IN THE MATTER OF AN ARBITRATION

BETWEEN:

SERVICE EMPLOYEES INTERNATIONAL UNION, LOCAL 1 CANADA

and

SUNRISE – THORNE MILL ON STEELES

Grievance of Jacqueline Ociones

Before: Jesse M. Nyman
Sole Arbitrator

Appearances

For the Employer: Katherine Ford – Counsel
Matthew Badrov – Counsel
Alyssa Barbuzzi – Student-at-Law
Adam James – Student-at-Law
Deborah Matheson – Regional Manager Employee Relations
Alberto Golia – Executive Director (July 8, 2016 only)
Athena Aird – Resident Care Director

For the Union: Meg Atkinson – Counsel
John Romanelli – Union Representative
Dervent Davis – Chief Steward
Jacqueline Ociones - Grievor

This grievance proceeded to a hearing in Toronto, Ontario on July 8, September 8, November 10 and 15 and December 14, 2016 and January 31, 2017.

1. The employer, Sunrise – Thorne Mill on Steeles ("TMOS" or the "Employer") operates a retirement residence in Thornhill. The union, Service Employees International Union, Local 1 Canada (the "SEIU" or the "Union") represents a bargaining unit of employees employed by TMOS. The Employer and the Union are parties to a collective agreement covering the employees in the bargaining unit (the "Collective Agreement")

2. This grievance concerns the Greivor's termination from employment on May 4, 2015 following an incident on April 24, 2015 involving a resident, Mr. X.[1] The SEIU grieved that the discharge was without just cause. The SEIU's primary position is that no discipline was warranted. In the alternative, the SEIU argues discharge is excessive. This decision determines that issue. At the hearing the parties agreed that if I find that there are grounds for discipline but that discharge is excessive, I should reconvene the hearing to hear submissions on the appropriate penalty.

3. Counsel are to be commended for their thorough and efficient work in presenting the evidence and arguing the issues that arose in this proceeding. Having carefully considered all of the evidence and the parties' representations I find that the grievor engaged in culpable conduct, but that I should exercise my discretion and substitute a penalty lesser than discharge. My reasons are as follows.

THE FACTS

4. TMOS called five witnesses: Mr. Alberto Golia, Ms. Athena Aird, Ms. Nasha Samuel, Mr. J and Ms. Lynda Welch. The SEIU called the grievor and Ms. Shirley Strachan-Jackman. Mr. Golia was the Executive Director of TMOS at the relevant time and made the ultimate decision to discharge the grievor. Ms. Aird was the Health Care Coordinator at TMOS in April, 2015. She is currently the Resident Care Director. She was the grievor's immediate supervisor and conducted the investigation that lead to the grievor's discharge. Ms. Samuel is a Care Manager at TMOS. She testified as to what she observed on April 24, 2015. Mr. J is Mr. X's grandson. He testified as to what he observed on April 24, 2015. Ms. Welch and Ms. Strachan-Jackman were called as expert witnesses to provide opinion evidence on the appropriate nursing standards and whether the grievor's actions on April 24, 2015 met those standards.

5. As counsel to TMOS noted, many of the facts are not in dispute. As such, the facts that follow are synthesized from all of the evidence of the witnesses. Where there were material distinctions in the evidence of two or more witnesses, those distinctions are noted and resolved below. The evidence of the two experts is dealt with separately.

6. TMOS is a retirement residence located in Thornhill, Ontario. It is Sunrise's largest retirement residence in Canada. It opened in 2008. The residents live in suites spread across twelve floors. There are also common areas including reception and a dining room.

[1] The parties agreed that the resident and his family should be anonymized for the purpose of this decision.

7. TMOS has approximately 266 residents. Approximately 200 residents live in independent living. These residents have their own suites with a kitchenette. The degree of care which they receive varies but by and large they are able to carry out most of the activities of daily living on their own. There is also reminiscent care for approximately 33 residents with cognitive challenges such as dementia and Alzheimer's disease. Finally, there are approximately 33 residents in assisted living who require higher levels of care.

8. TMOS has approximately 145 employees including bargaining unit and non-bargaining unit employees.

9. There are a number of classifications in the bargaining unit including Care Managers and Wellness Nurses. Care Managers are equivalent to Personal Support Workers. They assist the residents as needed with their activities of daily living including dressing, cleaning, meals and hygiene. The Wellness Nurses are Registered Practical Nurses ("RPN"). Wellness Nurses tend to the health care needs of the residents in the building. This includes caring for wounds, checking blood pressure and monitoring residents' overall health.

10. Ms. Aird is an RPN and has been a member of the College of Nurses since 2011. In April, 2015 Ms. Aird was the Health Care Coordinator at TMOS. In that role she oversaw all of the Wellness Nurses and the Medication Care Managers (or Care Technicians) employed by TMOS. Medication Care Managers are trained to deliver medication to the residents. There are nine Wellness Nurses and approximately twelve Medication Care Managers under her direction.

11. There are two ways in which TMOS residents can seek nursing care. The first is to visit the Wellness desk on the second floor. The second is to pull a cord located in their suite (there are two or three cords in each suite depending on the size of the suite). When the cord is pulled, it rings on a scout phone. The Care Managers and Wellness Nurses carry a scout phone with them and either may respond to a pull cord call. The time frame to respond to a pull cord call is seven to nine minutes. If the Care Manager arrives and determines a nurse is required, the Care Manager will call the Wellness Nurse.

12. All patient care interactions are charted in YARDI which is a computerized medical record maintained by TMOS.

13. The grievor completed her training as a nurse in the Philippines in 1993 and worked as a nurse for several years thereafter. In 2001 she moved to Canada.

14. The grievor was hired as a Care Manager at TMOS' initial job fair and began working at TMOS in February 2008. In 2009 she was promoted to Lead Care

Manager. In April 2009, the grievor received her license to practice nursing in Ontario and in 2010 she was promoted to a Wellness Nurse position. From 2010 to 2013, she worked as a night Wellness Nurse. In 2013, the grievor moved to the day shift.[2]

15. Prior to her discharge the grievor had no discipline on her file and the evidence before me indicates that TMOS was generally happy with her work performance.

16. The grievor estimated that she would call 911 between four and ten times per month since the time she was promoted to the Wellness Nurse position.

17. Mr. X and his wife, Ms. X, live in an independent living suite at TMOS. They received some care but by and large lived independently. The entrance to their suite is in the living room. The kitchen is to the right of the entrance. Past the living room is a television room and a bedroom.

18. In April 2015 Mr. X was 92 years old. Ms. X was approximately 81 years old.

19. The grievor had never met Mr. or Ms. X prior to April 24, 2017. Neither had Ms. Samuel.

20. At some point between 8:00 a.m. and 8:30 a.m. on April 24, 2015, Ms. X noticed that Mr. X was having difficulty holding his toothbrush and his speech was slurred. At some point before 10:30 a.m. she spoke with her daughter C. C was clearly concerned about her father's health and believed he was suffering a stroke. C called her son J who headed to TMOS. Either C or Ms. X spoke with C's brother M who also headed to TMOS.

21. At approximately 10:30 a.m. Ms. Samuel received a pull cord call from Ms. X. She proceeded to Mr. and Ms. X's suite and met Ms. X at the door to the bedroom. Ms. Samuel testified that Ms. X said that Mr. X. was not feeling well. Mr. X was sitting on a chair putting his pants on. He was not having difficulty doing so and was talking. Ms. Samuel told Ms. X she would call the nurse and she stepped out of the room and called the grievor. Ms. Samuel told the grievor that Ms. X said her husband was not feeling well and the grievor said she would come. Ms. Samuel told Mr. and Ms. X that the nurse was on her way.

22. At the time she gave her evidence, Ms. Samuel could not recall if Ms. X had told her that she thought Mr. X had had a stroke.

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[2] There was a dispute about whether the grievor was promoted to a Lead Care Nurse position. I find it unnecessary to resolve the dispute. In any event, it ultimately appeared there was simply confusion about the title of the day nurse position.

23. At 10:30 a.m. on April 24, 2015 there were only two nurses on duty at TMOS: Ms. Aird and the grievor. At the time of the call Ms. Aird and the grievor were together in the suite of another resident whom Ms. Aird described as "aggressive". The call from Ms. Samuel came through saying Mr. X needed assistance. Ms. Aird could not really remember what reason was given on the call for Mr. X needing a nurse. Ms. Aird directed the grievor to respond to the call. The grievor left Ms. Aird and proceeded to Mr. X's suite.

