

NATIONAL LABOR RELATIONS BOARD

REGION SEVEN

In the Matter of:

OAKWOOD HEALTHCARE, INC.,

Employer

and

Case No. 7-RC-22141

INTERNATIONAL UNION UNITED  
AUTOMOBILE AEROSPACE AND  
AGRICULTURAL IMPLEMENT  
WORKERS OF AMERICA, UAW,

Petitioner.

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EMPLOYER OAKWOOD HEALTHCARE INC.'S BRIEF ON REVIEW

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## INTRODUCTION

Oakwood Healthcare, Inc. (“OHI” or “Employer”), by its attorneys, Dykema Gossett PLLC, and pursuant to Section 102.67 of the Board’s Rules and Regulations, submits this Brief on Review. On February 4, 2002, the Regional Director issued his Decision (“Dec.”), holding that the Employer’s charge nurses are not supervisors under the Act and directing an election in a bargaining unit comprised of certain registered nurses at Oakwood Hospital Heritage Center (“Heritage”). (Ex. A).

Before the Board on Review is the Regional Director’s determination that the Employer’s charge nurses are not supervisors within the meaning of Section 2(11) of the Act. Respectfully, this determination is in error. As the overwhelming evidence adduced at the hearing demonstrates, the Employer’s charge nurses assign and responsibly direct the RNs on their units, as well as all other nursing personnel. In light of the Supreme Court’s recent decision in NLRB v. Kentucky River Community Care, 121 S. Ct. 1861 (2001), there can be no reasonable question but that the possession and exercise of this authority confers supervisory status on the charge nurses.

## PROCEDURAL HISTORY

On December 21, 2001, the International Union United Automobile Aerospace and Agricultural Implement Workers of America, UAW (“Union” or “UAW”) filed a representation petition seeking to represent certain registered nurses at Heritage (one of four acute care hospitals owned and operated by the Employer). The representation hearing was held in this matter on January 9-11, 2002. At the hearing, OHI maintained that the registered nurses at Heritage working as charge nurses are supervisors within the meaning of Section 2(11) of the Act and are thereby excluded from a bargaining unit of registered nurses. The Union argued that none of the petitioned-for registered nurses are supervisors within the meaning of the Act.

OHI also maintained that the appropriate bargaining unit is a multi-facility unit consisting of all four of its acute care hospitals: Heritage, Oakwood Hospital and Medical Center-Dearborn (“Dearborn”), Oakwood Hospital Annapolis Center (“Annapolis”), and Oakwood Hospital Seaway Center (“Seaway”). The UAW contended that the petitioned-for single-facility bargaining unit limited to Heritage is appropriate.

The Regional Director’s Decision holds (1) that the Employer’s charge nurses are employees under the Act and includes them in the petitioned-for RN unit, and (2) that a single-facility bargaining unit comprised of registered nurses at Heritage is appropriate. On February 18, 2002, the Employer filed its Request for Review, and, on March 5, 2002, the Board granted review on the issue of the supervisory status of the Employer’s charge nurses. (Ex. B). The Employer submits this Brief on Review in order to more fully set forth its position on this issue.<sup>1</sup>

## FACTS

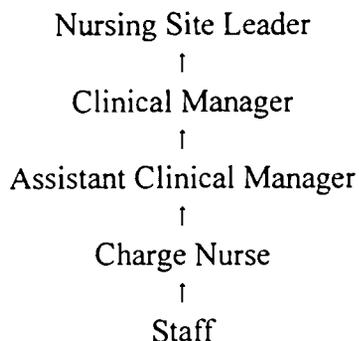
### **A. Nursing Department Structure**

For the most part, the Decision of the Regional Director correctly states the organizational structure of Heritage’s nursing department. As set forth in the Decision, Heritage is one of four acute care hospitals owned and operated by OHI, a Michigan corporation. (Ex. A, Dec. 2). Heritage is a 257-bed, licensed acute care hospital located in Taylor, Michigan. (Ex. A, Dec. 4). Brenda Theisen (“Theisen”), the Nursing Site Leader and Director of Patient Care Services at Heritage, has overall responsibility for all aspects of nursing care at Heritage and reports directly to Barbara Medvec, the Chief Nursing Officer for the entire OHI system. (Ex. A, Dec. 6).

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<sup>1</sup>For ease of reference, the Employer will refer to the record as “Tr. at \_\_\_.” Exhibits will be referred to as “ER-\_\_\_” (Employer exhibits), “P-\_\_\_” (Petitioner exhibits), and “JT-\_\_\_” (Joint exhibits).

Reporting directly to Theisen are Heritage’s clinical supervisors and clinical managers, along with various other non-nursing department heads. (Ex. A, Dec. 6). Below the clinical managers are assistant clinical managers, charge nurses, and other staff,<sup>2</sup> as indicated below:



As the Decision of the Regional Director recognizes, the responsibilities of the Nursing Site Leader, the clinical managers, and the assistant clinical managers do not include the day-to-day, hands-on supervision of the Hospital’s various nursing units. (Ex. A, Dec. 6-7). Theisen, the Nursing Site Leader at Heritage, spends only about thirty minutes per day on the nursing units and plays no role in directly supervising the nursing personnel responsible for providing care on the units. (Ex. A, Dec. 6). Heritage’s clinical managers (who work the day shift) each oversee the multiple nursing units and engage in virtually no clinical work, instead devoting the majority of their time to administrative concerns such as formulating policy, developing budgets, scheduling, and attending meetings. (Ex. A, Dec. 7). These individuals dress in street clothes, are paid on a salary basis, and, for all intents and purposes, have only the broadest oversight responsibility for their units. Similarly, assistant clinical managers also engage in little or no clinical work, instead functioning as “part of the management team” and sharing responsibility

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<sup>2</sup>“Staff” refers to all individuals who are supervised by charge nurses, including registered nurses (RN), licensed practical nurses (LPN), nursing assistants, mental health workers, emergency room techs, paramedics, and desk secretaries.

for the clinical managers' scheduling, budgeting, and other administrative duties. (Ex. A, Dec. 7).

Heritage also employs clinical supervisors (a.k.a. "house supervisors"). (Ex. A, Dec. 6). These individuals only work on the off shifts, i.e., afternoons, midnights, weekends, and holidays. (Ex. A, Dec. 6). Only one clinical supervisor is on duty on each such shift, and that person is responsible for the entire hospital, meaning both nursing and non-nursing areas. (Ex. A, Dec. 6). When on duty, the clinical supervisor is the highest-ranking administrative representative in the entire Hospital. (Ex. A, Dec. 6).

**B. Responsibilities of Charge Nurses**

*1. Generally*

Although the Regional Director concedes that the administrative responsibilities of Heritage's Nursing Site Leader, clinical supervisors, clinical managers, and assistant clinical managers leave them little time to engage in day-to-day supervision of the Hospital's various nursing units, the Decision fails to recognize the extent to which Heritage relies on its charge nurses to supervise its staff RNs, LPNs, nursing assistants, mental health workers, and others. Charge nurses cover all three shifts, seven days per week and, on off shifts, are the highest ranking nursing personnel on the nursing units. Charge nurses are paid a premium – \$1.50 per hour – for time spent in that role in order to compensate for "the stress of the job" and the fact that the charge nurse job "is a difficult job to do." (Tr. 102).

The Decision makes little mention of the broad, supervisory responsibility vested in Heritage's charge nurses. When asked about the expectations and the functions of charge nurses at Heritage, Theisen said:

. . . generally they oversee the unit for the shift that they are working with the staff who are working the unit that day. They do

the assignment of all the staff that are working on that shift. They monitor in general all the patients that are in the unit that day, are kind of front line to meet with Physicians if we have a Physician who has an issue with the Nurse or with a patient. They are the front line if we have a patient or a family member with a complaint.

(Tr. 74-75). Thus, on any given day, while clinical managers and assistant clinical managers are busy attending to the administrative concerns of their multiple units, charge nurses are responsible for ensuring the proper functioning of their individual nursing units.

Significantly, the Decision does not even mention the fact that, over time, several documents have been developed at Heritage to define the roles of the charge nurse. These documents were entered into evidence as ER-4 and ER-5(a)-(d) (attached as Ex. C and D respectively). Employer 4 is a draft hospital-wide Charge Nurse Policy. As the testimony established, ER-4 is a codification of previous charge nurse policies and practices in force at Heritage. Both ER-4 and the various longstanding charge nurse policies (ER-5) list similar expectations of the Heritage charge nurses, including the assignment and direction of staff:

- “Responsible for staff assignments, bed assignments, and breaks/lunches for staff” (Ex. C, ER-4);
- “Make daily patient assignments to RNs, LPNs and NA and Secretary” (Ex. D, ER-5(a));
- “Remember you are the first step in the chain of command” (Ex. D, ER-5(a));
- “Assign break times for all staff members and provide coverage as needed” (Ex. D, ER-5(a))
- “Assigns patient care assignments according to staff’s job description, competency, and patient’s acuity”(Ex. D, ER-5(b), 5(c));
- “Assigns coverage and delegates appropriate responsibilities for all unit nursing personnel” (Ex. D, ER-5(b), 5(c));
- “Assigns break/lunch periods” (Ex. D, ER-5(b), 5(c));

- “Determine patient care assignments for RN, LPN, GN, NE and NA with consideration to staff capabilities/competence” (Ex. D, ER-5(d));
  - “Assign RN coverage for LPN, NE and GN” (Ex. D, ER-5(d));
  - “Assign breaks and lunches to maintain adequate patient coverage” (Ex. D, ER-5(d)).
2. ***Charge Nurses Assign and Responsibly Direct the Nursing Staff and Do So With Independent Judgment***

The Regional Director devotes a significant portion of his Decision to an analysis of the charge nurses’ authority to assign and responsibly direct subordinate staff. The Decision correctly concludes that Heritage’s charge nurses are responsible for the assignment and direction of the RNs, LPNs, mental health workers, nursing assistants, and other personnel on the unit. (Ex. A, Dec. 11). **Moreover, the Decision recognizes that this responsibility includes assigning and reassigning staff to patients, assigning admissions, transfers, and discharges, assigning breaks and lunches, and assigning any additional unit-specific tasks that need to be performed during the course of a day.** (Ex. A, Dec. 13-15). Beyond this, however, there are a number of inaccuracies in the factual conclusions drawn by the Regional Director.

a. Charge Nurses Assign Staff to Care for Patients

The Regional Director appropriately acknowledges the primary responsibility of charge nurses at Heritage, which is to assign staff to patients at the beginning of a shift and to adjust this assignment as necessary. (Ex. A, Dec. 13). **The Decision further recognizes that, in making out the daily assignment, the charge nurse must consider various factors, including patient acuity, employee interest, employee ability, personality, and experience.** (Ex. A, Dec. 13). The way in which these factors influence a charge nurse’s decision-making process on a daily basis was explained by several witnesses. For example, Theisen described certain criteria considered by charge nurses in assigning staff to patients:

We have to look at the acuity and the competency of the Nurse, the staff that is working in the unit. If you have LPNs for instance there are certain things they cannot do and you have other things that RNs are required to do. You also have a mixed staff and that you may have staff that are working the unit who are not [ACLS] certified, you may have staff working in the unit who are pulled for that area from for instance monitored unit and they were pulled from a Med-Surg area so you have to make an intelligent decision about the competency of each of the staff working.

(Tr. 109). Similarly, Carol Carney, the assistant clinical manager for the Behavioral Health unit, described several considerations (in addition to patient acuity) that may play into the charge nurse's assignment:

- “For instance, if we have an aggressive male, then [the charge nurse] may want a male mental health worker to take care of him.” (Tr. 302).
- “. . . if it's a patient that has medical problems, [the charge nurse] might assign that patient to an RN.” (Tr. 303).
- “. . . if the staff has a good rapport with the patient, then that would be the staff that [the charge nurse] would assign, generally.” (Tr. 304).
- “. . . [the charge nurse] considers the patient's behavior from what she has gotten from report. She considers what staff might work best with those patients, taking their behavior into consideration. Like, if it was a female patient that was sexually preoccupied, she would give that patient to a female staff.” (Tr. 305).
- “Often, it's also a matter of their ethnic background. Even we have Arabic patients, so, sometimes, if we have an Arabic staff, obviously, [the charge nurse] would assign the Arabic staff to that patient so they can communicate back and forth.” (Tr. 307).

Likewise, Sue Caines, the clinical manager for Med/Surg West and Med/Surg East, indicated that charge nurses on her units must consider factors such as patient acuity and staff competency in making assignments. Caines further explained how charge nurses must use independent judgment in assessing and reacting to these variables:

I believe [the charge nurses] need to assign the patient care – assign patient care according to staff's job description, competency, and the patient acuity.

\* \* \*

As far as the staff's competency, again, I referred to sometimes we have pediatric patients, sometimes we have chemo patients, sometimes we have orthopedic patients that need special care and those that have had special training would be the ones you would want to have assigned to those patients.

And then the patient's acuity. You have to take that into effect, again, because you want a fair assignment. Some may have four patients. Some may have five patients, but it would still be a fair assignment based on the acuity of the patient or the needs that they're presenting that they need to have cared for. (Tr. 381).

The Regional Director recognizes that the role and responsibilities of the charge nurse in making staff assignments is well-documented in the Employer's policies. (Ex. A, Dec. 13). Specifically, ER-6 (Assignment of Patients) and ER-7 (Assignment of Nursing Personnel) (attached as Ex. E and F respectively) describe in detail both the charge nurses' role in assignment and the factors they must consider in doing so. ER-6 states:

- 4.1 B. Assistant Nurse Manager/Charge Nurse (assigned by the Nurse Manager) assigns/delegates care needs based on the ability of the patient to do self care, degree of illness, complexity of nursing skills required, and the competency and qualifications of staff.

ER-7 contains the following:

- II. C. Patient care assignments are made by the Clinical Manager or the Registered Nurse in charge for that shift. Assignment will be reviewed on an ongoing basis and changes made in response to the patients' changing conditions.
  - II. D. The assignment of the patient takes into consideration the acuity level and clinical needs as identified by the Acuity System and the clinical assessment by the Charge Nurse. The patient's acuity is used to determine the level of skill required to care for the patient.
  - III.B.1. The Charge Nurse will meet with the assigned staff to review patient condition and care activities to be completed for that shift.
2. Specific patient care tasks will be assigned based on competencies and classification of the staff, and care required.

