15, both Stewart and Knaub submitted similar letters to Doney indicating that they had been forced to resign. On December 16, Stewart and Knaub met with Sandy MacDonald, a Personnel Specialist, at the Billings Area Office. MacDonald discussed with them the option of resigning or being terminated. He explained that a voluntary resignation meant that there is no adverse inference regarding an employee's leaving in an employee's record. Termination, on the other hand, requires that the reason for leaving be stated and becomes a permanent part of the record. Following this discussion with MacDonald, both Stewart and Knaub confirmed that they would not rescind their resignations in lieu of termination. Stewart's and Knaub's resignations were effective on December 14.

Stewart was unemployed for six months following her resignation. She resumed employment with the Indian Health Service, at its Northern Cheyenne Service Unit, Lame Deer, Montana on June 21, 1999. The Northern Cheyenne Service Unit has a different nursing environment from the one Stewart was in at the Respondent.

#### Marcella Knaub - Employment and Protected Activity

Marcella Knaub was one of the nurses requesting the meeting with Hayes on September 28, 1998 and was a signatory of the group grievance, described above. During this meeting, Knaub complained that Hayes scheduled herself to work the floor when there was a staff shortage, and then

would not report to work unless there were 10 or more patients.

Knaub complained about the manner in which "low census" annual leave was being handled by Hayes. A practice had developed at the work site whereby a nurse would be given the opportunity to take leave if the workload, as indicated by a low patient census, would permit the nurse to be absent. The nurses had developed a rotation system to determine whose turn it was to take the "low census" leave, when it became available. It was alleged that Hayes was disrupting this rotation system by scheduling herself to work a shift, and then electing not to report for work if the patient census was sufficiently low. During the meeting, Knaub asked Hayes if the other nurses would be permitted to follow the same practice and simply call in to discover if they had to report to work, and Hayes said that would not be permitted.

Hayes replied to Knaub's complaint with an entry in the communication book. Hayes' entry in the communication book indicated that a nurse must first report to work before requesting "low census" annual leave.

On October 20-21, the medication errors occurred involving Stewart and Knaub, as described above.

On October 30, Knaub called Hayes on the telephone and requested leave for the following day in the event that the workload, due to a low census of patients, would permit her absence. Knaub had discovered that a co-worker had been permitted to take leave due to a low census of patients on October 30, and Knaub, who was next in the rotation to request such leave, expected that the same conditions would permit her to take leave on October 31. Knaub wanted to be able to confirm whether there was a the low patient census over the telephone and did not want to drive in to work the following day unless it was necessary. In response, Hayes reminded Knaub that as a result of the nurses' grievance meeting, nurses would have to report to work before receiving leave due to low patient census. Knaub subsequently reported for work on the following day, October 31. After she reported for work, Kaub who was on the day shift, observed Hayes reporting for work later in the afternoon in order to relieve another nurse prior to the end of her shift.

On November 1, Knaub was assigned to work the day shift, and during her shift she received a report from the charge nurse that a counselor, Karl Schlepp, had telephoned and been granted leave due to a low patient census without

having to report to work. Based on these events, Knaub concluded that she was being treated unfairly and that Hayes was giving preferential treatment to her co-workers.

On November 12, Hayes informed Knaub that Millie Stewart had reported that Knaub had given her half a tablet of Ativan for a patient. Knaub immediately acknowledged that this was true. In response, Hayes said that you know you are not supposed to do that, and Knaub said that all the other nurses did it too. Hayes said that you're just not supposed to do that, and that she could have Knaub's license taken away, but since she was a nice guy, she was not going to do that. According to Knaub, Hayes laughed and said not to do that again. Knaub agreed and said that she would not do it again, and the meeting came to an end.

On November 15, Knaub filed a written grievance against Hayes. The grievance was based on Knaub's efforts to receive leave on October 31 and November 1, and Hayes allegedly giving Knaub's co-workers preferential treatment in the administration of leave. On November 15, Knaub delivered a copy of the grievance to Valandra's mailbox at the work site, and personally delivered a copy to LaForge. Approximately two weeks after Knaub had delivered the grievance to Valandra's mailbox, she made efforts to retrieve the grievance from him. Knaub decided that Valandra was delaying a response to the grievance and wanted to send the grievance on to Duane Jeanotte, the Billings Area Director in Billings, Montana. When Knaub asked Valandra for the grievance back, he said he was in the process of preparing his response. (Valandra did finally provide a written response to Knaub's grievance, and delivered the response, which was dated November 17, 1998, to Knaub on December 14, 1998, the same day she resigned/was terminated.)