24. The grievor testified that the call came to her at 10:38 a.m. and that she knew that because she checked the time that the computer had recorded the call when she documented the incident. The grievor testified that Ms. Samuel told her on the initial call that Mr. X was not feeling well.

25. When the grievor arrived at Mr. and Ms. X's suite she met Ms. Samuel at the door. The grievor testified that Ms. Samuel told her that Ms. X had noted signs of a stroke in the morning but that Mr. X seemed fine to Ms. Samuel. Ms. Samuel reported that Mr. X had put his pants on and asked Ms. Samuel why she was there. The grievor testified that she and Ms. Samuel walked into the suite to check on Mr. X.

26. Ms. Samuel testified that when the grievor arrived she started talking with Mr. X and took his blood pressure. The grievor then asked Ms. X if Mr. X had taken his blood pressure medications. Ms. Samuel testified that Mr. X could not remember if he had taken his medication. The grievor suggested that Mr. X take his blood pressure medication and she would recheck Mr. X's vitals after. Ms. Samuel could not recall how long the grievor said she would wait.

27. The grievor testified that when she entered the room Mr. X was pointing at his wife and saying "go ahead and have your lunch, don't worry about me." The grievor testified that she asked Ms. X what was wrong and Ms. X said she had observed slurred speech at approximately 8:00 a.m. in the morning when Mr. X woke up. The grievor testified that she asked Mr. X what happened and he said he was fine. The grievor asked if there was a concern and Mr. X responded "what?" The grievor's perception was that he had difficulty hearing so she kneeled in front of him and said "I am here to check on you."

28. The grievor testified that she was trying to calm Mr. X and that she rubbed his back and asked him to relax so she could take his blood pressure. She testified that he kept trying to stand and asking why she was there. The grievor put the cuff on Mr. X's arm and received a blood pressure reading of 200/90. She also noted that his temperature, pulse and breathing rate were all normal. The grievor did not have any familiarity with Mr. X and did not have his medical files so she asked Ms. X if he took blood pressure medication. Ms. X said he did but did not know if he had taken it that morning. The grievor testified that she did

not believe the initial blood pressure reading was accurate because Mr. X was anxious and moving around. She testified that she suggested he sit down and have a drink of water and relax so she could retake the blood pressure and that was when J arrived.

29. The grievor testified that at that point Mr. X's pulse, breathing and temperature were all normal. He also seemed alert and stable and was talking. The only concern she noted was the blood pressure. The grievor testified that she also considered that Ms. X had told her that Mr. X had slurred his speech in the morning. The grievor testified that she thought it was possible that Mr. X had suffered a Transient Ischemic Attack ("TIA")[3] that had since resolved. It was acknowledged by both parties that the symptoms of a TIA can come and go over time.

30. Ms. Samuel testified that J arrived after the grievor had taken Mr. X's blood pressure and had inquired about his blood pressure medication. She testified that Mr. X kept asking why everyone was there. Her impression was that he was hard of hearing but was not confused. She testified that he was not behaving in a way that raised any concern for her. Ms. Samuel testified that J was saying his grandfather did not normally act this way and he wanted to take him to the hospital. Ms. Samuel testified that the grievor told J that he could take his grandfather to the hospital because Mr. and Ms. X lived in independent living. The grievor also told J that Mr. X's blood pressure was high and that she was trying to get him to calm down. At that point Ms. Samuel received a call to assist a resident on the fourth floor and she left Mr. and Ms. X's suite.

31. The grievior testified that she told J his grandfather's blood pressure was high and that J was telling her his grandfather "is not like that." The grievor testified that she told J that Mr. X was anxious and she needed to retake his blood pressure. She said she told Mr. X that if his blood pressure was still high he needed to go to hospital for further evaluation and that it was better to be safe. The grievor testified that Mr. X said he did not want to go to the hospital and wait for hours and hours. J was trying to convince his grandfather to go to the hospital but Mr. X kept asking why everyone was there. The grievor testified that J said he would take his grandfather to the hospital, not that 911 should be called.

32. The grievor testified that M and his wife arrived and M told Mr. X he needed to go to the hospital. The grievor testified that she began speaking with M and that J and Mr. X were having their own conversation.

[3] In very simplistic terms, a TIA is a very mild stroke that resolves itself.

33. J testified that he is in sales. He has no formal medical training. He testified in cross examination that his grandparents are incapable of determining whether they are facing an emergency. He confirmed his grandfather wears a hearing aid. He testified that he was able to determine his grandfather's medical condition because he has seen commercials on television and has friends who went to medical school with whom he has "had countless conversations about people suffering heart attacks and strokes." He also took first aid training in 2006. He testified that it is not hard to recognize a stroke.

34. J testified that his mother phoned him on the morning of April 24, 2017 and told him that his grandfather was "feeling off" and "having trouble speaking." After receiving that call he went straight to TMOS and arrived at approximately 10:30 a.m. Upon arrival, he proceeded directly to reception and told the receptionist his grandfather had likely had a stroke. He had reached that conclusion based on the information conveyed to him by his mother.

35. J testified that when he arrived at his grandparents' suite he saw his grandparents and two nurses in the television room. He testified that he asked his grandfather how he was feeling and that his grandfather looked flustered and was having trouble putting together sentences. J testified that his grandfather's demeanour was very out of character.

36. J testified that he discussed his grandfather's demeanour with the grievor and Ms. Samuel in the room. He testified that the nurses then took Mr. X's blood pressure which was 200/90. J testified that he told the nurses that his grandfather was having a stroke. He testified that one of the nurses disagreed and said he was flustered, needed some water and food and she would come back in a half an hour to an hour to check on him. He testified that he told the nurse his grandfather needed an ambulance but she disagreed and said if he wanted to call one he could, but she was not going to. He denied that the grievor said she was trying to get Mr. X to calm down. He also denied that she said she wanted to retake his blood pressure in five minutes or that she recommended he go to the hospital if his blood pressure did not come down in five minutes. He did not recall the grievor asking if Mr. X had taken his blood pressure medication.

37. J also denied that Mr. X said he did not want to go to the hospital. He said that would have been surprising given his grandfather's state. In cross examination, he said his grandfather was confused because "his brain was hemorrhaging." He testified that he believed this because he understood that the hospital had subsequently confirmed Mr. X had a stroke. J conceded he could not say when the stroke occurred on April 24, 2015.

38. J testified that a few moments later his uncle M arrived and spoke with the nurses and J told his uncle that Mr. X needed an ambulance. J testified that M

called for an ambulance after assessing the situation. J testified that he remained in the television room with his grandfather and that everyone else was in the living room. In cross examination, he testified that he had no knowledge of the conversation between M and the grievor because he was in the television room and they were in the living room. The ambulance arrived ten to fifteen minutes later and determined that Mr. X had to go to the hospital based on the high blood pressure and slurred speech. J testified that by the time EMS arrived Mr. X was having greater difficulty speaking. He testified that this deterioration occurred between the time 911 was called and EMS arrived.

39. The grievor denied that she ever suggested they wait an hour to an hour and half to recheck Mr. X's blood pressure. She also denied suggesting he eat something first.

40. The grievor testified that after M arrived he asked her if he should call 911 or would she. The grievor testified that she responded that he could call if he liked but that if he wanted she could call 911. M responded that he would call 911 and he went to do that. The grievor estimated that M called 911 approximately a minute and a half after she took Mr. X's blood pressure. While M called 911, the grievor told M's wife that she needed to attend to another resident, wrote Mr. X's vitals on a piece of paper and told her to call the Wellness desk if she needed any assistance. The grievor then told Mr. X that everything would be alright and "911 was on its way". At that point the grievor left to assist Ms. Samuel with the resident on the fourth floor.

41. The grievor testified that Mr. X remained stable and talkative and that his disposition did not observably change during the time she was in the suite. She testified that she did not perceive any urgent medical situation but believed Mr. X should go to the hospital for further evaluation. The grievor testified that she did not take Mr. X's blood pressure a second time because he had never really relaxed, he appeared stable and EMS was on its way. She also testified that she believed her assistance was required with the resident on the fourth floor and that no other nurse was available at the time.