As the Regional Director notes, Section III.C. of ER-7 sets forth detailed criteria that must be evaluated and applied when a charge nurse makes an assignment. (Ex. A, Dec. 13).

Even the two UAW witnesses, who went to great lengths to mischaracterize the life and death assignment decisions attendant to the care of critically ill patients in an acute care hospital as involving nothing more than viewing the Hospital's patients as a "pie" and mechanically dividing that pie up among the staff, were forced to concede on cross-examination that this is not the case. Thus, the testimony of both Employer and Union witnesses clearly establishes that charge nurses are responsible for using independent judgment in assigning and reassigning the nursing personnel on their units.

Despite extensive testimony on the intricacies of the assignment process, and despite his own recognition of the numerous factors to be considered by charge nurses in assigning patients to staff, the Regional Director improperly minimizes the import of this function, saying:

The assignment of staff nurses to patients is much more perfunctory in practice than the Employer's written assignment policy indicates. The assignment of work is generally rotated, or based on where a person worked the previous day. When making assignments as a charge nurse, reference is made to a staffing sheet showing where everyone worked the day before. It usually takes only a few minutes to do the assignments.

(Ex. A, Dec. 14). This statement is simply untrue and is based entirely on the testimony of one UAW witness, who testified only about the day shift in the Emergency Department.

Carol Welch, a UAW witness who works part-time in the Emergency Department, testified as to the manner in which she, an Emergency Room charge nurse on the day shift, assigns staff. Concededly, the assignment of staff in that area is quite different than in other areas of the hospital, particularly on the day shift. In the Emergency Department, a "geographic" assignment is possible, as the Department consists of a small geographic area and all patients are

presumed to be highly acute. And, as Welch admitted, the most common reassignment in the Emergency Department – from the Emergency Department to the “quick care” area and vice versa – occurs only on the afternoon and midnight shifts, so she would have no knowledge of such occurrences.<sup>3</sup> (Tr. 525-26). Thus, although the Regional Director’s description of the assignment process may accurately summarize the testimony of a single UAW witness, who based on her experience as a part-time nurse, was testifying about the functioning of the unique Emergency Department on a single shift, it was a crucial error for the Regional Director to extrapolate this process to other areas of the Hospital.

The Decision of the Regional Director also downplays the way in which charge nurses in the Intermediate Care Unit (“IMC”) assign patients to staff, saying:

When the nurses arrive for their shifts in the [IMC], they all listen to the report from the charge nurse of the previous shift. Then the charge nurse makes the assignments by asking who knows which patients have the highest acuity (these patients are referred to as the “completes”). They get a slip from the staffing office showing who is supposed to be there that day. The charge nurse then makes out the assignments. First, the completes are divided up evenly. After that, they look at who was there the day before, and try to give them the same assignment they had in order to maintain continuity.

(Ex. A, Dec. 14). This description of the allegedly blithe manner in which IMC charge nurses assign patients to staff flies in the face of the testimony of UAW witness Nancy Coffee, who admitted:

- That in assigning and reassigning staff, she considers factors such as patient acuity, employee workload, admissions, transfers, and employee skill. (Tr. 593, 602).

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<sup>3</sup>Moreover, Welch’s testimony was inconsistent with that of Debbie Vogel, the assistant clinical manager in the Emergency Department. Vogel testified that the Emergency Department’s charge nurses are responsible for assigning patients to staff (considering any variation in staff abilities), reassigning personnel between the main Emergency Department and the quick care area as needed, and assigning and/or covering breaks and lunches. (Tr. 465-67).

- That, when assigning staff to patients, she considers the varying skills and training of her staff. (Tr. 602-03). Specifically, when assigned flex pool staff or staff pulled from another unit, these individuals would “have to be [assigned to] someone who is not a cardiac patient and someone who is not on any drips like nitroglycerin or cardizone or any drips that they are not trained for.” (Tr. 602).

Thus, the Regional Director’s characterization of the assignment process in IMC as one involving little independent judgment is belied by even the UAW witnesses.

b. Charge Nurses Reassign Staff as Necessary

Although the Decision of the Regional Director appears to recognize that charge nurses commonly step in and reassign employees throughout the course of a shift (Ex. A, Dec. 13-14), the Decision incorrectly minimizes the authority of the charge nurses in this regard, saying:

Furthermore, RNs usually work together to help each other out, as a common courtesy of their profession. If RNs need help with a patient, they may go directly to another nurse and ask rather than going to the charge nurse.

(Ex. A, Dec. 14). Although it may be true that nurses are working with each other (as opposed to against each other), the fact remains that it is Heritage’s charge nurses who are **responsible** for making necessary reassignments. (Ex. A, Dec. 14).

In order to assess whether reassignment is necessary, the charge nurse must observe and evaluate how her staff are performing their assignments and anticipate any fluctuations in workload. If a staff nurse (or other nursing personnel) experiences a change necessitating reassignment (such as an unexpected admission, discharge, or change in patient acuity), she knows to approach the charge nurse and inform her of the changing circumstances. (Ex. A, Dec. 14). At that point, the charge nurse is responsible for assessing the situation and making an informed decision as to whether reassignment is necessary and, if so, what that reassignment should be. (Ex. A, Dec. 14). Nursing Site Leader Brenda Theisen explained how this process works in practice:

- Q. What circumstances might lead to this person becoming unhappy or a staff member becoming unhappy about an assignment?
- A. Could be the feeling that well maybe the Charge Nurse didn't really realize how heavy a patient this was going to be or something is going on with the patient that is new, maybe a new medication that is being ordered that is going to keep them tied up with a patient for a length of time and they don't think the Charge Nurse has given allowance for the amount of time that they are going to be tied up with that particular patient.
- Q. If that staff member complains to the Charge Nurse must the Charge Nurse change the assignment?
- A. No, they must make an intelligent decision about whether or not it needs to be changed though.

(Tr. 115-16). Thus, the fact that the nurses work together to adequately care for patients does not diminish the fact that it is the sole responsibility of the charge nurse to consider and decide upon any reassignment.

c. Charge Nurses Assign and Alter Employee Breaks and Lunches

The Decision of the Regional Director correctly recognizes that, in addition to the assignment of nursing personnel, Heritage's charge nurses also are responsible for assigning breaks and lunches. (Ex. A, Dec. 20). The Regional Director minimizes the import of this function, however, by saying that, ". . . the charge nurse generally sets up the break times in order to ensure coverage on the floor, and receives input from the nursing staff as to when they would like to take their break." (Ex. A, Dec. 20). This statement downplays the role of Heritage's charge nurses in the smooth functioning of the Employer's operation.

Like any operation, there are preferred times for breaks at Heritage, but because of the nature of an acute care hospital, the determination of break and lunch times is a matter of sound supervisory judgment and is not left up to individual staff members. As conditions change, the charge nurse retains both the responsibility and the authority to juggle breaks and lunches as

needed to ensure adequate patient care. (Tr. 250, 384). Moreover, when a staff member leaves the floor for a break or lunch, she is required to notify her charge nurse. (Tr. 315).

d. Charge Nurses Assign Other Tasks as Necessary

The record testimony demonstrates that charge nurses also are responsible for ensuring that certain tasks are completed on each shift, a fact that the Decision conspicuously fails to mention. Depending on the unit, these tasks may include completing narcotics counts, checking the “crash cart,” attending shift report and interdisciplinary rounds, and maintaining data on falls and restraints. (Tr. 91-95; Ex. C, ER-4; Ex. D, ER-5). With respect to each of these tasks, the charge nurse is responsible for either doing them herself or assigning them to another staff member. (Tr. 92). UAW witness Nancy Coffee explained how this works:

Q. Your assignment sheet. Those duties to be assigned listed at the bottom there, those are the duties that you assign as charge nurse, correct?

A. If the charge nurse does not have patients, she does them herself.

Q. Okay. And if the charge has patients, she assigns them to the other RN's?

A. Yes.

(Tr. 584). Thus, although the charge nurse may either do them herself or assign these tasks to other staff members, she is ultimately responsible for assuring that all of the tasks are completed on her shift.

e. Charge Nurses Are Held Accountable for the Performance of Their Staff/Units

The Decision of the Regional Director concludes that, “The RNs do not evaluate the work of the less skilled employees or ensure that they have completed a task or done so correctly.” (Ex. A, Dec. 20). Although it is true that charge nurses do not complete performance evaluations for other employees, the Decision is wholly incorrect in concluding that Heritage’s charge nurses

are not held accountable for the performance of their unit staff. Nursing Site Leader Brenda

Theisen testified as follows:

Q. As the Nursing Site Leader, as the person responsible for all the Nursing operations, who is the person in your estimation that is directly responsible for the day to day functioning of the staff on the Nursing units?

A. The Charge Nurse.

(Tr. 128). Assistant clinical manager Carol Carney also testified that she views the charge nurse as the person ultimately responsible for her unit's performance on a given shift:

Q. Once the charge nurse makes out the assignment at the beginning of the shift, does she maintain any kind of ultimate responsibility for seeing that everything gets done according to plan on the shift?

A. Yes, she does.

Q. And, as the assistant clinical manager, is she the one you'd hold responsible if everything didn't get done on a given shift?

A. Yes. (Tr. 319).

**Further, the Regional Director concedes that, in their annual performance appraisals, charge nurses are evaluated on their "leadership" skills and, specifically, on their performance as a charge nurse. (Ex. A, Dec. 10-11). This fact was acknowledged by the testimony of each and every witness at the representation hearing (including those witnesses called by the UAW).<sup>4</sup> For example:**

- Brenda Theisen testified that a nurse's performance as charge nurse is evaluated when determining whether that nurse has demonstrated "effective leadership." (Tr. 195).

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<sup>4</sup>Although one of the union's witnesses, Carol Welch, initially denied that her performance as charge nurse had ever been mentioned during the course of a performance appraisal, she was forced to admit on cross examination that this had, in fact, happened on more than one occasion. (Tr. 548-49; Ex. G, ER-15, 16).

- UAW witness Nancy Coffee admitted that her performance as a charge nurse has been discussed at her annual performance evaluations and figures into her “leadership” rating. (Tr. 589-90).

Clearly, the Regional Director’s factual finding on this point should have compelled a conclusion that charge nurses are held accountable for their performance in that role.

Finally, the Regional Director’s Decision ignores the fact that charge nurses can be disciplined for poor performance of their assignment function, and that this has, in fact, happened. (Tr. 98). When asked to give an example of this occurring, Theisen explained:

Staff from a unit [went to] the manager and complained that they didn’t feel as though the assignment had been done fairly, that some people were given a heavier assignment than others.

\* \* \*

The Nurse Manager met with the Nurse who had been in charge and reviewed the assignment, pointed out what was inappropriate about it, wrote it into a discipline.

(Tr. 98-99). Similarly, a charge nurse can be disciplined if she otherwise fails to perform those duties required of her as a charge. Theisen recounted one such example:

A. There was an example on one of our units on afternoon shift where the Supervisor was in a crisis situation in the ER and called to a Charge Nurse in a unit and said I need you to come or to send someone to the ER to help us we are in a crisis. And the person didn’t send anyone, turned around to staff and said oh, they are calling, they want somebody to go to ER, just kind of a general statement, didn’t assign anyone to go, didn’t go herself and there was a crisis that was a serious situation going on in the ER so there was a disciplinary action.

Q. Do you recall the level of the discipline?

A. It was a suspension.

Thus, charge nurses are held accountable if their assignments (or the performance of their staff) are not sufficient to ensure the completion of all necessary tasks on a shift.

### 3. *Charge Nurses Do Substantially Less Patient Care than Staff Nurses*

As the Regional Director recognizes, nearly all of Heritage's charge nurses take a substantially lighter patient load than that of a staff RN. (Ex. A, Dec. 14). However, the Regional Director fails to mention that many charge nurses take no patient assignment at all. Tellingly, the charge nurses themselves are responsible for determining whether they will take a patient load on any given day and, if so, how heavy that load will be. (Ex. A, Dec. 14). UAW witness Nancy Coffee admitted that, when functioning as a charge nurse, she is solely responsible for determining her patient load on a given day and, in fact, as charge nurse, she typically has a lighter patient load than the staff RNs on her unit. (Tr. 585). These facts should have compelled the Regional Director to conclude that Heritage's charge nurses, though working supervisors, do substantially less patient care than they assign to the staff RNs working under them.

### 4. *Charge Nurses Adjust Grievances*

In response to significant evidence establishing the role of charge nurses in addressing and resolving employee problems, the Decision says only, "There is no evidence that the charge nurses are empowered to adjust any *formal* employee grievances." (Ex. A, Dec. 19) (emphasis added). This superficial analysis reveals a fundamental misunderstanding of the role of the Employer's charge nurses.

At the hearing in this matter, the evidence clearly established that employee problems are regularly brought to and solved by charge nurses. (Tr. 117, 386-87). Theisen testified:

Q. If a Nurse had a problem with an Aide or an Aide had a problem with a Nurse and the two of them couldn't work it out according to how they might otherwise deal with each other, where would they take that problem?

A. To the Charge Nurse.

Q. And what would the Charge Nurse do in that instance?

A. They would try to facilitate resolution, whatever the problem was working with them to see if they can find out what was causing the problem and straighten it out. It might require reassignment of one of the Nursing Assistant[s], it might require just some direction, it might be just some problem solving on the spot.

Q. Would that same scenario hold true if the Staff Nurse was having a problem with another Staff Nurse on a given shift?

A. Yes.

(Tr. 117). When asked later by the hearing officer to give an example of how a charge nurse resolves disputes between employees, Theisen explained:

If a nursing assistant complains that someone isn't doing what they're directing them to do, for instance, they could come up to the charge nurse and say, well, I told this nursing assistant to do this and she refused to do it and I tried talking to her, would you go talk to her, and the charge nurse would get involved in it at that point. (Tr. 244-45).

The Decision of the Regional Director makes no mention of Employer Exhibit 8 (attached as Ex. G), the nursing Chain of Command Policy, which further describes the charge nurse's role in resolving problems on the unit. That document states as its objective "To provide a mechanism for the nursing staff to communicate and resolve issues and concerns," and sets forth a chain of command beginning with:

Nursing staff member communicates verbally and/or in writing of a concern/issue to **charge nurse** and/or Clinical Manager/Clinical Supervisor.