On December 1, following the conclusion of Hayes' meeting with Stewart, described above, Hayes met with Knaub for the purpose of discussing a procedural note with her. During this meeting, Knaub was accompanied by LaForge, Half, and Long as her Union representatives. At the outset of the meeting, Hayes handed Knaub a procedural note which addressed Knaub having received 1 mg. of Ativan from the Pyxis machine for a patient, and providing 0.5 mg. to Stewart for administration to the same patient. During this discussion, Hayes told Knaub that she was placing her on a performance improvement plan (PIP) for the alleged medication error. Knaub stated that she thought the matter had been resolved during their previous meeting on November 12. Hayes responded that Knaub was going to be on a PIP under the nurse educator for six months with respect to

medication administration. Knaub's procedural note stated that progressive discipline would occur if this type of error occurred again, and that the procedural note would not be a permanent part of her record.

During this meeting, Half and LaForge again took the position that the use of procedural notes had been abolished through an agreement between the Service Unit Director and LaForge, and they advised Knaub not to sign the procedural note. Knaub's signature, however, appears on the procedural note.

Following these meetings, on December 1, Knaub submitted a written grievance to LaForge concerning her receipt of the procedural note. As noted above, based on the complaints of Knaub and Stewart, the Union submitted data requests, notified Hayes of the complaints, and met with Service Director Doney.

On December 8, Knaub was working the day shift when she was called by Hayes at the nurses' station and told that she was to leave work at 1:00 p.m. that afternoon, and then report for duty later that evening at 7:00 p.m. to work the night shift. In response, Knaub stated that she did not want to work the night shift. Hayes said that the other nurse also did not want to work the night shift, and that she would have to work the shift. Hayes also told Knaub that she would have to work two additional night shifts that week. Knaub told Hayes that this was the weekend when she usually visited her daughter. Hayes replied that if she had any problems, to come talk to her.

Knaub immediately attempted to contact Union President LaForge, but he was unavailable. In LaForge's absence, Knaub contacted Union steward Jerome White Hip, who accompanied Knaub to Hayes' office where they resumed discussing her complaint over being assigned to work the night shift. Hayes told Knaub that she had to do it. Knaub worked the night shifts as directed.

On December 14, Valandra, Director of Nursing, handed Knaub his response to the grievance that Knaub had filed on November 15. In his response, dated November 17, Valandra stated, "Not all situations will routinely generate the same conclusion and therefore, I support the decisions my supervisors make." Valandra also stated, "If this is disagreeable to the inpatient nursing staff, we can take the option of not allowing 'low census' leave for anyone."

Later that same day, Hayes instructed Knaub to go to the conference room where she met with Hayes, Valandra,

Personnel Specialist Old Bear, and LaForge. LaForge was acting as Knaub's Union representative.

During the meeting, Knaub was advised of the letter of her termination which had been signed by Hayes. As was the case with Stewart, responsibility for the termination decision was shared with Valandra. Doney, Fisher, and Harding were consulted or engaged in discussions concerning the proper decision.

Knaub was informed that she could either resign or be terminated. Knaub turned to LaForge and asked what she was supposed to do, and she asked if they could talk. Valandra said that they could not talk. LaForge advised Knaub to just sign the paper and she did. The meeting then came to an end, and Knaub left the room.

As noted above, on December 15, Knaub and Stewart submitted similar letters indicating that they had been forced to resign, but following a discussion with MacDonald at the Billings Area Office on December 16, Stewart and Knaub decided not to rescind their resignations in lieu of termination. Their resignations were effective on December 14.

Knaub was unemployed until January 5, 1999. At that time, she was again employed by the Indian Health Service at the Northern Cheyenne Service Unit in Lame Deer, Montana. The Northern Cheyenne Service Unit has a different nursing environment from the one Knaub was in at the Respondent.