42. When the grievor reached the fourth floor Ms. Samuel advised her that the resident had only wanted her lunch. Rather than returning to Mr. X's suite, the grievor proceeded to the second floor to review Mr. X's chart. What she found was an incomplete record. She then received a call from a Medication Care Manager requesting that she check the medications for a resident on the ninth floor. She left the second floor and proceeded to the ninth floor.

43. When Ms. Aird finished with the aggressive resident she went downstairs and saw an ambulance. She was told it was for Mr. X and she proceeded to her office. Shortly thereafter she received a call from the receptionist asking her to

come downstairs to meet with a family that was upset. When she arrived at reception she met C and J.

44. She testified that C and J were clearly upset. She recalled that J used the word negligent. They were upset that the nurse on duty did not call 911. They said that Mr. X's blood pressure was 200/90 and he was "clearly stroking" and the nurse did nothing. They demanded she come down in front of them immediately.

45. The grievor was called down from the ninth floor to meet with the family. J was irate and called the grievor negligent. Ms. Aird testified that the grievor tried to explain she was going to return. The grievor testified that she told the family she was giving Mr. X an opportunity to determine on his own if he wanted to call 911 and that if he did not want to she ultimately would have. Ms. Aird testified that C and J stormed off.

46. Ms. Aird asked the grievor for her explanation and then Ms. Aird and the grievor returned to work. The grievor subsequently prepared a written statement which she provided to Ms. Aird on April 24, 2015. The statement reads:

> April 24, 2015 @10:38 hours
>
> Re: [Mr. X]
>
> While dealing with the emergency On the Rem community together with the HCC, Writer received a call from the IL care manager stating that the wife of the resident asking to see the resident. Responded and seen resident sitting on the couch alert and talking to his wife telling her to go and eat and do not worry about him. Writer asked what is the concern and wife said that, at 0800 hours she noted slurred speech on her husband as well as husband anxious and nervous, so she phones her son and daughter. Writer assess resident and there is no slurred speech noted, he talks and talks.
>
> While taking vital signs, the grandson arrived, BP 200/90 P89, R20 and T 36.7. Inform the grandson that BP is high. Encourage resident to relax and have some water and retake the BP after 5 minutes and if the BP does not go down then resident need to go to the hospital. The grandson said that his grandpa is not like that (resident talks a lot). When the resident hear that he go to the hospital he reacts and said he do not want to go and wait for hours and hours.
>
> While writer speaking to the resident encourage him that it is better to be safe, the son and the wife arrived and the son said that dad, you need to go. The son ask writer if he call ambulance, writer stated that he can call or if he want writer to call that is fine but the son said I will call, he called ambulance. Writer ask the family if there is a help that

> writer can do, please call wellness. The son and wife as well as the resident's wife are thankful for the writer and the IL care manager who responded for the call.
>
> COMMENT: Neglect resident as per daughter and son. Writer responded when call received. Secondly encouraging resident to go to the hospital and son arrived and call ambulance. There is no time wasted, PROTOCOL FOLLOWED.

47. Ms. Aird testified that if blood pressure is 200/90 it is very high and that at even 170 a nurse would do a double take

48. Ms. Aird testified that, approximately an hour after the ambulance departed, the family of Mr. X called and reported that he had had a stroke.

49. Mr. X returned to TMOS the next day or the day after. While the records indicate that Mr. X had suffered some sort of medical incident it was never clear whether what he had suffered was a TIA or an ischemic stroke. It is not necessary to determine Mr. X's exact diagnosis for the purpose of this decision. In cross-examination Ms. Aird agreed that TMOS did not know if Mr. X had suffered a stroke or TIA before or after he was seen by the grievor.

50. On April 27, 2015 Ms. Aird met with Ms. Samuel. The notes of that meeting were entered in evidence and Ms. Samuel confirmed they were accurate. The notes indicate that when Ms. Samuel arrived Mr. X appeared "ok" and was putting on his clothes and asked why she was there. Ms. Samuel confirmed that the grievor had arrived and taken Mr. X's blood pressure and that it was high. Ms. Samuel remembered the grievor asking if Mr. X had taken his pills and Ms. X said he had. Ms. Samuel said that it was at this point that J arrived. J spoke with the grievor and said something was wrong with his grandfather. The grievor suggested they wait a bit to see if the blood pressure would go down but J wanted to call 911. Ms. Samuel said that the grievor said J could go ahead and call 911 because he is independent. At that point Ms. Samuel left.

51. Ms. Aird also received a statement from J on April 27, 2015. J testified that he was asked to prepare it by TMOS. J testified that the note accurately reflected what had occurred on April 24, 2017. That statement reads:

> I, [J], arrived at Thornemill approximately at 10:30 am on Friday April 24th because my mother informed me that my grandfather, [Mr. X], had likely had a stroke. I walked in and immediately informed the front desk that my grandfather had likely had a stroke and then I proceeded directly to my grandparent's [*sic*] apartment. When I walked in my grandfather was with two nurses, who had just taken his blood pressure. His blood pressure was 200/90, which is dangerously high.

> The nurse told my grandfather it is a bit high and she would give him some water and come back in half an hour to an hour to check his blood pressure again. I saw something was wrong immediately because my grandfather could not put together coherent sentences. I told the nurse that an ambulance needs to be called immediately because of the combination of dangerously high blood pressure and slurred, incoherent speech were [*sic*] the telltale signs of a stroke. The nurse claimed that she didn't think this was anything alarming because maybe he was just anxious and told me if I wanted an ambulance to be called I could do that myself. She did not take any responsibility for the situation, and it was clear that if I, my uncle, my mother or my aunt had not arrived my grandfather would have likely died. This was blatant negligence on the part of the nurse and it is completely unacceptable. The lives of my grandparents have been entrusted to this person, and if they cannot see the basic warning signs of a stroke, then they are likely not qualified to be working their post.

52. J prepared his statement at home and brought it in to Ms. Aird. Ms. Aird testified that she did not otherwise meet with or interview J or other members of Mr. X's family. Nor did she interview Mr. X.

53. The grievor returned to work on April 28, 2015 and was interviewed by Ms. Aird on April 28, 2015 and again on April 30, 2015. The grievor was placed on a paid administrative leave following the April 28, 2015 interview.

54. During each interview, Ms. Aird asked the grievor a series of prepared questions and her answers were recorded. On April 28, 2015, the grievor said that Ms. Samuel had told her that Mr. X's wife thought Mr. X had had a stroke and that she was only in the suite for approximately five minutes. She denied that she said she would come back in a half hour to an hour and repeated her statement that she had told Mr. X he would have to go to the hospital but that Mr. X did not want to go. She also denied telling J he could "call 911 himself if they wanted because they are independent residents."

55. She also explained that she understood the protocol was to take blood pressure twice and then call the family to inform them that she was sending the resident to the hospital. She stated if an independent-living resident or their Power of Attorney refuses, she understood that she should not send the individual to the hospital without his or her permission.

56. The grievor explained to Ms. Aird that she only took the blood pressure once because at that point the grandson arrived and began talking about taking Mr. X to the hospital. The grievor reiterated that she did not observe any signs of stroke and that Mr. X was talking, there was no facial droop, he was standing and

was telling his family not to worry about him. She did not deny that she left the suite before EMS arrived.

57. On April 30, 2015, the grievor reiterated her understanding that she was to contact the family before sending an independent-living resident to the hospital. She said that she had not seen a policy that said this but believed it was what she had been told. The grievor testified that when she was asked this question at the interview she understood the question to be general in nature and not specific to Mr. X's situation. She also correctly identified that slurred speech, drooling, lethargy and weakness were all signs of a stroke.

58. The interview notes reflect that the grievor maintained that after J arrived she was explaining to Mr. X that he should go to the hospital and that Mr. X was saying no. When M arrived he encouraged his father to go to the hospital. He then asked the grievor if he or she should call 911. She responded that either was fine and he said he would call.

59. Finally, the grievor reiterated that it was her understanding that independent-living residents have the right to decide what care they will receive and can refuse to call 911. She repeated that she did not observe Mr. X in any distress.

60. Ms. Aird testified that there is no policy against calling 911 for independent-living residents. It was her evidence that the appropriate practice, if the nurse determines emergency services may be required, is to call 911 and let EMS and the resident determine how the situation will be handled.