(Ex. G, ER-8) (emphasis added). When UAW witness Nancy Coffee was asked about the policy, she admitted its application and testified:

Q. If [a concern] is communicated to you, would you then do what is in the second step [of the policy], which is to take it to the next level?

A. **If I couldn't resolve it, yes.**

(Tr. 588) (emphasis added).

That the charge nurses are the “first line” in the chain of command and, in that capacity, hear and act on employee concerns about co-workers, assignments and similar matters is precisely what is contemplated by “adjusting grievances” under the Act. The Regional Director’s Decision improperly discredits substantial testimony on this point, choosing instead to conclude that Heritage’s charge nurses do nothing more than relay staff complaints to clinical managers or assistant clinical managers. This factual conclusion is simply incorrect.

5. *Other Considerations*

a. Charge Nurses are Provided Orientation and Training

The Decision of the Regional Director correctly recognizes that Heritage’s charge nurses are provided orientation and training:

RNs learn the responsibilities of a charge nurse through their education, and by initially working with a preceptor, or mentor. Preceptors will work along with the RNs as charge nurses until the RNs are able to perform the job on their own.

(Ex. A, Dec. 12). This statement fails to mention numerous critical facts.

In reality, each nurse hired in at Heritage goes through a general orientation, which includes specific training on functioning in the charge nurse position. (Tr. 234). After being oriented with respect to providing patient care, each nurse is “buddied” with a preceptor, who performs the charge nurse duties under the new nurse’s observation. (Tr. 237-38). Gradually, the preceptor hands over charge nurse responsibilities to the new nurse, who would perform these duties under the preceptor’s supervision. (Tr. 238). During this time, the clinical manager and assistant clinical managers observe the new nurse’s performance in the charge nurse role and evaluate her ability to function in the position. (Tr. 238, 301). In determining whether a nurse is ready to function in the charge nurse role, the managers consider various factors, including

“leadership qualities,” “judgment,” “problem-solving,” and “communication.” (Tr. 301).

Clearly, it is only when a manager is comfortable with and confident in a nurse’s ability to assume substantial responsibility that the nurse is allowed to assume the charge nurse position.

In addition to this hospital-wide charge nurse training, some units have put in place more formal programs and/or established written tools to evaluate an individual’s ability to perform as a charge nurse. For example, Carol Carney, the Assistant Clinical Manager for Behavioral Health, testified that, on her unit, several training sessions were recently conducted to educate staff RNs on their duties and responsibilities when rotating through the charge position. (Tr. 298-99). Sue Caines, the clinical manager of Med/Surg East and Med/Surg West, testified that her predecessor utilized written documents, entitled “Checklist for Charge Nurse Orientation,” to assess her nurses’ ability to perform in the charge nurse role. (Tr. 396-97; Ex. H, ER-14). These checklists were completed for most of the RNs currently working under Caines on these two units and remain in their files to this day. (Tr. 397-98; Ex. H, ER-14).

b. Staff-to-Supervisor Ratios

The Decision of the Regional Director also dismisses out of hand the facts relevant to the supervisor to employee ratio, without so much as a mention of the data presented. ER-9 shows the actual staffing at Heritage from Sunday, November 18, 2001 through Saturday, December 8, 2001 (attached as Ex. I). These days were selected in order to provide an accurate sample of the staff to supervisor ratio, on all three shifts, given the daily fluctuations in these numbers. For each day, each shift is shown with an indication of the number of clinical supervisors, clinical managers, and assistant clinical managers on duty. (Tr. 120). Thus, this document reflects what the staff to supervisor ratio would be if charge nurses were not supervisors.

Upon review of ER-9, one cannot help but question the Regional Director's summary rejection of this evidence. As set forth below, if Heritage's charge nurses are not supervisors, the staff to supervisor ratio varies as follows for each shift:

**Ratio of Staff to Supervisors**

	<u>High</u>	<u>Low</u>
Day Shift	80:1	10:1
Afternoon Shift	86:1	19:1
Midnight Shift	58:1	26:1

In addition to the sheer absurdity of these ratios, there are other factors to consider:

- The Regional Director acknowledged that the clinical managers and assistant clinical managers on the day shift are not doing any day-to-day supervision of the nursing units. (Ex. A, Dec. 6-7).
- Only one house supervisor is working on each off shift, and that individual is responsible for the entire hospital, not just the nursing areas. (Ex. A, Dec. 6). This involves overseeing all aspects of the hospital, including staffing, housekeeping, and maintenance, as well as nursing areas. (Ex. A, Dec. 6).

The evidence regarding the ratio of staff to supervisors in the instant case, in and of itself, is sufficiently compelling to support a finding that the charge nurses are supervisors under the Act. If the charge nurses are not supervisors, the staff to supervisor ratio at Heritage would range from 10:1 to an incredible 86:1. Additionally, these figures include Heritage's clinical supervisor, who is responsible for all areas of the hospital – both nursing and non-nursing – and Heritage's clinical managers and assistant clinical managers who manage their areas and have no role in the day-to-day supervision of unit personnel.<sup>5</sup>

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<sup>5</sup>Rather than address the statistical evidence presented at the hearing, the Regional Director says only, "... if all staff nurses are found to be supervisors, the ratio of nursing supervisors to nursing staff would be one supervisor for less than every two employees." (Ex. A, Dec. at 20). This statement is simply incorrect. The Employer's staff nurses are "supervisors" when they function in the charge nurse role. In that role, they are supervising not only the lesser-skilled unit employees referenced in the Regional Director's ratio calculation but also the other registered nurses on the unit.

c. Permanent Charge Nurses vs. Rotating Charge Nurses

The Decision of the Regional Director correctly draws no distinction between permanent and rotating charge nurses. Although the Decision of the Regional Director correctly recognizes that Heritage utilizes both permanent and rotating charge nurses, it omits certain crucial facts about the dual nature of this position. (Ex. A, Dec. 12). Neither the duties nor the authority of a charge nurse differ by virtue of the fact that she is a permanent charge rather than a rotating charge. (Ex. A, Dec. 12). In fact, the Employer and the Union stipulated that charge nurses throughout Heritage – both permanent and rotating – are vested with the same authority. (Ex. A, Dec. 12).

The Decision of the Regional Director correctly describes a permanent charge nurse as an RN who functions as a charge nurse every time she works. (Ex. A, Dec. 12). Not every unit has permanent charge nurses, and even those units that do have permanent charges do not have one on every shift. (Ex. A, Dec. 12). In fact, the Decision recognizes that there are only eleven (11) permanent charge nurses at Heritage. (Ex. A, Dec. 12). The Decision further recognizes that, “Where there is a permanent charge on a particular shift, the rotating charges on that shift take turns acting as a charge nurse on the days when the permanent charge is not working.” (Ex. A, Dec. 12). What the Decision fails to mention, however, is that permanent charge nurses work only ten days in a fourteen-day pay period, leaving four days every two weeks when the charge position is filled by another staff RN on a rotating basis. (Tr. 152, 156).<sup>6</sup>

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<sup>6</sup>The Decision also acknowledges that, although virtually all of Heritage’s RNs rotate through charge, there are a few RNs who do not for one reason or another. (Ex. A, Dec. 12). Most nurses who do not rotate through charge are relatively new hires who have not yet demonstrated the ability to shoulder the additional responsibilities of the charge nurse position. (Ex. A, Dec. 12).

**ARGUMENT**

**A. General Standards**

Section 2(11) of the National Labor Relations Act defines “supervisor” as:

... any individual having authority, in the interest of the employer, to hire, transfer, suspend, lay off, recall, promote, discharge, assign, reward, or discipline other employees, or responsibly to direct them, or to adjust their grievances, or effectively to recommend such action, if in connection with the foregoing the exercise of such authority is not of merely routine or clerical nature, but requires the use of independent judgment.

This section is to be read in the disjunctive, which means that if any one of the indicia listed above is found to exist with respect to Heritage’s charge nurses, they are supervisors under the

considerable binding precedent holding that individuals possessing such authority are statutory supervisors and, therefore, excluded from the coverage of the Act.

*1. The Charge Nurses' Authority is Not "Merely Routine"*

The Decision of the Regional Director concluded that the assignment and direction of staff by Heritage's charge nurses is "merely routine," and thus fails to evidence sufficient "independent judgment" to confer supervisory status. (Ex. A, Dec. 19-20). The Regional Director's dismissive portrayal of the charge nurses supervisory duties as "merely routine" is a predictable and long-effective way to avoid rightfully acknowledging their supervisory status. But no more. Such attempts to minimize the supervisory authority of charge nurses have been roundly rejected by the Sixth Circuit and recently by the United States Supreme Court.

The Sixth Circuit has repeatedly and adamantly held that there is nothing "routine" about directing others in the care of patients. See, e.g., Integrated Health Servs. v. NLRB, 191 F.3d 703, 711 (6<sup>th</sup> Cir. 1999); Grancare, Inc. v. NLRB, 137 F.3d 372, 375-76 (6<sup>th</sup> Cir. 1998). Moreover, the Sixth Circuit has regularly held that the authority to assign and reassign staff in the care of patients is unquestionably indicative of supervisory authority to "assign" and "responsibly to direct." See Caremore, Inc. v. NLRB, 129 F.3d 365, 369 (6<sup>th</sup> Cir. 1997). See also Beverly Health & Rehab. Servs. v. NLRB, Nos. 98-5160, 98-5259, 1999 WL 282695 (unpublished) (6<sup>th</sup> Cir., April 28, 1999) (providing direction to staff regarding patient care and moving staff between wings of facility "constitutes the authority 'responsibly to direct'" pursuant to §2(11) of the Act).

The Sixth Circuit has long rejected the Board's conclusions that supervisory duties do not establish the supervisory status of nurses because such duties flow from the nurses' professional "knowledge and training" and thus are "essentially routine in nature, and not requiring the

exercise of independent judgment." Integrated Health Servs., 191 F.3d at 711. Rather, that Court has held that it is "**perfectly obvious** that the kind of judgment exercised by registered nurses in directing nurse's aides in the care of patients occupying skilled and intermediate care beds in a nursing home is not 'merely routine.'" Id. (emphasis added).

The Supreme Court's recent holding in NLRB v. Kentucky River Community Care, 121 S. Ct 1861, 1867 (2001), affirmed the Sixth Circuit's long-held position that independent judgment is no less independent where it is exercised by professionals such as charge nurses:

The only basis asserted by the Board, before the Court of Appeals and here, for rejecting respondent's proof of supervisory status with respect to directing patient care was the Board's interpretation of the second part of the test – to wit, that employees do use 'independent judgment' when they exercise 'ordinary professional or technical judgment in directing less-skilled employees to deliver

a. “Independent Judgment” in Light of Employer Rules and Policies

In the instant case, the Regional Director concluded that, although the Employer’s charge nurses may assign and responsibly direct nursing staff in the performance of their duties, the charge nurses do so in keeping with “the superior’s standing orders and the employer’s operating regulations.” (Ex. A, Dec. 20). In essence, the Regional Director believes that the existence of the Employer’s “Assignment of Nursing Personnel” policy (ER-7) (attached as Ex. F) precludes a finding that Heritage’s charge nurses exercise independent judgment in assigning and responsibly directing nursing staff. With all due respect, this is ludicrous.

First and foremost, the policy at issue is nothing more than an articulation of the varied factors to be **considered and analyzed** by charge nurses in deciding which patients should be assigned to which staff members. (Ex. F, ER-7). In fact, the policy does little more than remind charge nurses to consider factors such as acuity, staff abilities, staff experience, and personality when making out an assignment. Even with the existence of this policy, the fact remains that, on each and every shift, a charge nurse must use independent judgment in **analyzing and applying these factors to meet the changing needs of her patients and the changing abilities of her staff.**

Moreover, in the brief time since the decision in Kentucky River was issued, courts have already expressed disagreement with the Board’s position that the existence of applicable rules or regulations precludes a finding of “independent judgment.” In NLRB v. Quinnipiac College, 256 F.3d 68, 75-76 (2d Cir. 2001), the court rejected the Board’s determination that the employer’s shift supervisors did not use independent judgment in assigning lower-level employees simply because the employer maintained “policies and procedures” governing this function. According to that court, **“the existence of governing policies and procedures and the exercise of**

**independent judgment are not mutually exclusive.”** *Id.* at 75-76 (emphasis added). Thus, the Regional Director’s Decision is doubly wrong: there are no Employer policies, orders, or regulations that *restrict the judgment* used by charge nurses in assigning and responsibly directing less-skilled employees and, even if there were, such policies do not preclude a finding that the charge nurses use independent judgment.

b. Assigning Tasks vs. Assigning Employees

The Regional Director’s attempt to deny supervisory status to the Employer’s charge nurses by concluding that they “assign discrete tasks” to employees, rather than “assigning employees” is a red herring. In his opinion, the Regional Director cites numerous examples of tasks assigned by *staff RNs*, not *charge nurses*, to lesser-skilled employees on the nursing units. (Ex. A, Dec. 11). From this, the Regional Director concludes that, “The limited authority of RNs to assign discrete tasks to less skilled employees . . . does not require the use of independent judgment in the direction of other employees.” (Ex. A, Dec. 19). This conclusion is not only legally questionable, but also misses the mark completely. It is not the Employer’s contention that every RN is exercising supervisory authority at all times, **but, rather, that when in charge, whether as a rotating or permanent charge, the *charge nurses* are most certainly using independent judgment in the exercise of their supervisory authority to assign and direct.** These charge nurses are not only making assignments for and issuing direction to the “less-skilled” members of the nursing units, but **also other RNs**. So doing, they are making the assignment of **all nursing personnel for the shift**. They are not simply assigning “tasks” to “lesser skilled” staff over the course of the shift.

C. Other Indicia of Supervisory Status

1. *Heritage's Charge Nurses Adjust Grievances*

The record evidence clearly establishes that employee problems are regularly addressed and resolved by Heritage's charge nurses. Nursing Site Leader Brenda Theisen gave one example of the way in which a charge nurse resolves disputes between employees:

If a nursing assistant complains that someone isn't doing what they're directing them to do, for instance, they could come up to the charge nurse and say, well, I told this nursing assistant to do this and she refused to do it and I tried talking to her, would you go talk to her, and the charge nurse would get involved in it at that point.