#### Other Medication - Procedural Errors

The parties stipulated that during the 3-year period between November 22, 1996, and November 22, 1999, there have been no instances of any employee of the Indian Health Service, Billings Area (which includes the Billings Area Office and eight Indian Health Service facilities in the states of Montana and Wyoming, and which employs approximately 1000 employees, including employees assigned to the IHS, Crow Service Unit), receiving any personnel action in the form of any counseling, written reprimand, suspension, removal action, or any like or related action (with the exception of Marcella Knaub and Millie Stewart), based on an act or acts similar to that upon which the Crow Service Unit, based its decision to terminate employees Marcella Knaub and Millie Stewart on December 14. Furthermore, the parties also stipulated that during the 3-year period between November 22, 1996, and November 22, 1999, there have been no instances of any employees of the Indian Health Service, Crow Service Unit, receiving any

medication error reports based on an act or acts similar to that upon which the Crow Service Unit, based its decision to terminate employees Marcella Knaub and Millie Stewart on December 14, 1998.

Doney, Fisher and Harding testified that they were not aware of any other instances where a health care provider had passed medication in the manner of Stewart and Knaub.

The record reflects other medication errors involving other nurses at the Crow Service Unit. On one occasion, on November 14, 1997, Hayes discovered a tubex of a controlled substance, morphine, in a patient's drawer. There were 6 mg. of unused morphine remaining in the tubex. The medication had been dispensed by the Pyxis machine to a nurse<sup>5</sup> assigned to the Med/Surg ward. The nurse had received a 10 mg. tubex of morphine and had been administering it to a patient 2 mgs. at a time, every 2 hours, but had failed to waste the rest. After Hayes discovered that the morphine had been left in the patient's drawer, she sent a memorandum to two employees. Through the memorandum, Hayes inquired concerning the morphine, but there is no evidence that subsequent medication error reports, counseling sessions, or disciplinary actions occurred as a result of the morphine being left in the patient's drawer.

On or about December 1, a permanent nurse<sup>6</sup> assigned to the Med/Surg ward at the Crow Hospital under the supervision of Hayes, committed a medication error that involved administering a medication intravenously that should have been administered through an intramuscular injection. This error could have caused kidney damage, liver damage, and a potentially fatal condition in which tiny clots form in the blood. In addition, on or about December 9, the same nurse committed another medication error that involved giving 4 doses of 15 cc's of Pediazole Suspension to an infant patient. The correct prescribed amount was 1.5 cc's, rather than the 15 cc's that was administered. This error raised the potential of extreme irreversible liver damage for the baby. The nurse involved has received more medication error reports than any of her co-workers, but has not received any disciplinary action such as a suspension from duty.

---

5

The nurse, not Stewart or Knaub, is identified in the hearing transcript.

6

The nurse, not Stewart or Knaub, is identified in the hearing transcript.

A probationary nurse assigned to the Med/Surg ward was involved in at least two medication errors during her probationary period. On or about February 23, 1999, the nurse over-dosed a patient by administering two Percocet tablets rather than the one tablet prescribed. Percocet is not a controlled substance. In addition, on or about November 16, 1999, the nurse was also involved in a medication error that resulted in an inability to account for 20 mgs. of Valium, a controlled substance. No disciplinary action, such as a suspension from duty, was taken against the nurse, a probationary employee, as a result of her actions.

### **Discussion and Conclusions**

Section 7116(a) (1) of the Statute provides that it shall be an unfair labor practice for an agency to interfere with, restrain, or coerce any employee in the exercise of any right provided by the Statute. Consistent with the findings and purpose of Congress as set forth in section 7101, section 7102 of the Statute sets forth certain employee rights including the right to form, join, or assist any labor organization freely and without fear of penalty or reprisal and that each employee shall be protected in the exercise of such right. Section 7116(a) (2) of the Statute provides that it shall be an unfair labor practice for an agency to encourage or discourage membership in any labor organization by discrimination in connection with hiring, tenure, promotion, or other conditions of employment.