61. The grievor testified that she was not given an opportunity to review the notes of the interviews. When it was pointed out to her in cross examination that she had in fact written her own clarifications on the notes she testified that she had only reviewed the bottom of the interview notes. I do not accept that testimony and prefer Ms. Aird's evidence that the grievor was given an opportunity to review the notes in their entirety.

62. Ms. Aird testified that, once the grievor had obtained the high blood pressure reading, she ought to have taken a second reading and called 911. Ms. Aird was also troubled by the fact that the grievor left Mr. X's suite before EMS arrived. As the individual with medical training, she had a responsibility to stay with Mr. X until EMS arrived.

63. A different incident occurred with Mr. X on April 28, 2015 at TMOS. I heard no direct evidence about the incident but it was recorded in YARDI. The YARDI note was made by another nurse at TMOS and reads:

04/28/2015

> 5:16 AM
> At approximately 0410 hrs, received a call from [independent living care manager] reporting that rt [resident] is on the floor. Writer went to check on the rt at once. Seen rt lying on the floor, in the washroom. Rt's alert, responsive. BP [blood pressure] – 185/110, P [pulse] – 122. Rechecked BP after 5 min 185/87, P 114. Noted a skin tear to right forearm approx.. 4x3 cm. Cleansed with normal saline and covered with clean gauze. 3 Team members tried to assist rt up from the floor, but rt was screaming in pain, wanted to lie down again. RT complained of pain in the neck, and back. Writer called 911. EMS arrived about 8 minutes after the call. RT was brought to McKenzie Hospital, accompanied by wife. As per wife, she will be calling her children once they arrive in the hospital. Wife was thankful to writer. Will endorse to incoming NOD and for follow-up.

64. Ms. Aird testified that this incident was handled adequately. She testified that the difference between a blood pressure reading of 185/110 and 200/90 is significant, and the latter reading requires the nurse to call 911 immediately.

65. On May 4, 2015 TMOS discharged the grievor. The relevant parts of the discharge letter read:

> Dear Jacqueline:
>
> **Re: Your Employment with Sunrise Senior Living**
>
> This letter is being provided further to our meeting with you of today's date in which you were advised that your employment with Sunrise Senior Living, Thorne Mill on Steeles ("Sunrise") is being terminated for cause. In light of your position, your actions in failing to immediately call 911 for a resident in distress, who subsequently suffered a stroke, constitutes gross misconduct and willful neglect of duty that cannot be condoned and has irreparably damaged the employment relationship.

66. Mr. Golia testified that he decided that discharge was warranted because of his concern that the grievor had not called 911 immediately. He testified that he relied upon Ms. Aird's opinion that the grievor had failed to meet the nursing standards. He testified that TMOS has a responsibility to deliver care and provide excellent service to meet its residents' needs. He was concerned by what he perceived as a lack of judgment and leadership displayed by the grievor. He testified that in the circumstances 911 should have been called, and if the resident did not want to go to the hospital that should have been sorted out between the resident and the 911 responders.

67. Ms. Aird testified that it was not just the high blood pressure that, in her opinion, triggered the need to call 911, or that showed the grievor had failed to meet the

necessary standards. She testified it was the "whole picture" including the fact that the grievor did not take Mr. X's blood pressure a second time after the high reading and that in Ms. Aird's opinion the grievor did not take the family's reports of slurred speech and weakness into consideration.

68. The grievor's discharge was not reported to the College of Nurses until this hearing began. Ms. Aird testified that she was unaware that a nurse's discharge had to be reported. Ultimately, the College decided not to initiate an investigation.

69. Mr. Golia testified that residents must be treated with dignity and respect and that they have a right to determine what care they receive. Those principles are reflected in TMOS' mission statement and principles of service. They are also in the Retirement Homes Regulatory Authority ("RHRA") Residents' Bill of Rights. Ms. Aird agreed that competent residents have the right to determine the care they receive.

70. TMOS has a Resident Complaint Policy. Mr. Golia testified that the April 24, 2015 incident did not arise under that policy because it was not so much a resident complaint as it was an issue of resident care. TMOS also has a Zero Tolerance of Abuse and Neglect Policy. Mr. Golia testified that the grievor had engaged in neglect because she failed to provide care to a resident.

71. TMOS also has a Responding to Medical Emergencies Policy. Nurses are provided with a copy of the policy during training. The grievor acknowledged being aware of the policy. The purpose of the policy "is to specify 1) Immediate response to emergencies and 2) The procedures for calling 911". With respect to emergencies it states that "[e]very emergency requires an individual response. The following are general guidelines." The policy goes on to list a number of situations where 911 must be called. The list does not include high blood pressure. It does include a sudden change in ability to talk.

72. Under section B after "Call 911 and follow the dispatcher's prompts" the policy directs that Team Members are to provide support and are to "[r]emain with the resident experiencing the emergency until the emergency medical team arrives." If only one Team Member is present, Team Members are directed to call another Team Member to assist. Finally, a Team Member is to be sent to an appropriate location to direct emergency services to the location of the resident.

73. The grievor testified that she did not call 911 because residents have choice in the care they receive, and Mr. X was expressing that he did not want to go to the hospital. When the family arrived the grievor believed it was appropriate to let the family decide, which M did. The grievor testified that if a resident is in distress she would call 911 immediately, but where a resident is not in distress

they can make a decision about the care they receive. In Mr. X's case, she did not see any signs of distress. While she believed he should go to the hospital for an assessment, she did not assess it as an emergency or immediate need because the only symptom she observed was high blood pressure. She believed his blood pressure was impacted by the fact that he was not calm.

74. The grievor also agreed in cross examination that the reason why she is supposed to stay with a resident when 911 is called is because she has medical training and can respond if the resident deteriorates. The grievor did not believe this applied in this case because she did not assess that it was an emergency.

75. The grievor's entire interaction with Mr. X and his family was approximately five minutes. I reach this conclusion because the grievor's evidence that she received the call from Ms. Samuel at 10:38 a.m. was never seriously challenged. It then took some time to travel from the suite she was in with Ms. Aird to Mr. X's suite. The EMS report that was entered into evidence records the call to EMS being made at 10:46 a.m. The grievor left the suite shortly after EMS was called.

76. The EMS report also records two other important observations. First, Mr. X's initial blood pressure reading taken by EMS at 11:10 a.m. is 235/108 which is higher than the reading taken by the grievor. Over the trip to the hospital his blood pressure decreased except for the last reading which was slightly elevated over the immediately prior reading. His blood pressure fluctuated over this time between 235/108 and 198/126. Ms. Strachan-Jackman (whose evidence is reviewed in greater detail below) testified that the progress notes at the hospital showed that his blood pressure continued to drop at the hospital without further treatment, and at 12:15 p.m. it was 185/79. At 12:50 it dropped further, to 170/74.

77. The EMS report also records that the family reported inappropriate words and slurred speech. Under symptoms/actual the EMS report records "inappropriate words/confusion" and under mental status it notes "confused". However, under the heading pertinent negatives that were recorded at the same time it records "no slurred words". However, the report identifies Mr. X as positive on the stroke scale, which means he was showing signs that the EMS responders found were consistent with a possible stroke or TIA.

78. TMOS argued that I should accept J's evidence over the grievors because he was disinterested in the outcome, that his evidence was more consistent with the timing and the EMS report. The SEIU argued that I should accept the grievor's evidence over J's because it more closely aligned with Ms. Samuel's evidence and J was argumentative and internally inconsistent.

79. Having considered the evidence and the parties' positions, I prefer the grievor's testimony over J's testimony and accept the grievor's evidence where they conflict. J was argumentative at times and prone to overstatement. He was clearly no more qualified to make medical assessments than any other lay person but instead of conceding that point, he maintained that the fact that he had friends who went to medical school had some bearing on his qualifications. The statement he provided to TMOS claims that his grandfather would likely have died if he and the rest of Mr. X's family had not arrived. Having heard all of the evidence, it is not clear to me that that is a reasonable conclusion for J to have reached.