(Tr. 244-45). Moreover, the Employer's nursing Chain of Command Policy further describes the charge nurse's role in resolving problems on the unit. That document states as its objective "To provide a mechanism for the nursing staff to communicate and resolve issues and concerns," and sets forth a chain of command beginning with:

Nursing staff member communicates verbally and/or in writing of a concern/issue to **charge nurse** and/or Clinical Manager/Clinical Supervisor.

(Ex. G, ER-8) (emphasis added). The UAW's own witness, Nancy Coffee, testified that, she (as a charge nurse) would only take an issue to higher management *if she could not resolve it herself*. (Tr. 588).

That the charge nurses are the "first line" in the chain of command and, in that capacity, hear and act on employee concerns about co-workers, assignments and similar matters is precisely what is contemplated by "adjusting grievances" under the Act. As the Board held in The Atlanta Newspapers, 306 NLRB 751 (1992), even the authority informally to "resolve squabbles" among employees is determinative of supervisory status.

2. *The Staff-to-Supervisor Ratios Support a Finding of Supervisory Status*

As discussed above, ER-9 (attached as Ex. I) shows the actual staffing at Heritage from Sunday, November 18, 2001, through Saturday, December 8, 2001. For each day, each shift is shown with an indication of the number of clinical supervisors, clinical managers, and assistant clinical managers on duty. (Tr. 120). Thus, this document reflects what the staff to supervisor ratio would be if charge nurses were not supervisors.

Upon review of ER-9, one cannot help but conclude that charge nurses must be supervisors. Otherwise, the staff to supervisor ratio varies as follows for each shift:

Ratio of Staff to Supervisors

	<u>High</u>	<u>Low</u>
Day Shift	80:1	10:1
Afternoon Shift	86:1	19:1
Midnight Shift	58:1	26:1

In addition to the sheer absurdity of the ratios if charge nurses are not supervisors, there are other factors to consider:

- The clinical managers and assistant clinical managers on the day shift are not doing any day-to-day supervision of the nursing units. (Tr. 43, 46).
- Only one clinical supervisor (house supervisor) is working on each off shift, and that individual is responsible for the entire hospital, not just the nursing areas. (Tr. 39-40). This involves overseeing all aspects of the hospital, including staffing, housekeeping, and maintenance, as well as nursing areas. (Tr. 41-42).

Although a “secondary indicia,” the Board clearly looks to the ratio of staff to supervisors when considering whether charge nurses are supervisors. See, e.g., Wright Memorial Hospital, 255 NLRB 1319 (1981) (finding charge nurses supervisors where “to find them not to be supervisors would result in an unrealistic ratio”); Northwoods Manor, 260 NLRB 854 (1982)

(stating “we also find it significant that if charge nurses are not supervisors an unrealistic supervisor-to-employee ratio would exist at the employer’s facilities”).<sup>8</sup>

The evidence regarding the ratio of staff to supervisors in the instant case, in and of itself, is sufficiently compelling to support a finding that the charge nurses are supervisors under the Act. If the charge nurses are not supervisors, the staff to supervisor ratio at Heritage would range from 10:1 to an incredible 86:1. Additionally, these figures include Heritage’s clinical supervisor, who is responsible for all areas of the hospital – both nursing and non-nursing – and Heritage’s clinical managers and assistant clinical managers who manage their areas and have no role in the day-to-day supervision of unit personnel. More so than in a factory, or even in other health care institutions (i.e., nursing homes), it is simply *unconscionable* to believe that the patient care areas of this acute care hospital are essentially unsupervised on the afternoon and midnight shifts and supervised at incredibly unworkable ratios even on the day shift.

### CONCLUSION

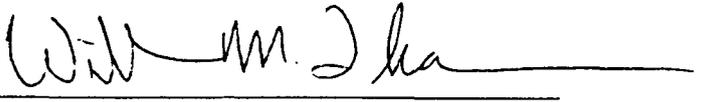
On the basis of the foregoing discussion, argument, and authority, OHI respectfully submits that the Employer’s charge nurses are supervisors under the Act. Consequently, it is respectfully requested that the Board reverse the Region’s Decision and Direction of Election.

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<sup>8</sup>The courts also attach great weight to ratio. The Sixth Circuit has found that a 1:31 ratio is “no way to run a business of this [nursing home] type.” Beverly California Corp. v. NLRB, 970 F.2d 1548, 1553 (6<sup>th</sup> Cir. 1992). Similarly, the Seventh Circuit considers ratio a “guiding light” in determining Section 2(11) status. Children’s Habilitation Center v. NLRB, 887 F.2d 130, 132 (7<sup>th</sup> Cir. 1989). See also Spentonbush/Red Star Co. v. NLRB, 106 F.3d 484 (2<sup>nd</sup> Cir. 1997).

Respectfully submitted,

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Date: April 10, 2002

UNITED STATES OF AMERICA  
BEFORE THE NATIONAL LABOR RELATIONS BOARD  
SEVENTH REGION

OAKWOOD HEALTHCARE, INC.<sup>1</sup>

Employer

and

CASE 7-RC-22141

INTERNATIONAL UNION, UNITED AUTOMOBILE,  
AEROSPACE AND AGRICULTURAL IMPLEMENT  
WORKERS OF AMERICA (UAW), AFL-CIO

Petitioner

APPEARANCES:

William M. Thacker and Claire S. Harrison, Attorneys, of Ann Arbor, Michigan,  
for the Employer.

Blair Simmons, Attorney, of Detroit, Michigan, for the Petitioner.

DECISION AND DIRECTION OF ELECTION

Upon a petition duly filed under Section 9(c) of the National Labor Relations Act, as amended, hereinafter referred to as the Act, a hearing was held before a hearing officer of the National Labor Relations Board, hereinafter referred to as the Board.

Pursuant to the provisions of Section 3(b) of the Act, the Board has delegated its authority in this proceeding to the undersigned.

Upon the entire record<sup>2</sup> in this proceeding, the undersigned finds:

1. The hearing officer's rulings made at the hearing are free from prejudicial error and are hereby affirmed.<sup>3</sup>

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<sup>1</sup> The name of the Employer appears as amended at the hearing.

<sup>2</sup> The parties submitted briefs, which were carefully considered.

Exhibit 17 is admitted to the extent it shows on average the frequency that staff nurses may work as charge nurses. Petitioner asserted by letter that assuming Exhibit 17 is used only for this purpose, it has no objection. The document is received, and the record is closed.

<sup>4</sup> The hospitals include Oakwood Heritage Hospital (Heritage); Oakwood Hospital and Medical Center (OHMC); Oakwood Annapolis Hospital (Annapolis); and Oakwood Seaway Hospital (Seaway).

been represented by Local 79, Service Employees International Union, AFL-CIO (hereinafter Local 79) in a multi-facility unit.

In 1999, Local 79 filed a petition in Case 7-RC-21970 to represent RNs at Annapolis. A hearing was held over the issue of whether a single facility unit was appropriate, or whether the only appropriate unit would be a system-wide unit of all registered nurses at Annapolis, Heritage, OHMC, and Seaway. A decision issued on May 9, 2001, wherein the undersigned found that a single facility unit, consisting only of RNs at Annapolis, was appropriate. The Employer filed a request for review, but Local 79 withdrew its petition before any decision by the Board. In the current case, the hearing officer took administrative notice of the entire record in the previous cases.

The Employer raises two issues in this matter. First, the Employer contends, as it did in Case 7-RC-21970 with respect to Annapolis, that a single-facility unit at Heritage is inappropriate, and that the only appropriate unit is a system-wide unit of all RNs at Heritage, Annapolis, OHMC, and Seaway. The parties stipulated that there are no material differences between Heritage and Annapolis as to the evidence regarding the appropriateness of a multi-site unit, and incorporated the record from the prior proceeding in 7-RC-21970 and 7-RC-20261 as the basis for determination in the instant matter.

Second, the Employer contends that the proposed bargaining unit is inappropriate because the RNs (referred to as staff nurses) sought by the Petitioner are supervisors within the meaning of the Act. The Employer submits that the primary indicia that the RNs are supervisors is their responsibility when serving as charge nurses to assign and direct other nurses, and adjust grievances.

OHI's president and chief executive officer is Gerald D. Fitzgerald. Directly under him is Joseph Diederich, the chief operating officer, who has overall responsibility for health care delivery at the four acute-care hospitals as well as numerous ambulatory, long-term care, and care management facilities and foundations. Due to the complicated series of transactions by which OHI acquired Annapolis, Heritage, and Seaway, those three acute-care hospitals are still nominally owned by a separate subsidiary corporation, Oakwood United Hospitals, Inc. However, OHI manages those hospitals, leases their real property and physical assets, and employs their staffs. In contrast to the situation prevailing at the time of the 1994 Heritage decision and election, Oakwood United Hospitals, Inc. no longer maintains a separate board or management structure.

Of the four acute-care hospitals, OHMC, by far the largest facility, offers the widest range of services, including, but not limited to, in-patient mental health, obstetrics, specialized cardiac care, neurosurgery, neonatal intensive care, cancer

PeopleSoft.

Heritage Hospital is an acute care hospital with 257 licensed beds. Heritage has medical surgical areas, Intensive Care and Intermediate Care, ER and OR services; rehab services, and psychiatric/behavioral health services. These services are divided into the following units within the hospital: Medical/Surgical West (MSW), Medical/Surgical East (MSE), Behavioral Health (BH), Post Anesthesia Care Unit/Recovery (PACU); Rehab, Intermediate Care Unit (IMU), Intensive Care Unit (ICU), Emergency Department (ER), and Operating Room/Anesthesia Department (OR). The pain clinic at Heritage is an outpatient clinic for patients who are being treated for chronic pain.

The corporate Human Resources Department is headed by Executive Vice President John Furman, who reports directly to President/CEO Fitzgerald. Under Furman are Corporate Director of Employee and Labor Relations Ed Frysinger and Corporate Director of Compensation and Benefits Dan Smorynski. Director of Employee and Labor Relations Verna Bastedo as well as the currently unfilled directors of staffing and human resources report to Frysinger, while a benefits manager, compensation manager, and pension analyst report to Smorynski. The corporate Human Resources Department has developed and issued standardized personnel forms for virtually all events and actions. It has promulgated uniform attendance, leave, and transfer policies and procedures. With the approval of senior management councils, it has formulated, and when necessary it revises, system-

employment recruiter, and one human resource manager; at Heritage, two human resource clericals, a part-time employment recruiter, and a part-time human resource manager; at Seaway, two part-time human resource clericals, a part-time employment recruiter (shared with Heritage), and a part-time human resource manager (shared with Heritage); and at OHMC, three human resource clericals, five or six employment recruiters, and one human resource director. Bastedo assigns human resource professionals to perform tasks at facilities different from their home base when the need arises. On-site human resource staff members answer questions, direct inquiries, and implement but may not modify corporate employment policies and practices. Except for OHMC, which stores employee personnel files at a corporate office known as Village Plaza, the hospitals maintain their respective personnel files.

The corporate office of staffing coordinates the recruitment of nurses on a system-wide basis. OHS advertises all job openings throughout its system on OHI's web site and in various print and electronic media. It sends recruiters to job fairs. Nurse recruiters concentrate on assigned geographical areas, but will direct interested applicants to job openings at any site. After completing a standard application form, a job candidate receives an initial screening by a nurse recruiter. This involves a preliminary inquiry into minimum qualifications and a background criminal check. The recruiter sends all candidates who pass this minimum threshold to be interviewed by the clinical manager -- the on-site, first-line supervisory nurse -- into whose unit the candidates seek entry. The interviews conducted by the clinical manager explore the applicants' experience levels and clinical competence. An Employer witness testified that the final hiring choice is normally the product of consensus between the recruiter and clinical manager. As far as the record reveals, however, the recruiter does not participate in the clinical manager's interview regarding specific job qualifications. An Employer exhibit culled from one of many written procedures approved by a multi-site body called the Acute Care Nursing Operations Council states that the clinical manager selects the most qualified candidate and informs the nurse recruiter of the decision.

All employees covered by the handbook described above are subject to the same progressive disciplinary system. For minor infractions, the progression is counseling, a first and second written warning, a three- or five-day suspension, and finally termination. Major infractions may meet with more severe punishment. The nurse's on-site immediate supervisor undertakes the counseling and initiates the warnings. According to the handbook, suspension decisions originate with local nursing management, but must be reviewed by human resource personnel on site in order to assure consistent and equitable treatment. Terminations require the approval of a corporate vice president. The record does not reveal whether, or how often, corporate human resource officials countermand nursing managers'

and director of patient care services at Heritage, reports to Hillbom regarding daily operations at Heritage. Theisen also reports to Barb Medvec, the chief nursing officer of OHS. The nursing site managers at Seaway, OHMC, and Annapolis also report to Medvec.<sup>5</sup> Medvec and Diedrich do not work on site at the Heritage facility. As the nursing site leader at Heritage, Theisen is responsible for anything having to do with nursing care that is delivered by the hospital, although she does not directly supervise nurses on a day-to-day basis.

Reporting to Theisen at Heritage are clinical supervisors (also known as nurse supervisors or house supervisors) and clinical managers (also known as nurse managers).<sup>6</sup> Clinical supervisors generally work on off shifts, such as afternoon shifts, midnights, holidays, and weekends. When they work they cover the entire hospital, nursing as well as every department within the hospital. Only one clinical supervisor works on a particular shift at a given time. The clinical supervisors do not spend too much time in a particular unit because they are overseeing the entire hospital. They spend considerable time in the ER, because they have to attend to any code (code blue, respiratory or cardiac arrest of a patient) that occurs. They also look at staffing for the next shift, call agencies or additional staff if needed, and document call-offs if someone is calling in sick. They also address any problems that may arise during their shift (i.e., fire alarm going off, flood.) When on duty, the clinical supervisor is the highest ranking administrative officer in the facility.

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<sup>5</sup> The parties stipulated at the hearing that Hillbom, Theisen, Medvec, and Deidrich are all statutory supervisors within the meaning of the Act based on their authority to discipline and independently direct employees.