#### The Authority's Analytical Framework

Under the Authority's analytical framework for resolving complaints of alleged discrimination under section 7116(a) (2) of the Statute, the General Counsel has, at all times, the overall burden to establish by a preponderance of the evidence that: (1) the employee against whom the alleged discriminatory action was taken was engaged in protected activity; and (2) such activity was a motivating factor in the agency's treatment of the employee in connection with hiring, tenure, promotion, or other conditions of employment. As a threshold matter, the General Counsel must offer sufficient evidence on these two elements to withstand a motion to dismiss. However, satisfying this threshold burden also establishes a violation of the Statute only if the respondent offers no evidence that it took the disputed action for legitimate reasons. Where the respondent offers evidence that it took the disputed action for legitimate reasons, it has the burden to establish, by a preponderance of the evidence, as an affirmative defense that: (1) there was a legitimate justification for its action; and (2) the

same action would have been taken even in the absence of protected activity. *United States Air Force Academy, Colorado Springs, Colorado*, 52 FLRA 874, 878-89 (1997); *Federal Emergency Management Agency*, 52 FLRA 486, 490 n.2 (1996); *Letterkenny Army Depot*, 35 FLRA 113, 118 (1990).

There is no dispute that Stewart and Knaub were involved in protected activity and that their actions were well known to management. Both Millie Stewart and Marcella Knaub engaged in extensive protected activity in the form of seeking Union assistance, pursuing grievances, and having the Union deal with Crow hospital management on their behalf. The General Counsel also satisfied the threshold burden of showing that consideration of such activity was a motivating factor in the selection process. This was shown by: (1) the closeness in time between the protected activity and management's decision, which may support an inference of illegal anti-union motivation, although it is not conclusive proof of a violation. *General Services Administration, Region IX, San Francisco, California*, 40 FLRA 973, 982 (1991); (2) the fact that Stewart and Knaub were active and aggressive in pursuing their protected activity and could have been considered a thorn in management's side. *United States Forces Korea/Eighth United States Army*, 11 FLRA 434, 436 (1983).

Although the General Counsel satisfied the threshold burden, the Respondent established an affirmative defense for its actions. The Respondent established, through the testimony of Hayes, Valandra, Fisher, and Harding, whom I credit in this respect, that it had a legitimate, nondiscriminatory justification for its action and that it would have taken the action even in the absence of the protected activity. The termination notices, resulting ultimately in voluntary resignations, were issued during the employees' probationary periods based on the uncontested fact that Ms. Knaub relinquished possession of a controlled substance, which was no longer definitively identifiable, to Ms. Stewart, who accepted the substance and administered it to a patient. The mishandling of the controlled substance was contrary to established procedures and potentially detrimental to the patient and the institution. Although management was aware of other medication errors by nurses, a preponderance of the evidence does not establish that management had knowledge of and acquiesced in comparable violations (transference of controlled medication between providers) by other probationary nurses and singled out Ms. Knaub and Ms. Stewart for release because of their protected activity.

I conclude that a preponderance of the evidence does not establish that the Respondent violated section 7116(a) (1) and (2), of the Statute as alleged. Based on the above findings and conclusions, it is recommended that the Authority issue the following Order:

**ORDER**

The consolidated complaint is dismissed.

Issued, Washington, DC, March 21, 2000.

---

GARVIN LEE OLIVER  
Administrative Law Judge



**CERTIFICATE OF SERVICE**

I hereby certify that copies of this **DECISION** issued by GARVIN LEE OLIVER, Administrative Law Judge, in Case Nos. DE-CA-90532 & DE-CA-90639, were sent to the following parties:

**CERTIFIED MAIL & RETURN RECEIPT**

**CERTIFIED NOS:**

Michael Farley, Esquire  
Federal Labor Relations Authority  
1244 Speer Blvd, Suite 100  
Denver, CO 80204

P168-060-162

Kim Nicholson, Representative  
Indian Health Service  
P.O. Box 2143  
Billings, MT 59103

P168-060-163

**REGULAR MAIL:**

Marcella Knaub  
P.O. Box 348  
Lodge Grass, MT 59050

Millie Stewart  
P.O. Box 1134  
Lame Deer, MT 59043

---

CATHERINE L. TURNER, LEGAL TECHNICIAN

DATED: MARCH 21, 2000  
WASHINGTON, DC