80. J arrived at TMOS on April 24, 2015 already convinced his grandfather was suffering a stroke without having observed or spoken to his grandfather. The very first thing he did when he arrived at TMOS was tell reception his grandfather had likely suffered a stroke. It is clear that at that point he was certain that his grandfather had been suffering a stroke for some time, and that an emergency existed. He was understandably concerned about his grandfather's condition given what his mother had told him earlier. However, that predisposition certainly impacted his perception and state of mind upon entering the suite where he observed two people he believed were nurses administering care to Mr. X. J admitted he had no idea how long the nurses had been present but did not allow that the fact that they had arrived only a few minutes before him had any bearing on their assessment of the situation. He expected immediate action. The grievor on the other hand had just arrived and was conducting an assessment with no preconceived outcome. In that context, it is easy to see how J may have distorted what was transpiring and what was said to him. I also note that while the grievor's English is good, it is clearly her second language, and that too may have contributed to a misunderstanding of what was transpiring. J did not allow for any of that.

81. Of all three witnesses who were in a position to testify about what transpired in Mr. and Ms. X's suite, Ms. Samuel had the least interest in the outcome. She was forthright, recognized what she could not remember and was consistent in what she did recall. Although she left the suite before the grievor did, her evidence more closely aligns with the grievor's up to that point in time. She did not suggest that the grievor argued with J (though she did recall the grievor telling J he could call 911 if he wished) or that the grievor said she would wait a half hour to an hour before making any determination.

82. Ms. Samuel's observations of Mr. X were also much closer to those of the grievor – in particular, to her Mr. X did not seem confused or unstable. Nor did she note any slurred speech. I also note that to the extent the EMS report suggests that Mr. X was showing signs of confusion and inappropriate speech, J's evidence was that Mr. X's position deteriorated between the time 911 was called and EMS

arriving. The net result being that the EMS report does not undermine the grievor's evidence.

83. Finally, the grievor was consistent in the statements she provided to TMOS, both in writing and in her interviews prior to her termination. She was also consistent on the material points of her evidence in chief and under a vigorous cross examination. While not determinative, this lends credibility to her testimony. On the other hand, J has some internal inconsistencies. The most prominent example being that in his written statement given to TMOS he said he arrived after the blood pressure was taken. His oral evidence was that he arrived before the blood pressure reading.

84. In all, I find the grievor's evidence to be more reliable than J's and where they conflict, I accept the grievor's evidence over J's.

THE EXPERT EVIDENCE

85. It was agreed that both Ms. Welch and Ms. Strachan-Jackman were qualified experts. Ms. Strachan-Jackman is an Adult Nurse Practitioner with clinical experience in an emergency room setting. One of her current roles is to assess patients to determine if they are suffering a stroke and to determine what diagnostic testing needs to be done to rule in or rule out a stroke. Ms. Welch is a Registered Nurse. Most of her career was spent as an administrator, manager and consultant for long-term care homes.

86. Both experts prepared comprehensive written reports that were agreed to represent the bulk of their evidence in chief. In order to prepare their reports, both experts reviewed essentially the same materials which included the notes and statements made by the grievor, Ms. Aird, J and Ms. Samuel, as well as statements made by C and M, Mr. X's EMS report, his progress notes from the hospital and various policies. I note that this differs slightly from the evidence before me in that neither C nor M were called as witnesses in this proceeding and neither TMOS nor I placed any weight on their unsworn statements in this proceeding.

87. The value of the expert evidence was to elaborate upon the applicable nursing standards and to provide an opinion on whether the grievor met those standards. It is, however, important to bear in mind that the ultimate determination as to whether and how the standards were or were not met, and the consequences, if any, that flow from it, is mine to make.

88. Both parties agreed that experts must be neutral and objective and must provide unbiased opinions. Both parties argued that their expert was unbiased and that the party opposite's witness was biased. In *Alfano v. Piersanti*, 2012 ONCA 297

the Ontario Court of Appeal affirmed that experts must approach their task with neutrality, objectivity and integrity (see paragraphs 107 and 108). The Court went on to hold that when expert evidence is attacked for being biased, the issue is addressed as a matter of weight to be given to the expert evidence rather than as a matter of admissibility (see paragraph 110).

89. Finally, there are some material conflicts in the stories of J, and other members of Mr. X's family, and the grievor. The experts heard no evidence, but to different degrees reached conclusions about the facts of what occurred on April 24, 2015. Those conclusions in turn impacted the experts' conclusions as to whether the grievor met the applicable nursing standards.

90. Ms. Strachan-Jackman's report focuses primarily upon what the grievor reported having occurred. Ms. Strachan-Jackman noted that Ms. X told the grievor that she noticed slurred speech and weakness around 8:00 a.m. but she otherwise does not refer to or address Mr. X's family's statements. Ms. Strachan-Jackman accepts that the only symptom observed by the grievor was high blood pressure. She also accepted, as do I, that Mr. X initially did not want an ambulance called and that it was not immediately apparent he lacked capacity to determine his care. Ms. Strachan-Jackman also accepts that the grievor recommended Mr. X go to the hospital and remained present until 911 was called but that she left thereafter.

91. Based upon these findings, Ms. Strachan-Jackman concludes in her report as follows:

> The College of Nurses of Ontario (CNO) identifies different values under the practice standard Ethics. The values they identify consist of client well-being, client choice, privacy and confidentiality, respect for life, maintaining commitments, truthfulness and fairness.
>
> Client choice "means self-determination and includes the right to the information necessary to make choices and to consent or refuse care" (CNO Practice Standard Ethics p. 6). Mr. [X] had the information that his blood pressure was elevated and that 911 could be called. Mr. [X] did not want the ambulance to be called. [The grievor] considered the client's wishes. [The grievor] was going to do a follow-up blood pressure.
>
> …
> [The grievor] did not breach the accepted ethical or professional standard of conduct. She used her judgment and assessed Mr. [X] as any RPN would do. She was not impaired by drugs or alcohol. She was not abusive. She did not take any property belonging to the [X] family.

> [The grievor] to [*sic*] not breach confidentiality or failed to share information with Mr. [X].
>
> [The grievor] maintained a nurse-client relationship. This means keeping promises, being honest and meeting implicit or explicit obligations. She respected [Mr. X's] wishes not to call an ambulance immediately but at the same time she was providing him with the rational [*sic*] as to why he should go and get checked out. Clients are entitled to make decisions regarding their health based on an understanding of the health information available.
>
> Neglect is a form of abuse. This would occur if the nurse is responsible for caring for someone who is unable to care for themselves but failed to do so. Mr. [X] lived in Independent Living with his wife. [The grievor] did not neglect him.

92. Ms. Strachan-Jackman testified that in circumstances where the only symptom is high blood pressure it is appropriate to wait and retake the blood pressure. She explained how she assists patients to relax before taking a second reading in a clinical setting. She also testified that she has seen other patients with blood pressure higher than Mr. X who, in the absence of any other symptoms, have been discharged from the hospital and referred to their family physician. In short, in her opinion the presence of elevated blood pressure, even 200/90, did not amount to a medical emergency or a basis for questioning Mr. X's capacity. She also testified that even with the earlier symptoms, which seemed to have resolved by the time the grievor arrived, there was no emergency. In her opinion, a follow-up within 24 hours was all that was warranted.

93. Ms. Strachan-Jackman testified that there is no nursing standard on when a blood pressure reading should be repeated. She testified that the American Heart Association says that if blood pressure is 180/110 a second reading should be retaken five minutes later, and that the policies of the respective organization would dictate more specifically when blood pressure should be repeated. Ms. Strachan-Jackman testified that in Mr. X's case it would have been appropriate to wait five minutes before rechecking the blood pressure but that by then EMS was on its way.

94. In her evidence in chief, Ms. Strachan-Jackman testified that if any other symptoms were noted beyond the high blood pressure the grievor ought to have stayed with Mr. X until EMS arrived. In cross examination Ms. Strachan-Jackman agreed that the grievor ought to have taken into account Ms. X's report of Mr. X's earlier weakness and slurred speech and J's view that something was not right with his grandfather. She testified that in those circumstances the grievor ought to have stayed with Mr. X until EMS arrived.

95. Ms. Strachan-Jackman explained that the EMS record and hospital notes showed that Mr. X's blood pressure had elevated to 235/108 at the time EMS arrived but that it dropped consistently on the way to the hospital. She testified that the hospital progress notes revealed that the only treatment given at the hospital was Aspirin, which is used to prevent clotting but does not drop blood pressure. In her opinion the commotion of the grievor arriving, then the family, followed by EMS, all contributed to elevating Mr. X's blood pressure.