<sup>6</sup> The parties stipulated, and I find, that clinical supervisors and clinical managers are supervisors as defined in Section 2(11) of the Act based on their authority to discipline and independently direct employees.

Clinical managers are responsible for several units in distinct geographical areas within the hospital. Clinical managers are all RNs. They normally work the day shift, and they oversee the units that they are responsible for as far as developing a unit budget, finalizing schedules, and drafting schedules that have been submitted by the nursing staff. They work on development of policy for their units, and attend meetings, corporate as well as site meetings and department meetings. They are not regularly engaged in actual clinical work/nursing functions. They each have an office located within one of their units. They are on call 24 hours a day, and address the day-to-day issues and problems that arise within their units, assuming such problems cannot be addressed at a lower level. Clinical supervisors and clinical managers are salaried positions.

There are eight assistant clinical managers (also referred to as assistant nurse managers or ACMs) who report to the nurse managers.<sup>7</sup> The ACMs are part of the management team and as such attend meetings, assist with schedules, and cover the clinical manager's responsibilities when the clinical manager is not in the building doing administrative functions. Not every unit has an ACM. The clinical managers direct the duties of the ACM. They work various shifts, determined by the clinical manager with whom they work. The position was created to enable the clinical manager to cover multiple units. The ACMs also handle day-to-day issues and problems if needed.

All registered nurses at the hospitals report directly to on-site nursing supervisors. With the recent advent of "service line" reporting configurations, however, the upper reach of supervisory hierarchy for nurses in certain specialties includes individuals who oversee that nursing specialty at more than one site. Nonetheless, the development of "service lines" has not erased the primacy of first-line supervision nor diminished the authority of the nursing site leader. A communication chain of command is contained in several written directives issued by the corporate Human Resources Department and approved by the Acute Care Nursing Operations Council. These policies specify that a nurse or charge nurse encountering any sort of patient, operational, or ethical problem is expected to notify a clinical manager or clinical nurse supervisor. The latter contacts the nursing site leader, who consults with the site administrator, service line leader, or risk manager as deemed necessary.<sup>8</sup>

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<sup>7</sup> The parties stipulated, and I find, that ACMs are supervisors as defined in Section 2(11) of the Act based on their authority to discipline and independently direct other employees.

<sup>8</sup> Because there is some conflict among witnesses, and between testimony and exhibits, the record is less than crystalline regarding which specialties are "service lines." It is clear that out of a nursing staff at Annapolis of 232, 65 to 70 nurses are in "service lines."

Staffing and scheduling guidelines emanate from the corporate Human Resources Department. These precepts are further refined by the Acute Care Nursing Operations Council. The work schedule for nurses on each nursing unit must be posted for four weeks. The corporation has adopted what is considered a standard work day, and also offers nurses the option of working alternative schedules. Within these parameters, specific choices of unit shifts (days, evenings, midnights, or rotation) and hour patterns (4-hour, 8-hour, 10-hour, or 12-hour) are established by the unit's clinical manager. Requests for shift changes must be made in writing and submitted to the clinical manager. Employees may adjust their schedules by trading with colleagues, but all trades must be requested of and approved in advance by the clinical manager. The amounts of allotted vacation time, sick leave, and personal time are centrally prescribed, but specific requests for vacation time and other leave are submitted to and acted upon by the nurse's immediate site supervisor. In particular, the clinical manager sets the limit on the number of simultaneous vacations that she will allow.

OHS enforces an across-the-board policy forbidding mandatory overtime, but overtime will be scheduled and offered in emergencies. The clinical manager or clinical nurse supervisor determines whether an emergency exists, and all overtime must be approved in advance by those individuals. The corporation has a uniform attendance program that correlates discipline with the number of unexcused absences. The clinical manager has discretion to characterize an "emergency" absence as excused and an undocumented absence as unexcused.

Staffing guidelines are centrally determined, and are based on prescribed criteria such as patient census and acuity. The clinical nurse supervisor is responsible for assuring that adequate staff is available and for initiating the use of overtime, system or in-house flex pool nurses, or outside agency nurses to cover staffing shortages. Each hospital's nursing site leader maintains 24-hour accountability and availability to assure that appropriate staffing levels are continuous.

An inter-site nursing leadership council has devised detailed job descriptions for each nursing position. As noted above, each job has a set wage range from which site managers may not vary. A newly hired or transferred nurse is assigned a wage rate within the range based upon her level of experience, in accordance with a centrally determined grid. How years of experience for this purpose are counted or weighted is not disclosed in the record. The wage ranges for each job classification are uniform across the four acute-care hospitals.

All employees subject to the handbook receive periodic performance appraisals, prepared by immediate site supervisors on centrally prescribed forms. The supervisor assigns a numerical rating in specific areas, and the individual

ratings are converted, in accordance with a predetermined formula, into an overall score. As stated in the handbook, all employees with a final score of 100 or more are entitled to whatever across-the-board pay increase that the Employer chooses to implement. Any applicable pay increase will be the same for all eligible employees, regardless of the exact appraisal score.

The handbook states that OHS encourages inter-corporate voluntary job transfers as a way for employees to seek personal advancement. All employees with six months seniority in their present position, who have been free of disciplinary suspensions within the last two years, are eligible for a voluntary transfer. A nursing site leader may grant an exception to the six-month requirement. A nurse initiates a voluntary transfer by completing a transfer request form and submitting it to the Human Resources Department. The clinical manager of the unit being requested receives a copy of such request. As a position becomes available, the clinical manager interviews all applicants who meet the foregoing minimal requirements. Prior to making her decision, the clinical manager of the receiving unit will request background information from the transferring clinical manager. The receiving clinical manager makes the final selection, utilizing defined clinical criteria. A nurse who transfers to a new site may carry her accumulated sick and vacation time, but not unused holidays or personal days. Her length of service will follow her to the new site for the purpose of determining eligibility for service awards, vacation, sick time, and health benefits.

Nurses normally may not use their corporate seniority to "bump" into the position of a less senior nurse at a different site. Such bumping is theoretically permitted only in the case of a reduction of force *and* if the two nurses are in the same service line. Whether these twin conditions have ever been met so as to trigger an occasion of bumping was not disclosed in the record.<sup>9</sup>

During the 14.5 month period preceding the hearing in Case 7-RC-21970, 9 nurses permanently transferred from Annapolis to another OHS acute-care hospital, and 24 nurses permanently transferred to Annapolis. In relation to the 232-nurse complement at Annapolis, this is a transfer rate of 14%. Of the 24 in-coming transfers, 14 were occasioned by the closing of Beyer Hospital, an acute-care facility formerly part of Oakwood United Hospital, Inc. The record does not reveal the reason for the other Annapolis transfers, or whether they were voluntary or

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<sup>9</sup> The Employer's closure of the Annapolis-Westland behavioral health facility in 1997 affected 20 nurses. According to Verna Bastedo, their unionized status meant that OHS' bumping procedures did not apply. Nonetheless, 13 of the 20 nurses were offered jobs in OHS' acute-care hospitals. Obstetric units in Seaway and Beyer, a now defunct facility, also closed in recent years. There is testimony that affected nurses were absorbed into the corporate system and retained their seniority, but no indication that they displaced other nurses via bumping.

involuntary. If the Beyer closing did not occur during the selected time span, Annapolis' transfer rate would be 8%. During the same period, 24 nurses made permanent transfers among OHMC, Seaway, and Heritage. In addition, OHMC, Seaway, and Heritage also absorbed 23 nurses due to OHI's closing of Beyer Hospital. Excluding the Beyer transfers as non-recurring events yields a transfer rate among OHMC, Seaway, and Heritage of less than 1.5%.

During the 5-month period ending shortly before the hearing in Case 7-RC-21970, there were 7 temporary transfers of nurses from other OHS hospitals into Annapolis, and 63 temporary transfers of Annapolis nurses to other hospitals. The intervals of time spent working at the outside site varied; most exceeded eight hours. The preponderance of such temporary transfers was due to the assignment of flex pool staff, nurses who receive premium pay in exchange for working flexible schedules. The reasons for these temporary transfers were not explored at the hearing.

Other than the contact occasioned by the transfers described above, nurses from one site may encounter nurses from another during the corporate stage of new employee orientation. This program, which follows a uniform syllabus, takes place at a central corporate office and is attended by all newly hired nurses. Nurses also receive site-specific orientation upon being hired or transferred.

At Heritage, there is some variability with the staff nurse position depending on the department, but in general, there is one written job description that generally applies to RNs working throughout the hospital. The description states that RNs are responsible for providing direct care to patients utilizing the nursing process under general direction, guiding and supervising nursing personnel, collaborating with other health care professionals, and coordinating ancillary staff.

The clinical manager reviews the job description with the nurses when they have their annual performance appraisals. Among other things, the RNs are evaluated in their performance appraisals on their ability to act as a resource person for trouble-shooting, contributing to the professional growth of peers, colleagues, and others; precepting and mentoring; and ability to perform as a charge RN.

The type of work performed is basically what is dictated by their profession, based on the education and experience of an RN. They follow doctors orders, which are usually written instructions as to what type of treatment is needed, including administering blood tests, passing medications, and observing patients more closely. For every task performed by a nurse, there is a very specific policy and procedure in writing. However, long-time RNs generally do not need to refer to the policy and procedure manuals because of their experience, and many of the RNs working at Heritage have worked for the Employer for over 10 years.

The employees working with the RNs are typically employees such as mental health workers, who assist in the Behavioral Health Department; licensed practical nurses (LPNs), who are licensed to perform certain nursing tasks but not the full duties of an RN; nursing assistants, who generally work with and assist RNs with daily tasks; desk secretaries, who answer telephones, answer call lights from patients, and enter orders for patients; nurse externs, who are nursing students who have not yet graduated; graduate nurse externs, who are nursing students who have graduated but have not yet passed their exams or received their license; OR Techs and Surgical Techs, who assist staff nurses with the care of a patient undergoing surgical intervention, and ER techs and paramedics, who work in the Emergency Department to assist the staff working in the ER.<sup>10</sup> The job descriptions of the majority of these positions state that they work under the direction of the RN. Most are also evaluated on whether they follow directions appropriately to meet the demands of the unit and the staff. The RNs are responsible for anyone else working under the RN level. This responsibility of "guiding and supervising nursing personnel" and/or "demonstrates effective leadership and professional development" is a criteria under which RNs are evaluated during their performance appraisals.

RNs may assign mental health workers, nursing assistants, techs, or other less skilled employees to do certain tasks that are within their ability. For example, they may assign a mental health worker to work with a group of patients, or they may instruct a nurse assistant to give a patient a bath, walk a patient to the bathroom, or give a patient a meal. They assign these tasks to the nurse assistants because that is what a nursing assistant's job is - to assist the staff. If something more important comes up, the RN may interrupt that task and assign the nurse assistant to something else. Nursing assistants and techs are also aware of certain jobs they can do and will take it upon themselves to do these jobs, without first being told. It would be insubordination if a nurse assistant refused to listen to the RN, and the RN could go to a superior to intervene. However, it could be proper for an assistant to refuse a task for good reason, such as if they were busy on a different assignment. Regardless, no situation has arisen where an assistant or other worker refused to perform a task. If this did occur, RNs do not believe that they have the authority to do very much about it other than going to the clinical manager, as they have no role in disciplining employees.

The RNs do not rotate shifts. They work straight shifts; day, afternoon, or midnight, or 12-hour shifts, which are ordinarily day shifts (7:00 a.m. to 7:00 p.m.) or midnight shifts (7:00 p.m. to 7:00 a.m.). However, they do take turns rotating the

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<sup>10</sup> The nursing assistants are the only employees mentioned in this group that are represented by a union, Local 79.

responsibility of charge nurse. On every shift in each unit, except the pain clinic, there is one RN assigned to work as a charge nurse. At times, however, assistant clinical managers have filled in as charge nurses. In particular, in late 2001 assistant managers filled in as charge nurses to decrease agency nurse hours.

Rotating charges are individuals who occasionally take charge nurse responsibilities in a unit. The frequency with which it happens depends on the size of the unit and the number of RNs that occasionally rotate. A permanent charge is a person who has requested to and agreed to be in permanent charge; each time they work, they work as a charge nurse. The duties of a charge nurse, whether rotating or permanent, are the same. RNs are paid hourly. They earn \$1.50 more per hour when they are working as a charge nurse.

In the IMC Department, if the assistant nurse manager is not there to take charge, they rotate the responsibility of charge nurse. Sometimes it is assigned by the clinical manager on the schedule, and sometimes it is not. If it is not assigned, then they take turns. RN Coffee testified that she is a charge nurse approximately one to two times during a two-week schedule.<sup>11</sup> Similarly, RN Welch testified that her work schedule in the ER indicates when she is assigned to the charge nurse responsibility. The schedules come out in a four-week time frame. As with Coffee, in a two-week time frame, she is usually in charge once or twice.

RNs must have at least one year of nursing experience to act as charge nurses. RNs learn the responsibilities of a charge nurse through their education, and by initially working with a preceptor, or mentor. Preceptors will work along with the RNs as charge nurses until the RNs are able to perform the job on their own.

Some RNs choose not to be in charge at all and there is not necessarily a permanent charge on each unit. However, a review of Employer's Exhibit 12 reflects that a majority of RNs, with the exception of those working at the Pain Clinic and in the Operating Room, take turns rotating as charge nurse. It appears from the record that most of the RNs who are not rotating are newer employees who are not yet ready to take on the charge nurse responsibilities. Also shown by Exhibit 12 is that only approximately 11 nurses are permanent charges.<sup>12</sup> In the Behavioral Health Unit, every RN is a rotating charge or a permanent charge. Where there is a permanent charge on a particular shift, the rotating charges on that shift take turns acting as a charge nurse on the days when the permanent charge is not working.

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<sup>11</sup> Coffee works part-time, which is five days out of every two weeks. As such, she is charge nurse approximately two out of every five days that she works.

<sup>12</sup> The majority of the permanent charges work in the Behavioral Health Unit.

shift take turns acting as a charge nurse on the days when the permanent charge is not working.