96. Ms. Strachan-Jackman testified that while a mild stroke was suspected it was not confirmed. She testified that, because Mr. X had scored so low on the stroke scale, no further testing was ordered to determine what had in fact occurred.

97. Ms. Welch's conclusions were different than those of Ms. Strachan-Jackman. It is important to note that I rejected a number of the facts that Ms. Welch based her opinion on. In particular, Ms. Welch accepted that the grievor told J she would come back in a half hour to an hour to recheck Mr. X's blood pressure. I do not find that that is what happened.

98. Ms. Welch also testified, and found in her report, that Mr. X was given Labetolol at the hospital. Ms. Strachan-Jackman's evidence, which I prefer given her clinical hospital experience, is that the report in fact indicates Labetolol was not given. Ms. Welch also found that Mr. X had an ischemic stroke. Again, Ms. Strachan-Jackman testified that the records actually state that an ischemic stroke was suspected but not conclusively diagnosed because there was no need to conduct further conclusive testing. One of the difficulties posed by Ms. Welch's report is it is not clear to what degree these facts influenced her conclusions. What is clear is that they affected her findings.

99. Ms. Welch concluded that, after recording Mr. X's blood pressure at 200/90, the grievor ought to have "immediately" retaken the blood pressure. Her oral evidence was that this meant waiting 30 to 60 seconds. In her opinion five minutes was too long.

100. Ms. Welch finds in her report as follows:

> Based on her vital signs assessment, and the feedback provided by the family, Mr. [X] met [the grievor's] definition of stroke: namely weakness and slurred speech. Instead of calling 911, [the grievor] entered into a debate with them about who should call 911. When the family indicated they would call, and after providing Mr. [X]'s daughter-in-law with the written blood pressure reading, [the grievor] then left the room, leaving an already anxious family to manage the next steps, and his unstable health status, on their own.

> While Mr. [X] was an independent and capable resident of [TMOS], on the morning of April 24, 2015 he was experiencing a legitimate health crisis that would have compromised his insight and judgment. By her own admission, [the grievor] indicated that the "family know [*sic*] him better than I do." This was even more reason to rely on the family's statements that he was not himself and was confused.
> …
> Mr. [X's] extremely high blood pressure and other symptoms of stoke, based on the observations shared by his family to [the grievor], clearly would have impacted his insight and judgment and his ability to make the right treatment decision. Indeed, in less than ten minutes following this exchange, the paramedics identified that neurologically he was using inappropriate words, and scored him as a positive on the stroke scale.
> …
> It is my opinion that the failure by [the grievor] to properly assess and respond to the changes in Mr. [X's] health status, call 911, and remain with Mr. [X] and his family until EMS responded, did not meet the expected standard of care.

101. There are a few difficulties with Ms. Welch's conclusions. First, the grievor did not enter into a debate about who would call 911. The uncontradicted evidence is that M asked who should call 911. The grievor responded that he could or she could. M said he would. The fact that the grievor said either option was fine does not make it a debate.

102. Second, Ms. Welch makes a leap in logic that Mr. X did not have the capacity to make a decision about his care. Both Ms. Ociones and Ms. Samuel, whose evidence I have accepted, did not believe he was confused or incapable of making a decision about his care. I accept Ms. Strachan-Jackman's evidence that it would not have been apparent to the grievor at that point that Mr. X lacked the capacity to make an informed decision about his care. In cross examination Ms. Welch maintained that Mr. X was "affected" by the medical event, but conceded she could not conclude he lacked capacity when he was interacting with the grievor.

103. Third, Ms. Welch concludes that, based on Ms. X's reporting of weakness and slurred speech two hours earlier, Mr. X was having a stroke and 911 ought to have been called immediately. She overlooks or downplays the fact that at the time the grievor assessed him she did not observe either of these symptoms. If the reporting that those symptoms were present two hours earlier triggered a need to immediately call 911, there was no need to take Mr. X's blood pressure and 911 should simply have been called. In any event, only about five minutes passed from the time the grievor first encountered Mr. X, and only a minute and half passed between when the grievor took Mr. X's blood pressure, and when

911 was called. During that time the grievor was trying to convince Mr. X that he needed to go to the hospital.

104. Ultimately, Ms. Welch's conclusion is that the grievor failed to meet a number of nursing standards. First, she failed to meet the standards by not immediately retaking Mr. X's blood pressure. Second, the grievor did not recognize the potential medical emergency that existed due to the abnormal blood pressure reading in combination with the information from Mr. X's family that he had slurred speech earlier in the day and was not himself. Finally, Ms. Welch also testified that the grievor neglected Mr. X by failing to provide adequate care and leaving the suite after 911 was called but before EMS arrived.

105. Both experts agreed on a few objective standards. First, they agreed that the first thing a nurse must do is assess a situation. This involves gathering subjective information from the patient or resident and objective information. In the case of Mr. X that meant gathering information from Mr. and Ms. X, observing Mr. X and drawing conclusions about his behavior and taking his vital statistics.

106. Both experts also agreed that it was appropriate to retake Mr. X's blood pressure after receiving a reading of 200/90 though they disagreed on how long the grievor could have waited. Ms. Welch testified it should have been taken within 30 to 60 seconds. Ms. Strachan-Jackman, who deals with potential stroke patients on a regular basis, believed five to fifteen minutes was acceptable.

107. Both experts agreed that a high blood pressure reading alone is not enough to warrant calling 911 immediately. While both agreed the reported weakness and slurred speech earlier in the morning were relevant factors to consider, they differed on the impact of that report. Ms. Welch believed they triggered an immediate need to call 911. Ms. Strachan-Jackman believed a follow-up within 24 hours would have been sufficient.

108. Finally, both nurses agreed that in the circumstances where Mr. X had extremely high blood pressure, his wife was reporting weakness and slurred speech earlier in the morning and J was reporting something was wrong, the grievor ought to have stayed with Mr. X until EMS arrived. In cross examination Ms. Welch testified that leaving Mr. X in these circumstances was the action that most concerned her.

POSITIONS OF THE PARTIES

109. TMOS argued that the grievor did not meet the standards required of a nurse in three ways. First, she failed to retake Mr. X's blood pressure. Second, she failed to recognize a need to immediately call 911. Third, she failed to stay with Mr. X until EMS arrived.

110. TMOS recognized that, by and large, cases involving discipline and discharge turn on their own unique facts. However, TMOS relied upon *Kennedy Lodge Nursing Home v. S.E.I.U., Local 204* (1991), 18 L.A.C. (4th) 38 (Davis); *Peel (Regional Municipality) and CUPE, Local 966 (Andrews)*, 2013 CarswellOnt 7302 (Stanley); and *Royal Victoria Hospital v. O.N.A.* (2011), 211 L.A.C. (4th) 363 (Luborsky) for general principles applicable to cases involving failures to provide proper care in the healthcare profession.

111. In *Kennedy Lodge*, *supra*, the arbitrator explained that the standard of conduct required of healthcare professionals is a necessarily high one as follows:

> 25 It is generally accepted that standards of conduct reasonably required of employees will vary according to the industry in which the individual is employed. It appears to be recognized by arbitrators that in the health care industry a much higher standard of performance is required of employees than would be so in the manufacturing industry, for instance, because the aspect of public trust involved in the care and treatment of the patients entrusted to the institution, be it a hospital, nursing home or other similar institution…
>
> At the same time discharge for the offence of patient abuse cannot be found to be an automatic response without regard to the factual underpinning in a specific case measured against the "very high standards of conduct expected of employees in the health care field"…

112. Along this same line, the arbitrator in *Royal Victoria Hospital*, *supra*, held as follows:

> 35 The standard of conduct expected of a registered nurse, along with other healthcare professionals, whose actions have life or death consequences, has long been recognized as a necessarily high one, even when no harm as a result of a nurse's negligence or willful wrongdoing has in fact occurred…

113. Later in that decision the arbitrator went on to observe as follows:

> 41 It seems that conduct deemed to be in the careless or negligent category (often characterized as an "error in judgment") is more amenable to considerations of the employee's motives or good intentions, many years of service and past clear record in assessing the appropriate penalty at less than discharge, notwithstanding the potentially devastating consequences of such conduct, as was the situation in *Re Bethania Mennonite PCH*, *supra*, and to a lesser extent in *Re Oshawa General Hospital*, *supra*, where the poor disciplinary record of the nurse for similar medication errors was an obvious factor

> in upholding the dismissal. (Although, as I noted at para. 18 in *Stelco Inc.*, *supra*, discussed further below, the more that such misconduct exposes workers or members of the public to the imminent risk of serious injury or death, the less likely that a progressive disciplinary response other than discharge will be considered appropriate.)
>
> 42 However, where as in the case of *Re Calgary Laboratory Services*, *supra*, the misconduct is more in the nature of willful or deliberate disobedience of known rules without acceptable excuse that puts the patient at risk of significant harm and exposes the institution to moral and/or legal liability, there is much less tolerance or opportunity to consider the good intentions, long service and clean disciplinary record in mitigation of the breach of trust so important to the maintenance of an ongoing, viable employment relationship in a healthcare setting.