Charge nurses are responsible for overseeing the unit for the shift that they are working, with the staff who are working the unit that day. They do the assignments of all the staff that are working on that shift. They monitor in general all the patients that are in the unit that day, and meet with physicians if a physician has an issue with a nurse or with a patient. They also meet with patients or family members who have a complaint. Some responsibilities vary within each unit. If a variance occurs during a shift, such as a medication error, patient fall, or any other incident, a form called a "quality assessment report" is filled out. The charge nurse is responsible for following up with the incident by examining the patient, and signing the report as the "person in charge." If necessary, the charge nurse will call a physician to evaluate the patient.

RNs are sometimes pulled to work in other units, but not if they are assigned to work on charge duty. If it is a nurse's turn to be pulled, and she is on charge duty, she will stay on that shift and go the next time. When RNs are pulled to work in other units, it usually happens at the start of the shift. The charge nurse is informed that a nurse is needed in another department, and is given the names of the nurses who are to be pulled by the clinical supervisor from the previous shift. Charge nurses can also be called in the middle of the shift – a supervisor may inform the charge nurse that one of her nurses is needed in another unit. The charge nurse cannot refuse that request. If the charge nurse refused to send someone, there would be disciplinary action. The charge nurse does not assign employees to shifts; that is done by a staffing office. When the charge nurse comes in, she is handed a list (prepared by the supervisor on the previous shift) of the nurses who are supposed to be working that day on her shift. If nurses on the list do not show up, the charge nurse calls the staffing office to find out where that person is.

OHS has a policy for the assignment of nursing personnel to provide adequate numbers of licensed staff and other personnel to deliver care to patients. Under this policy, assignments are to be made in accordance with the patient's need. In making assignments, the charge nurse must determine the acuity of the patient and determine the level of skill required to care for the patient – i.e., RNs can perform certain tasks that cannot be performed by LPNs, etc. Level of experience of the nurse, determining which nurses work well together as a team, as well as other activities that a particular nurse may also be responsible for, are also considered. On occasion, assignments will be changed mid-shift; for example, if there is a change in a patient's condition such that different care is warranted. The charge nurse also assigns nursing assistants or mental health workers either to particular patients or to work alongside specific RNs. After receiving their general assignment, the RN and/or the charge nurse may assign them more specific tasks

nurses when they would like to take their break, and their main goal in assigning breaks is to make sure the unit is covered at all times.

At times RNs may complain about particular assignments. The charge nurse can re-evaluate and make changes in assignments if appropriate. This could occur if a patient requires more work than expected, or if a patient's condition changes which requires more treatment or attention. However, the record does not indicate any instances of a serious conflict based on job assignments. Furthermore, RNs usually work together to help each other out, as a common courtesy of their profession. If RNs need help with a patient, they may go directly to another nurse and ask rather than going to the charge nurse. Many of the tasks handled by the charge nurse, including complaints of family members, can be handled by any RN. One RN testified that she does not interact any differently with other RNs on staff when she is a charge nurse compared to when she is not.

Some charge nurses may take patient assignments in addition to their other responsibilities. Whether or not a charge nurse takes an assignments typically depends on what department they work in and on what shift they work. Charge nurses on each shift are responsible for deciding whether or not they take assignments. Charge nurses frequently do take patients, although they will often take fewer patients than the other staff nurses on duty.

The assignment of staff nurses to patients is much more perfunctory in practice than the Employer's written assignment policy indicates. The assignment of work is generally rotated, or based on where a person worked the previous day. When making assignments as a charge nurse, reference is made to a staffing sheet showing where everyone worked the day before. It usually takes only a few minutes to do the assignments. There was testimony that the main responsibility of the charge nurses is to be familiar with what is going on in their particular units, and to basically be the go-to person for questions or issues that arise. For example in the ER, the charge nurse has to answer to the clinical supervisor's or manager's inquiries about whether there will be patient admissions. This will determine whether extra staffing is needed for a particular unit, such as ICU.

When the nurses arrive for their shifts in the IMU, they all listen to the report from the charge nurse of the previous shift. Then the charge nurse makes the assignments by asking who knows which patients have the highest acuity (these patients are referred to as the "completes"). They get a slip from the staffing office showing who is supposed to be there that day. The charge nurse then makes out the assignments. First, the completes are divided up evenly. After that, they look at who was there the day before, and try and give them the same assignment they had in order to maintain continuity. In IMU, nurse assistants make out their own assignments.

The charge nurse in IMU is also responsible for assigning beds to new patients or transfers from ICU. When determining where to assign the new patient as far as the staff is concerned, the charge nurse will go by who did an admission the day before – or, who currently has three patients instead of four. If necessary, the charge nurse may assign the patient to herself. If everyone had a full load, she would go to the manager. It also becomes necessary to reassign patients to different staff, if, for example, there is a personality conflict between a nurse and a patient. This could be handled by asking another nurse if she would take the patient. It is questionable whether the charge nurse has the authority to force another nurse to take another patient.

Generally, it is the clinical manager who hires, fires, and handles conflicts within the unit. They also handle performance evaluations, finalize schedules, and handle staffing issues and patient complaints. The assistant manager also does these things. Charge nurses do not make the decision to hold someone past the end of their shift if they are short staffed, nor do they authorize overtime. Charge nurses can be, and have been, disciplined by clinical managers.

Congress instructed the Board to make unit findings so as “to assure to employees the fullest freedom in exercising the rights guaranteed by this Act.” 29 U.S.C. §159(b). It is axiomatic that nothing in the Act requires a bargaining unit to be the *only*, or the *ultimate*, or the *most appropriate* grouping. *Overnite Transportation Co.*, 322 NLRB 723 (1996); *Capital Bakers*, 168 NLRB 904, 905 (1967); *Morand Bros. Beverage Co.*, 91 NLRB 409 (1950), *enfd.* 190 F.2d 576 (7<sup>th</sup> Cir. 1951). A union need not seek representation in the most comprehensive grouping of employees unless an appropriate unit compatible with the union’s request does not exist. *Purity Food Stores*, 160 NLRB 651 (1966); *P. Ballantine & Sons*, 141 NLRB 1103 (1963). A union’s desire is always a relevant, although not a dispositive, consideration. *E. H. Koester Bakery & Co.*, 136 NLRB 1006 (1962).

A single facility of a multi-location employer is a presumptively appropriate unit. *Hegins Corp.*, 255 NLRB 160 (1981). The Board, with court approval, uses the same single-facility presumption in fashioning health care units. *Manor Healthcare Corp.*, 285 NLRB 224 (1987); *Presbyterian University Hospital v. NLRB*, 88 F.3d 1300, 1309 (3<sup>rd</sup> Cir. 1996); *Staten Island University Hospital v. NLRB*, 24 F.3d 450, 456-467 (2<sup>nd</sup> Cir. 1994).

*Manor Healthcare* mandates consideration of traditional factors in deciding whether the presumption has been overcome. Such factors are geographic proximity, bargaining history, employee interchange and transfer, functional integration, administrative centralization, and common supervision. Thus, the presumption is normally overcome only if employees from the single location have

been blended into a wider unit by bargaining history, or if the single location has been so integrated with a wider group as to cause it to lose its separate identity. *Heritage Park Health Care Center*, 324 NLRB 447, 451 (1997), enf. 159 F.3d 1346 (2<sup>nd</sup> Cir. 1998); *Passavant Retirement & Health Center*, 313 NLRB 1216 (1994); see also *Centurion Auto Transport*, 329 NLRB No. 42 (1999). The presumption may also be rebutted in the health care setting by a showing that approval of a single-facility unit will increase the kinds of disruptions to continuity of patient care that Congress sought to prevent in cautioning against proliferation of units in the health care industry. *Mercywood Health Building*, 287 NLRB 1114, 1116 (1988), enf. denied on other grounds sub. nom. *NLRB v. Catherine McAuley Health Center*, 885 F.2d 341 (6<sup>th</sup> Cir. 1989).

The Employer has undertaken a number of measures to streamline its enterprises. This has resulted in centralization of many administrative functions, including marketing, purchasing, recruitment, payroll, and human resources. Wages, benefits, and disciplinary procedures exhibit a high degree of uniformity. The advent of service lines affects the reporting structure by making certain mid- and high- level nursing supervisors responsible for coordinating nursing services at more than one facility.

Nonetheless, each nurse at Heritage reports to a supervisor on site, and on-site management still exercises significant autonomy over the Heritage nurses' work lives. Clinical managers control work schedules, choice of shifts, and hours. They grant or deny leave requests, determine how many vacations will be permitted at a time, and decide whether overtime will be worked. Management at Heritage interviews and selects new hires and transferees from pools of eligible nurses. A clinical manager has some discretion in the classifying of an absence as excused or unexcused.

Heritage management and supervisory personnel initiate all disciplinary actions, and, as far as the record reveals, take conclusive unilateral action with respect to counseling and written warnings. Similarly, Heritage management has the authority to resolve grievances at the first two steps of the dispute resolution procedure. A nurse's job performance appraisal by her nurse manager determines her eligibility for any across-the-board wage increase. When professional, operational, and ethical problems arise, nurses are specifically instructed to follow the chain of command that originates at the first level of nursing management at the site, and travel through the site's hierarchy to the nursing site leader.

The foregoing recital demonstrates that within the Employer's framework, Heritage nurse management retains significant authority. The presence of local control is a decisive factor and overcomes even strong evidence of centralization. *NLRB v. HeartShare Human Services of New York, Inc.*, 108 F.3d 467 (2<sup>nd</sup> Cir.

1997), enforcing 317 NLRB 611 (1995) (finding single facility appropriate). In *RB Associates*, 324 NLRB 874 (1997), the Board, relying in part on the existence of local supervision, found a single hotel unit to be appropriate, despite the close proximity of other hotels; common personnel policies, handbook, benefits, rules, and regulations; central hiring; commonly conducted orientation; intercession of a corporate human resource director in hiring, discipline, and performance evaluations; identical employee skills and functions; and open transfers without loss of benefits or seniority. See also *Children's Hospital of San Francisco*, 312 NLRB 920 (1993), enfd. sub. nom. *California Pacific Medical Center v. NLRB*, 87 F.3d 304 (9<sup>th</sup> Cir. 1996).

There is no relevant bargaining history in this case militating against the appropriateness of a single-facility finding. The evidence does not show, nor does OHI contend, that a single-facility unit finding will threaten the continuity of patient care. *Hartford Hospital*, 318 NLRB 183, 193 (1995), enfd. 101 F.3d 108 (2<sup>nd</sup> Cir. 1996).

The evidence of interchange, as introduced in Case 7-RC-21970, is limited. The majority of permanent transfers in the period under examination was caused by the closure of an acute-care hospital. The remaining permanent transfers were statistically negligible in the overall unit sought by the Employer. Many more temporary transfers were attributable to the use of flex pool nurses than to migration of the stationary nursing corps.

I find the cases relied upon by the Employer to be distinguishable. In *West Jersey Health System*, 292 NLRB 749 (1989), the Board had a concern, absent here, that unit fragmentation would adversely affect patient care services. The record in *West Jersey* also demonstrated considerably more employee interchange, with 147 permanent transfers in a 14-month period, regular temporary rotation of unit employees to other facilities, and the availability of seniority bumping rights.<sup>13</sup> In *Presbyterian/St. Luke's Medical Center*, 289 NLRB 249 (1988), the Board found that a "significant number" of transfers had occurred and that physicians need not make separate applications, as they do here, to be admitted to practice. In *Montefiore Hospital*, 261 NLRB 569 (1982), neither party sought a single-facility unit, and the Board's task was to delineate an appropriate unit among competing multi-location groupings.

The Employer has adduced evidence tending to show that a unit comprised of its four acute-care hospitals may be appropriate. However, that a wider unit may

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<sup>13</sup> In *West Jersey*, employees could transfer by exercising bumping rights. At the Employer, no voluntary transfers may be accomplished by bumping. Rather, seniority may be exercised on an inter-site basis only within the same service line during a reduction in force.

be appropriate does not imply that a narrower one is inappropriate. *Children's Hospital of San Francisco*, supra at 928. The Employer bears the burden of establishing that consolidation and centralization have destroyed Heritage's identity. For the reasons discussed above and based upon the entire record, I find that the Employer has not met that burden.

Section 2(3) of the Act excludes from the definition of the term "employee" "any individual employed as a supervisor." Section 2(11) of the Act defines a "supervisor" as:

any individual having authority, in the interest of the employer, to hire, transfer, suspend, lay off, recall, promote, discharge, assign, reward, or discipline other employees, or responsibly to direct them, or to adjust their grievances, or effectively to recommend such action, if in connection with the foregoing the exercise of such authority is not merely of a routine or clerical nature, but requires the use of independent judgment.

Section 2(11) is to be interpreted in the disjunctive and the possession of any one of the authorities listed in that section places the employee invested with this authority in the supervisory class. *Ohio Power Co. v. NLRB*, 176 F.2d 385 (6<sup>th</sup> Cir. 1949), cert. denied 338 U.S. 899 (1949); *Allen Services Co.*, 314 NLRB 1060 (1994).

On May 29, 2001, the Supreme Court issued its decision in *NLRB v Kentucky River Community Care*, 532 U.S. 706, 121 S.Ct. 1861, 167 LRRM 2164 (2001), wherein the Court upheld the Board's longstanding rule that the burden of proving Section 2(11) supervisory status rests with the party asserting it. See *Ohio Masonic Home*, 295 NLRB 390, 393 fn.7 (1989); *Bowen of Houston, Inc.*, 280 NLRB 1222, 1223 (1986). However, the Court rejected the Board's interpretation of "independent judgment" in Section 2(11)'s test for supervisory status, i.e., that registered nurses will not be deemed to have used "independent judgment" when they exercise "ordinary professional or technical judgment in directing less-skilled employees to deliver services in accordance with employer-specified standards." 121 S.Ct. at 1863. Although the Court found the Board's interpretation of "independent judgment" in this respect to be inconsistent with the Act, it recognized that it is within the Board's discretion to determine, within reason, what scope or degree of "independent judgment" meets the statutory threshold. See *Beverly Health & Rehabilitation Services*, 335 NLRB No. 54 (Aug. 27, 2001). However, the Court did agree with the Board in that the term "independent judgment" is ambiguous as to the *degree* of discretion required for supervisory status and that such degree of judgment "that might ordinarily be required to conduct a particular task may be reduced below the statutory threshold by detailed orders and

regulations issued by the employer.” 121 S.Ct. at 1867. In discussing the tension in the Act between the Section 2(11) definition of supervisors and the Section 2(12) definition of professionals, the Court also left open the question of the interpretation of the Section 2(11) supervisory function of “responsible direction,” noting the possibility of “distinguishing employees who direct the manner of others’ performance of discrete tasks from employees who direct other employees.” 121 S.Ct. at 1871. See *Majestic Star Casino*, 335 NLRB No. 36 (Aug. 27, 2001).