114. TMOS argued that the consequences in this case could have been severe, that the grievor has refused to admit any wrongdoing or accept responsibility, and that this militates against reducing the penalty. TMOS also argued that the grievor has not been forthright and offered different reasons on the stand for not taking Mr. X's blood pressure a second time: the first being that Mr. X was moving around and not calm and the second that 911 had already been called.

115. TMOS also argued that the grievor should not be believed when she says she would have called 911 if M had not done so. TMOS argues that, if that was true, the grievor would have called 911 before M arrived.

116. Finally, TMOS argues that the failure to stay with Mr. X until EMS arrived was a significant breach of the required standard. Moreover, the grievor has never acknowledged it was a mistake or taken any responsibility for the failure to do so.

117. The SEIU argues that TMOS' reliance on the grievor leaving Mr. X's suite prior to EMS arriving is a change of grounds, and that I should not permit TMOS to rely upon it. The SEIU relied on *U.S.W.A. v. Aerocide Dispensers Ltd.* (1965), 15 L.A.C. 416 (Laskin, Chair) in support. The SEIU argued that it was prejudiced by TMOS' reliance on this allegation at the hearing because the SEIU's expert's report had been prepared before TMOS made the SEIU aware that it was relying on that allegation.

118. The SEIU argued that while the standard on healthcare professionals is high, it is not a standard of perfection. The SEIU argued that in most situations, including the circumstances before the grievor on April 24, 2015, a healthcare professional has a range of acceptable responses that are open to him or her, and the question is whether the one that was chosen was reasonable. The SEIU referred me to *College of Nurses of Ontario and The Member*, 2007 CanLII 82765 (ON

CNO) for the proposition that mere errors in judgment or discretionary decisions made reasonably (though others may have made them differently) do not amount to unprofessional conduct.

119. The SEIU argued that, based upon the grievor's observations of Mr. X, her actions on April 24, 2015 were reasonable. At the time M arrived, the grievor was still conducting her assessment and the only observable symptom was high blood pressure. In those circumstances, it was reasonable to continue the assessment and retake the blood pressure. When M decided to call 911, the need for further assessment disappeared.

120. The SEIU referred to the April 28, 2015 YARDI note documenting an incident where Mr. X was found on his bathroom floor. At the time he was discovered, he had high blood pressure and was cut. In that circumstance TMOS did not find the nurse engaged in culpable conduct when she retook Mr. X's blood pressure five minutes later and did not call 911 until the nurse tried to help Mr. X to stand and discovered he could not. The SEIU argues that this is evidence that TMOS does not believe a simple high blood pressure reading warrants calling 911 immediately or that it is inappropriate to retake blood pressure five minutes later.

121. The SEIU also argued that when the grievor left the suite he was in the care of his family, the family knew how to contact the Wellness desk if anything occurred and there were no symptoms other than high blood pressure and no basis for the grievor to perceive an emergency. The SEIU argued that the reason the grievor left was to attend to another resident, which it characterized as a "fair" reason to leave. Finally, the SEIU argued that TMOS' Responding to Medical Emergencies policy did not apply because the only symptom noted was high blood pressure, and thus there was no automatic requirement to call 911. The SEIU argued that therefore there was no violation of that policy.

122. The SEIU referred to *City of Toronto and Canadian Union of Public Employees, Local 79*, 2016 CanLII 50783 (ON LA) concerning the factors to consider when determining whether to substitute a lesser penalty. They include the nature of the misconduct, what lead to the misconduct, the grievor's length of service and discipline record, whether the grievor recognized his or her wrongdoing and accepted responsibility, and any significant economic circumstances.

123. The SEIU argued that even if the grievor had engaged in some culpable conduct, her long service and clean discipline record militated heavily in favour of a penalty lesser than discharge. The SEIU also highlighted that the grievor never tried to hide her actions and was cooperative throughout TMOS' investigation.

124. The SEIU argued that all of TMOS' cases were distinguishable on their facts.

125. In reply TMOS argued that there was no expansion of grounds and no prejudice to the SEIU. TMOS argued that the grievor was discharged in relation to the totality of her conduct on April 24, 2015. TMOS argued that the failure to remain in the suite was raised prior to the commencement of the hearing and that the SEIU's expert and the grievor had an opportunity to give oral evidence regarding this allegation. TMOS referred to and relied upon *North Bay Nuggett v. North Bay Newspaper Guild, Local 30241* (2005), 143 L.A.C. (4th) 106 (Luborsky) and *Santa Maria Foods ULC and SEIU, Local 2 (Padilla)*, 2016 CarswellOnt 5513 (Nyman) in support of its position.

126. TMOS argued that its Responding to Medical Emergencies Policy has two parts – the first sets out some examples of situations when 911 must be called and the second is what to do when 911 is called. Once 911 was called by M, the second part of the policy was engaged, and it was incumbent on the grievor to remain with Mr. X until EMS arrived.

127. TMOS argued that the circumstances of the April 28, 2015 YARDI note were fundamentally different. In particular, Mr. X's blood pressure on that occasion was 185/110 which was lower than his blood pressure on April 24, 2016. Nor was there any report of stroke symptoms accompanying the high blood pressure.

128. TMOS also argued that the decision in *College of Nurses*, *supra*, dealt with professional misconduct, which is a different standard, and thus the case is of limited assistance.

DECISION

129. I will deal first with the expansion of grounds argument. I find that it is not improper for TMOS to rely on the allegation that the grievor did not remain in Mr. X's suite until EMS arrived.

130. For ease of reference, the relevant sentence in the TMOS' discharge letter reads: "In light of your position, your actions in failing to immediately call 911 for a resident in distress, who subsequently suffered a stroke, constitutes gross misconduct and willful neglect of duty that cannot be condoned and has irreparably damaged the employment relationship." If this sentence is read narrowly, one can appreciate the SEIU's position.

131. However, in *North Bay Nuggett*, *supra*, the arbitrator, at paragraph 6, held that "[w]hile it is considered improper for an employer to fundamentally change the grounds of discipline at arbitration from those stated when the discipline was originally issued, arbitrators have resisted overly technical interpretations of the disciplinary letter setting out those grounds." The arbitrator went on to explain

that the employer is permitted to clarify and expand on the reasons given in its discharge letter. What it cannot do is rely on some new and different offence.

132. In *Santa Maria Foods*, *supra*, I agreed with this approach. I also held that the issue is primarily one of fairness, and that an employer should not be precluded from relying on a ground of discharge where no prejudice or unfairness results.

133. TMOS' discharge letter relates to the grievor's conduct during her interaction with Mr. X on April 24, 2015. There was no confusion about this issue. While the letter refers expressly to the alleged failure to call 911, it should not be given an overly technical or narrow reading. A fair reading is that TMOS relied on all of the grievor's actions involving Mr. X.

134. Second, I am not convinced that there is sufficient or any prejudice that warrants precluding TMOS from relying on the allegation concerning the grievor's failure to stay. The SEIU alleged it suffered prejudice because it was not able to address the allegation in Ms. Strachan-Jackman's report. That may be the case, but the SEIU was aware of TMOS' reliance on the allegation prior to Ms. Strachan-Jackman taking the stand, and Ms. Strachan-Jackman was given an opportunity while she was on the stand to comment on the grievor's failure to remain in Mr. X's suite. As a result, there was no real prejudice to the SEIU or the grievor. For all of these reasons I find that this is not the type of case where TMOS should be precluded from relying on the allegation that the grievor failed to remain with Mr. X until EMS arrived.