For instance, direction as to a specific and discrete task falls below the supervisory threshold if the use of independent judgment and discretion is circumscribed by the superior’s standing orders and the employer’s operating regulations, which require the individuals to contact a superior when anything unusual occurs or when problems occur. *Dynamic Science, Inc.*, 334 NLRB No. 56 (June 27, 2001); *Chevron Shipping Co.*, 317 NLRB 379, 381 (1995).

In the instant case, there is no evidence that the RNs, whether acting as a charge nurse or a staff nurse, have independent authority with respect to the hire, promotion, demotion, layoff, recall, reward, or discharge of employees. They do not make staffing decisions, and they do not authorize overtime. The Employer rests its claim of supervisory authority primarily upon other indicia, i.e., the alleged ability to adjust grievances, and the alleged authority to assign and direct the work of less skilled employees.

There is no evidence that the charge nurses are empowered to adjust any formal employee grievances. Charge nurses are not part of the grievance process outlined in the Local 79 contract covering other members of the nursing staff. For the most part, complaints or disputes brought by the nursing staff to the charge nurse that cannot be resolved quickly in an informal manner are relayed to supervision. See *Ken-Crest Services*, 335 NLRB No. 63 (Aug. 27, 2001). Furthermore, there is a lack of evidence that RNs have actually adjusted grievances. The limited authority exercised by charge nurses to resolve interpersonal conflicts among employees does not confer supervisory status. *St. Francis Medical Center-West*, 323 NLRB 1046, 1047-48 (1997).

For every task performed by an RN, there is a very specific policy and procedure in writing. These procedures are available for review by the RNs in their work area; however, some of the more experienced RNs do not need to refer to the policies and procedures on a regular basis due to their length of experience. The limited authority of RNs to assign discrete tasks to less skilled employees, based on doctor’s orders, hospital policy and procedures or standing orders, or what is dictated by their profession, does not require the use of independent judgment in the direction of other employees. *Ferguson Electric Co.*, 335 NLRB No. 15 (Aug. 24,

2001). The RNs do not evaluate the work of the less skilled employees or ensure that they have completed a task or done so correctly.

The Employer asserts that charge nurses exercise independent judgment when they assign staff nurses to particular patients or beds, by matching the level of experience of the employee with the level of acuity of the patient. However, the Employer has a very detailed written policy for the assignment of patients by charge nurses or assistant clinical managers. Pursuant to this policy, it is the responsibility of clinical managers or assistant clinical managers to ensure adequate staffing levels, and the composition of staff as to skill level when it comes to caring for the patients in a particular unit. Direction as to specific and discrete tasks and even the assignment of employees detailing when and where they are to carry out their duties falls below the supervisory threshold if the use of independent judgment and discretion is supervised by the superior's standing orders and the employer's operating regulations. *Dynamic Science, Inc.*, 334 NLRB No. 56 (June 27, 2001); *Chevron Shipping Co.*, 317 NLRB 379, 381 (1995). Furthermore, the weight of the evidence suggests that in practice, the assignments are routine in nature, and are based mainly on principles of fairness and the even distribution of work. *Byers Engineering Corp.*, 324 NLRB 740 (1997); *Providence Hospital*, supra; *Ohio Masonic Home*, supra. For the most part, the schedule is based on the schedule from the previous day, and providing continuity for the patients. Finally, the RNs work together to resolve any problems with patient assignments, based on the very nature of the rotating charge nurse position. A charge nurse assigning a patient to a staff nurse one day, can the next day be assigned a patient from that same staff nurse, when the roles are reversed. A charge nurse also assigns break times for other employees. However, the charge nurse generally sets up the break times in order to ensure coverage on the floor, and receives input from the nursing staff as to when they would like to take their break.

The Employer submits that if RNs are not supervisors, the ratio of nursing supervisors to nursing staff would be preposterous. However, on the other hand, if all staff nurses are found to be supervisors, the ratio of nursing supervisors to nursing staff would be one supervisor for less than every two employees. *Naples Community Hospital*, 318 NLRB 272 (1995); *Essbar Equipment Co.*, 315 NLRB 461 (1994); *Beverly California Corp. v. NLRB*, 970 F.2d 1548, 1550 fn. 3 (6<sup>th</sup> Cir. 1992). Furthermore, clinical supervisors, assistant clinical managers and/or clinical managers are present or on call 24 hours a day to handle any problems that may arise. Consequently, I find that the RN staff nurses/charge nurses are not statutory supervisors.<sup>14</sup>

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<sup>14</sup> Due to the rotating nature of the charge nurse position, the frequency with which each RN serves as a charge nurse varies. Some are permanent charges; some spend nearly half of their time as a charge nurse, and some are hardly ever in charge. Because I find that the charge nurses, whether permanent or rotating, do

5. For the above reasons, and based on the record as a whole, the following employees of the Employer constitute a unit appropriate for the purposes of collective bargaining within Section 9(b) of the Act.

All full-time, regular part-time contingent and in-house flex registered nurses at the Employer's facility, Oakwood Heritage Center, located in Taylor, Michigan; but excluding all physicians, technical employees, other professionals, business office clericals, support service employees, skilled maintenance employees, confidential employees, director of surgical services, nursing site leader, clinical nurse supervisor, assistant clinical manager, clinical manager, nurse externs, graduate nurse externs, and all managers, supervisors, and guards as defined in the Act.

Those eligible shall vote as set forth in the attached Direction of Election.

Dated at Detroit, Michigan this 4th day of February, 2002.

(SEAL)

/s/ Stephen M. Glasser  
Stephen M. Glasser, Acting Regional Director  
National Labor Relations Board, Seventh Region  
Patrick V. McNamara Federal Building  
477 Michigan Avenue, Room 300  
Detroit, Michigan 48226

177-8520-0000  
177-8560-1000  
177-8560-1500  
440-1700

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not exercise statutory supervisory authority, the frequency with which a particular nurse may serve as a charge nurse is not controlling.

## DIRECTION OF ELECTION

An election by secret ballot shall be conducted under the direction and supervision of the undersigned among the employees in the unit(s) found appropriate at the time and place set forth in the notice of election to be issued subsequently, subject to the Board's Rules and Regulations. Eligible to vote are those employees in the unit(s) who were employed during the payroll period ending immediately preceding the date of this Decision, including employees who did not work during that period because they were ill, on vacation, or temporarily laid off. Also eligible are employees engaged in an economic strike which commenced less than 12 months before the election date and who retained their status as such during the eligibility period and their replacements. Those in the military service of the United States may vote if they appear in person at the polls. Ineligible to vote are employees who have quit or been discharged for cause since the commencement thereof and who have not been rehired or reinstated before the election date and employees engaged in an economic strike which commenced more than 12 months before the election date and who have been permanently replaced. Those eligible shall vote whether or not they desire to be represented for collective bargaining purposes by:

INTERNATIONAL UNION, UNITED AUTOMOBILE, AEROSPACE AND  
AGRICULTURAL IMPLEMENT WORKERS OF AMERICA (UAW), AFL-CIO

### LIST OF VOTERS<sup>1</sup>

In order to ensure that all eligible voters may have the opportunity to be informed of the issues in the exercise of their statutory right to vote, all parties to the election should have access to a list of voters and their addresses which may be used to communicate with them. *Excelsior Underwear, Inc.*, 156 NLRB 1236 (1966); *NLRB v. Wyman-Gordon Company*, 394 U.S. 759 (1969); *North Macon Health Care Facility*, 315 NLRB 359 (1994). Accordingly, it is hereby directed that within 7 days of the date of this Decision, 2 copies of an election eligibility list, containing the full names and addresses of all the eligible voters, shall be filed by the Employer with the undersigned who shall make the list available to all parties to the election. The list must be of sufficient clarity to be clearly legible. The list may be submitted by facsimile transmission, in which case only one copy need be submitted. In order to be timely filed, such list must be received in the DETROIT REGIONAL OFFICE on or before FEBRUARY 11, 2002. No extension of time to file this list shall be granted except in extraordinary circumstances, nor shall the filing of a request for review operate to stay the requirement here imposed.

### RIGHT TO REQUEST REVIEW

Under the provisions of Section 102.67 of the Board's Rules and Regulations, a request for review of this Decision may be filed with the National Labor Relations Board, addressed to the Executive Secretary, Franklin Court, 1099 14th Street N.W., Washington D.C. 20570. This request must be received by the Board in Washington by: FEBRUARY 19, 2002.

Section 103.20 of the Board's Rule concerns the posting of election notices. Your attention is directed to the attached copy of that Section.

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<sup>1</sup> If the election involves professional and nonprofessional employees, it is requested that separate lists be submitted for each voting group.

UNITED STATES OF AMERICA  
BEFORE THE NATIONAL LABOR RELATIONS BOARD

OAKWOOD HEALTHCARE, INC.  
Employer

and

Case 7-RC-22141

INTERNATIONAL UNION, UNITED AUTOMOBILE,  
AEROSPACE AND AGRICULTURAL IMPLEMENT  
WORKERS OF AMERICA (UAW), AFL-CIO  
Petitioner

ORDER

Employer's Request for Review of the Acting Regional Director's Decision and Direction of Election is granted solely with respect to the supervisory status of the registered nurses. The Request for Review is denied in all other respects.

PETER J. HURTGEN, CHAIRMAN

WILLIAM B. COWEN, MEMBER

MICHAEL J. BARTLETT, MEMBER

Dated, Washington, D.C., March 5, 2002.

Charge Nurse Policy  
Draft

Purpose: To provide the staff RN with guidelines for the Charge RN role.

Role requirements: RN with one year nursing experience. Must possess good communication, organization, problem solving and prioritization skills. A Service First attitude is necessary.

Procedure:

The Charge RN will:

1. Be responsible for staff assignments, bed assignments, and breaks/lunches for staff.
2. Be responsible for narcotic sheets every shift.
3. Keep the unit in compliance to regulatory requirements.
4. Have a broad knowledge of the patients on their units.
5. Be present at shift report and rounds (if applicable).
6. Create and nurture relationships with other disciplines including physicians.
7. Maintain their unit's Charge RN book by entering data for falls and restraints.
8. Be assigned other tasks as appropriate by unit Clinical Nurse Managers.

Case No. 7RC 22141 Official Exhibit No. EMP 4

Disposition: Identified x  
Rejected Received x

IN THE MATTER OF:

OAKWOOD  
Date: 1-9-02 Witness: THEISEN DD Reporter:

No. Pages:

## IMC CHARGE NURSE RESPONSIBILITIES

1. Make daily pt assignments to RN's, LPN's and NA and Secretary.
2. Assign break times for all staff members and provide coverage as needed.
3. Cover LPN's IV medications and co-sign all phone orders for LPNs.
4. Check pt.'s charts to ensure documentation of daily weights by NA's.
5. Facilitate Nursing rounds on Tuesdays and Thursdays.
6. Facilitate admissions, discharges and transfers, so they occur timely.
7. Assist staff with contacting Doctors for pt orders, change in condition of pt, etc.
8. Remember, you are the first step in the chain of command.
9. Perform Data collection responsibilities each shift.
10. Perform acuity sheet at the end of each shift and document on Acuity log.
11. Make sure all QAR's are filled out and appropriate personnel notified.
12. Observe Cardiac Monitors for arrhythmias and assist with appropriate treatment.
13. Report off to oncoming Charge Nurse who has received admissions/transfers.

5-A

Case No. 7RC 22141 Official Exhibit No. EMPS (A-D)

Disposition: Identified x  
Rejected Received x

IN THE MATTER OF:

OAKWOOD  
Plaintiff vs. Reporter:

1-9-02 THOMAS DP

## Oakwood Heritage Hospital MSW Charge Nurse Responsibilities

1. Assigns patient care assignments according to staff's job description, competency, and patient's acuity.
2. Documents assignments in "Log Book."
3. Assigns coverage and delegates appropriate responsibilities for all unit nursing personnel.
4. Assigns break/lunch periods.
5. Assures "Patient Acuity" forms are completed and reported to supervisor two hours prior to start of next shift.
6. Assists Clinical Manager/designee with QA/QI activities
7. Assures that the responsibility of narcotic count between shifts is completed.
8. Informs Clinical Manager/designee of any acute changes in patient status.
9. Informs Clinical Manager/designee of any problems that are encountered on unit.
10. Correlates bed assignments of newly admitted and/or transferred patients with Bed Control (with regard to patient age, status, and diagnosis).
11. Assures that crash cart is inspected for: properly functioning defibrillator, charged battery, verification of lock, and availability of appropriate equipment (located on top and side of cart).
12. Assist co-workers as needed to promote continuity and flow on unit - champion and encourage team approach to patient care.

5.6

NICHE

### Oakwood Heritage Hospital MSE Geriatric Registered Nurse (GRN) Responsibilities

1. Assigns patient care assignments according to staff's job description, competency and patient's acuity.
2. Documents assignments in "Log Book."
3. Assigns coverage and delegates appropriate responsibilities for all unit nursing personnel.
4. Assigns break/lunch periods.
5. Assures "Patient Acuity" forms are completed and reported to supervisor two hours prior to start of next shift.
6. Assists Clinical Manager/designee with QA/QI activities (D/C data, Fall data, FIM data, etc).
7. Monitors DSPICES; consult creation.
8. Assures that the responsibility of narcotic count between shifts is completed.
9. Informs Clinical Manager/designee of any acute changes in patient status.
10. Informs Clinical Manager/designee of any problems that are encountered on unit.
11. Correlates bed assignments of newly admitted and/or transferred patients with Bed Control (with regard to patient age, status, and diagnosis).
12. Assures that crash cart is inspected for: properly functioning defibrillator, charged battery, verification of lock, and availability of appropriate equipment (located on top and side of cart).
13. Assist co-workers as needed to promote continuity and flow on unit - champion and encourage team approach to patient care.

Sue Caines

MSE

January 2001

REVIEWED 1/95, 3/90, 3/97

5-C

APPROVED BY	TITLE
BRENDA THEISEN RN	UNIT GUIDELINE: CHARGE NURSE RESPONSIBILITIES

- I PURPOSE Responsibilities of the Charge Nurse defined.
- II EQUIPMENT
- III GENERAL INFORMATION
  - 3.1 Policy
    - A Charge Nurse assignments will be made by the Nurse Manager or designee in SCU. On assigned day, Charge Nurse will not be "pulled" to any other zone, however, will be added to next pull rotation.
    - B Charge Nurse will have demonstrated competency in fulfilling these duties.
- IV PROCESS
  - 4.1 Procedure - The Charge Nurse will:
    - A Determine patient care assignments for RN, LPN, GN, NE, and NA with consideration to staff capabilities/competence.



- |  |   |
|--|---|
| <input type="checkbox"/> OHS                           | <input type="checkbox"/> Ambulatory _____ |
| <input type="checkbox"/> OH & Medical Center-Dearborn  | <input type="checkbox"/> LTC _____        |
| <input checked="" type="checkbox"/> OH Heritage Center | <input type="checkbox"/> Department _____ |
| <input type="checkbox"/> OH Annapolis                  | <input type="checkbox"/> Other _____      |
| <input type="checkbox"/> OH Beyer Center               |   |
| <input type="checkbox"/> OH Seaway Center              |   |

TITLE: ASSIGNMENT (PATIENTS)

I. PURPOSE

To provide guidelines for determining patient care assignments.

II. EQUIPMENT

- Acuity reports
- Competency Logs
- Shift to shift reports
- Assignment sheets

III. GENERAL INFORMATION

3.1 POLICY

Decisions for patient care assignments are based on the degree and complexity of care required by the patient and competency of staff to meet those needs.

IV. PROCESS

4.1 PROCEDURE

- A. Nursing staff is allocated to the inpatient units by Nurse Manager/Administrative Nursing Supervisor.
- B. Assistant Nurse Manager/Charge Nurse (assigned by the Nurse Manager)
  - assigns/delegates care needs based on the ability of the patient to do self care, degree of illness, complexity of nursing skills required, and the competency and qualifications of staff.



OHS	Ambulatory
OH & Medical Center - Dearborn	LTC
OH Heritage	Department
OH Annapolis Center	Other
OH Beyer	
OH Seaway Center	

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#### ASSIGNMENT OF NURSING PERSONNEL

Approved by: Acute Care Nursing Operations Council

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- I. OBJECTIVE: To establish guidelines for the assignment of nursing personnel and to provide adequate numbers of licensed staff and other personnel to deliver care to patients.
  
- II. GENERAL INFORMATION:
  - A. An RN must assign the care of each patient to other members of the healthcare team in accordance with the patient's need, and the qualifications and competency of the Nursing staff.
  - B. The assigned Registered Nurse retains overall responsibility for his/her assigned patients when care is provided by students and/or other non-Oakwood personnel.
  - C. Patient care assignments are made by the Clinical Manager or the Registered Nurse in charge for that shift. Assignment will be reviewed on an ongoing basis and changes made in response to the patients' changing conditions.
  - D. The assignment of the patient takes into consideration the acuity level and clinical needs as identified by the Acuity System and the clinical assessment by the Charge Nurse. The patient's acuity is used to determine the level of skill required to care for the patient.
  - E. A Clinical Supervisor or designee is on duty on all shifts to ensure the immediate availability of licensed staff (including but not limited to the System Flex Pool and the in-house Flex Pool) for bedside care of any patient, in the event of a sudden increase in census and/or acuity. The Supervisor or designee makes rounds on all units, assessing unit activity and acuity, and makes assignments for additional staff based on these, and other, parameters.

- F. The Registered Nurse is responsible for the completion of an admission assessment and developing the initial plan of care. Refer to "Admission of a Patient", Policy and Procedure.
- G. Delegation of nursing care activities is the responsibility of the Registered Nurse.
- H. Sudden changes in acuity or census may require the additional support of licensed and other staff. The Clinical Supervisor or designee must be notified and arrangements made for the assignment of a System Flex RN, a Flex RN, or other staff.
- I. Nursing Site Leaders, or designee, maintain 24 hour accountability and availability to ensure continuous appropriate staffing levels and the availability of resources.

### III. PROCEDURE:

- A. When reviewing the unit schedule, the Clinical Manager may make assignment of unit personnel to specific areas, teams or other responsibilities, such as Charge Nurse.
- B. After receiving report, the Charge Nurse and Team Leaders will determine staff assignments.
  - 1. The Charge Nurse will meet with the assigned staff to review patient condition and care activities to be completed for that shift.
  - 2. Specific patient care tasks will be assigned based on competencies and classification of the staff, and care required.
  - 3. All attempts will be made to distribute workload evenly among team members.
  - 4. Special assignments are made at the beginning of the shift, i.e., Code Blue, crash cart checks, lunches and breaks.
- C. General considerations for the assignment of staff to patient care.

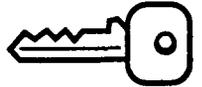
1. The educational preparation and experience of personnel should meet the patient's requirements, i.e., patients with complicated treatments or requiring frequent assessments for change in status may be assigned to a Registered Nurse, while convalescing patients with minimal treatments or educational needs may be assigned to an LPN under the direction of a RN.
2. Assignment of complex care to people requiring additional supervision should only be made if such supervision is available, i.e., new personnel should be assigned to care activities that can be adequately supervised by identified preceptors.
3. Patients should be assigned based on needs within the group, i.e., workload with the team should be evenly distributed by activities and responsibilities and not strictly numbers of patients. (LPN's may be able to handle larger number of patients than the Registered Nurse who is caring for more complex patients or who has additional responsibilities).
4. Patients should be assigned to nursing personnel so as to provide continuity of care, i.e., a nurse may be assigned to the same group of patients from one day off to another so as to change assignments no more than necessary.
5. Assignments should be made in such a way as to avoid cross-contamination, i.e., patients with known infections should not be assigned to the same person who is caring for patients who have open wounds, are immunosuppressed or are receiving medications which result in immunosuppression. There are other patient conditions that restrict assignments. These can be seen in the Infection Control guidelines.
6. Assignments must be flexible and allow for changes in patients' conditions.
7. Other considerations for assignment:
  - a. The Clinical Manager/Charge Nurse should view other activities for the shift and make appropriate assignments.
  - b. Such activities include the following:
    - 1) patient care conferences
    - 2) inservices, workshops
    - 3) committee meetings



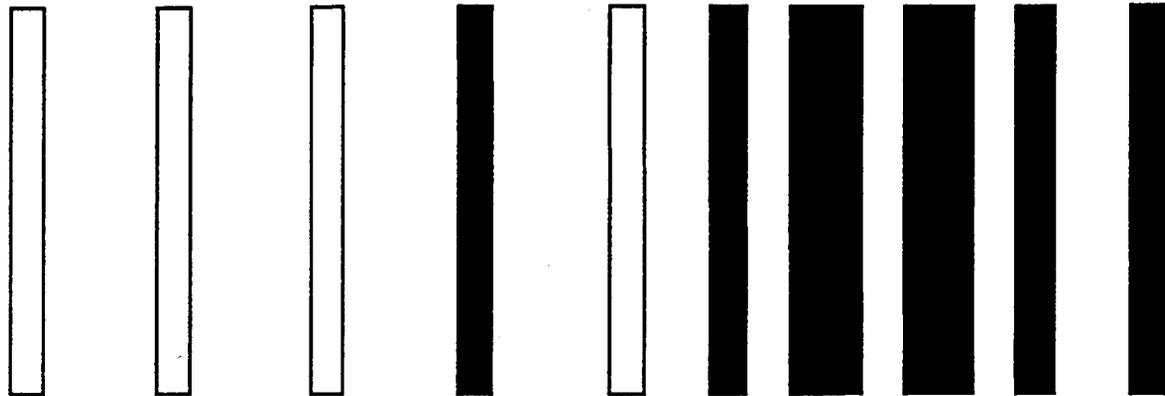
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Effective Date: 8/15/99  
Revised: 6/9/00

- 4) unit maintenance activities, such as painting of rooms
  - 5) personnel development - library time
- c. Assignments will be recorded on a specific form and will include:
- 1) date of care
  - 2) specific assignment for each employee
  - 3) resource person for LPN, nurse extern's, NA's
  - 4) any special assignment, i.e., Code Blue, crash cart checks

# Kodak ImageSource 110 Copier Key Sheet



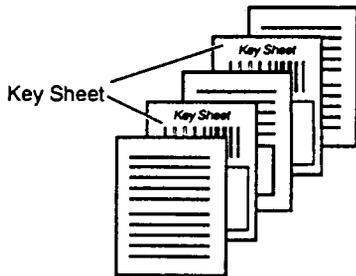
## Inserts - Preprinted/Blank



O P E R A T O R

I N S T R U C T I O N S

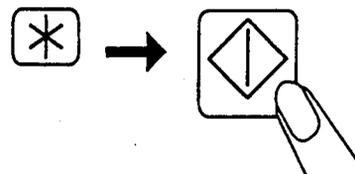
- 1 Place the Key Sheet(s) exactly where the insert is to be placed.



- 2 Place your originals and Key Sheets in the feeder face up and make your Standard Features selections.

- 3 Place the preprinted/blank inserts in the upper paper supply.

- 4 Press "Star" then "Start" to activate the Key Sheet.



**Note:** The Key Sheets will exit into the positioner exit hopper. Copies of this Key Sheet may also be used.



OHS	Ambulatory
OH & Medical Center - Dearborn	LTC
OH Heritage	Department
OH Annapolis Center	Other
OH Beyer	
OH Seaway Center	

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#### CHAIN OF COMMAND: NURSING

Approved by: Acute Care Nursing Operations Council

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I. OBJECTIVE: To provide a mechanism for the nursing staff to communicate and resolve issues/concerns.

II. GENERAL INFORMATION:

When a nurse encounters a problem he/she is unable to resolve, (i.e., in rendering patient care; carrying out a physician's order in a timely manner such as lab work, x-rays; treatments not being done; or not being able to procure needed equipment) the chain of command will be instituted.

III. PROCEDURE:

Process of Chain of Command:

1. Nursing staff member communicates verbally and/or in writing of a concern/issue to charge nurse and/or Clinical Manager/Clinical Supervisor.
2. If unable to resolve, the nurse manager/supervisor will contact the Nursing Site Leader.
3. If unable to resolve, the Nursing Site Leader will contact the Administrator/Service Line Leader/Risk Management, as deemed necessary. Situations requiring notification of the Administrator on call are, but not all inclusive:
  - a. disaster (fire, severe weather; may be internal and/or external).
  - b. medical staff events needing assistance.
  - c. media contacts (TV, radio, etc.).



Oakwood  
Healthcare System

Page 2 of 2

Effective Date: 8/15/99

Supersedes Policy Dated: 9/96

- d. request by a significant third party (i.e., patient, family and/or physician requests, Administrator(s) of another Oakwood facility/hospital).
  
- e. any incident or situation that would have a significant impact on the site/organization.

CHECKLIST FOR CHARGE NURSE ORIENTATIC

NAME: Hudok Pam  
 UNIT: 2 EAST  
 SHIFT: 7-3<sup>30</sup>P  
 MANAGER: Monroe RN  
 DATE: 1-96

The above named has successfully performed the following responsibilities required of a Charge Nurse:

- YES  NO Assigns patient care assignments according to staffs job descriptions.
- YES  NO Documents assignments in log book.
- YES  NO Assigns coverage and delegates appropriate responsibilities for GN, LPN and Nurse Extern.
- YES  NO Assigns breaks and lunches.
- YES  NO Assures Patient Classification Forms are completed and sent to Information Systems on time.
- YES  NO Assigns Code Beeper in ICU and Beeper in Behavioral Medicine.
- YES  NO Assists Nurse Manager with QA/QI activities.
- YES  NO Assures that the responsibility of narcotic count between shifts is completed.
- YES  NO Informs Nurse Manager or designee of any acute changes in patient status.
- YES  NO Informs Nurse Manager of designee of any problems that are encountered on thier unit.
- YES  NO Correlates bed assignments of newly admitted patients with admitting and patient diagnosis.
- YES  NO Reorders necessary supplies for units optimal functioning.
- YES  NO Assures that crash cart is inspected for properly functioning defibrillator, batteries are charged, lock verification and appropriate equipment is located on top and sides.

Signature/Title: Monroe RN - NM

Signature/Title: \_\_\_\_\_

Clinical Supervisor / Nurse Manager / Assistant Clinical Manager to Staff Ratios

DAY	DATE	EVENINGS	DAYS	MIDNIGHTS
Sunday	November 18	3:84	1:80	1:52
Monday	November 19	3:89	7:91	1:52
Tuesday	November 20	4:81	8:89	1:53
Wednesday	November 21	3:81	5:86	1:55
Thursday	November 22	1:71	1:76	1:51
Friday	November 23	1:77	4:80	1:48
Saturday	November 24	2:79	1:78	1:54
Sunday	November 25	1:80	1:74	1:53
Monday	November 26	3:79	5:83	1:52
Tuesday	November 27	4:79	6:81	1:53
Wednesday	November 28	2:80	8:81	1:54
Thursday	November 29	2:78	7:87	1:53
Friday	November 30	1:73	7:83	1:50
Saturday	December 1	1:80	1:77	1:52
Sunday	December 2	3:73	1:77	1:52
Monday	December 3	2:83	5:80	1:50
Tuesday	December 4	4:84	8:92	1:58
Wednesday	December 5	1:86	6:88	1:57
Thursday	December 6	1:78	7:83	1:56
Friday	December 7	2:77	6:84	1:52
Saturday	December 8	1:72	1:75	2:52

Case No. TRC 22141 Official Exhibit # EMP 9

Disposition: Identified X  
 Rejected Received X

IN THE MATTER OF:

OAKWOOD  
 Date: 1-9-02 Witness: THEISEN DD