135. I turn now to the merits of the grievance.

136. TMOS argued the grievor failed to meet the necessary standard of conduct in three ways: 1) by failing to retake the blood pressure; 2) failing to call 911 immediately; and, 3) failing to remain with Mr. X until EMS arrived.

137. There is no question that the standard required of healthcare professionals is necessarily high given the special position they occupy. This said, I also accept that is not a standard of perfection and that there are circumstances in which a range of potential actions will be reasonable and acceptable.

138. Both experts agreed that the first thing Ms. Ociones ought to have done upon entering Mr. X's suite was conduct an assessment by gathering objective and subjective information. The grievor did that. Her evidence, which I have accepted, is that she entered the suite, and considered Ms. X's statement that Mr. X had had weakness and slurred speech earlier in the morning. Her observation, which was confirmed by Ms. Samuel, was that Mr. X was no longer suffering those symptoms. She made this determination by speaking with him

and observing his conduct. There was no suggestion that anything she did in this regard was improper.

139. The grievor also took Mr. X's vital signs. There was no disagreement that the only vital sign that was abnormal was the blood pressure. It was agreed that Mr. X's blood pressure was extremely high. It was also agreed that it was appropriate to retake the blood pressure.

140. The grievor's testimony was that she believed Mr. X's blood pressure reading was affected by the fact that he was anxious and moving around. Ms. Strachan-Jackman, who routinely deals with patients who are suspected of suffering from a stroke, testified that it would be appropriate to try to calm Mr. X down and retake his blood pressure in five minutes. That is not out of line with the American Heart Association guidelines. The grievor testified, and I accept, that that was her intention.

141. In reaching this conclusion I place little weight on the incident involving Mr. X that occurred on April 28, 2015 that is recorded in YARDI. It is evidence that in some instances it is acceptable to retake high blood pressure after waiting five minutes. However, the circumstances of that event and the April 24, 2015 incident are sufficiently different that one does not really provide much guidance for the other.

142. When J arrived he told the grievor that something was not right with his grandfather. Mr. X expressed to the grievor that he did not want to go to the hospital. I accept Ms. Strachan-Jackman's evidence that it was not unreasonable for the grievor to take Mr. X's wishes about his care into account at that point, and that it was not apparent he lacked capacity to determine care decisions. Taking Mr. X's wishes into account is also consistent with TMOS' mission, its policies and the RHRA Residents' Bill of Rights. The grievor did that, but she also considered that Mr. X may have suffered a TIA earlier in the morning and ought to be assessed at the hospital. She therefore attempted to convince him that going to the hospital was the right course of action.

143. Within a minute, M arrived and immediately determined Mr. X should go to the hospital. The grievor was open to calling 911 or letting M call. M chose to call.

144. Ms. Welch testified that the grievor ought to have retaken Mr. X's blood pressure within 30 to 60 seconds of the first reading. Ms. Welch also testified that she ought to have called 911 immediately. The uncontradicted evidence is that 911 was called within a minute and half of the grievor taking Mr. X's blood pressure. During that time J arrived, and then M, and then 911 was called. Moreover, the grievor was also in the process of attempting to convince Mr. X to go to the hospital voluntarily.

145. Given all that transpired in that short time, it is difficult to find fault with how the grievor handled the situation up to the point that 911 was called. She identified a possible medical concern, assessed that the grievor was not in distress but should be seen at the hospital, explained that to him and took into account his desire not to go. She also determined a second blood pressure reading should be taken. All of that met the professional standards identified by Ms. Strachan-Jackman. Moreover, within a minute or two of taking the first blood pressure reading, M called 911. Even if Ms. Welch's view that a second blood pressure reading should have been taken within one minute is accepted, the evidence did not establish that it was so rigid a rule that a delay of two minutes, as opposed to one, would be a concern. Particularly given all that transpired during that time including the grievor's attempts to calm Mr. X and convince him to go for a follow up at the hospital.

146. The same, however, cannot be said about the grievor's decisions after 911 was called. Both experts agreed that the combination of the high blood pressure, the family's reports of slurred speech earlier in the morning and the present concern that "something was not right" meant that once a decision was made that 911 should be called, the grievor ought to have stayed with Mr. X until EMS arrived. That makes sense given that the grievor was the one person in the suite with professional medical training.

147. The grievor testified that it had crossed her mind that Mr. X had suffered a TIA and she was aware that symptoms could come and go. She also believed that he should be assessed at a hospital. Given this, it is problematic that, as she was the only person with formal medical training, she left the suite.

148. Nor do I accept the SEIU's position that the Responding to Medical Emergencies policy had no application. The policy is separated into two parts. The first is "immediate response emergencies". The second sets out the "procedures for calling 911." Even if the situation in Mr. X's suite on April 24, 2015 did not qualify as an immediate response emergency, part 2 of the policy governs what happens once the decision to call 911 is made for whatever reason. Part 1 specifies that "every emergency requires an individual response. The following are general guidelines." What follows is a non-exhaustive list of situations where 911 must be called. Given that the list is non-exhaustive, it cannot be that the procedures for calling 911 only apply to emergencies found on the list. If that were the case there would be no written procedures for calling 911 in situations not captured by part 1. The better interpretation is that part 1 is a list of some of the situations that require 911 to be called immediately, and part 2 is the procedure to be followed when the decision is made to call 911 for any reason. The grievor therefore violated the policy when she left Mr. X's suite after 911 was called.

149. The grievor's rationale for leaving and not returning is also troubling. Ms. Samuel left to attend the resident on the fourth floor. There was nothing to suggest the call to the fourth floor was urgent or even medical in nature. While the grievor knew the resident on the fourth floor was fragile and needy, without more it is somewhat puzzling why she left a resident whom she thought may be suffering TIA, who had high blood pressure and for whom an ambulance was on its way. Moreover, when she arrived at the fourth floor and discovered she was not needed, she did not return to Mr. X's suite, but instead proceeded to attend to other duties.

150. In addition to leaving the suite, both experts agreed that a second blood pressure reading was appropriate. While it is true that 911 was called before the second blood pressure reading was taken, a course of events which I do not believe warrants discipline, the fact is the grievor left the suite without repeating the blood pressure reading or gathering what might have been vital information.

151. The grievor's conduct was serious but not malicious. While she violated the Responding to Medical Emergencies policy, her violation was more an act of carelessness and misunderstanding the policy than a deliberate flaunting of the rule. All of that said, the grievor did engage in conduct which warranted discipline. The question therefore becomes whether I ought to exercise my discretion and substitute a penalty lesser than discharge.

152. At the time of her discharge the grievor had seven years of discipline free service. While this is not a long service record, neither can it be characterized as short service given that that is as long as TMOS has been in business. Moreover, since being promoted to the Wellness Nurse position the grievor has called 911 on behalf of residents many times without incident or concern.

153. In addition, the grievor's act of leaving the suite was not callous, uncaring or neglectful. She left Mr. X in the care of his family, made sure any information she had gathered was recorded so it could be passed on to 911 and provided the means to contact her if further help was needed. In other words, she did not leave Mr. X to fend for himself or leave him in a situation of peril. She made some effort to ensure he was cared for, and that all necessary steps to ensure a safe and effective transfer to the hospital were in place.

154. The grievor was also cooperative and truthful throughout TMOS' investigation. She did not attempt to conceal or hide her conduct. She was defensive on the stand in cross examination, and perhaps not entirely forthright about the extent to which she reviewed the interview notes. While that is not ideal, in the circumstances of this case, and considering her testimony and conduct as a whole, her integrity or honesty remained, by-and-large, intact.

155. All of these considerations suggest that while the grievor made a mistake, and committed a serious error in judgment, she is capable of being a caring and professional nurse and of being trusted by TMOS to carry-out her duties professionally and with integrity in the future. This all weighs in favour of something less than termination in this case.

156. I am troubled somewhat by the fact that the grievor has not admitted that leaving Mr. X's suite was a mistake and has offered reasons why she left that are less than satisfactory, particularly given that she did not return to the suite when it was discovered she was not needed on the fourth floor. That concern however does not outweigh the mitigating factors that are present in this case and is best weighed in the context of fashioning an appropriate remedy.

157. For the foregoing reasons, I conclude that the grievor engaged in conduct that warranted discipline, but that I would exercise my discretion and substitute a lesser penalty than termination. In light of the parties' agreement at the hearing, the determination as to what penalty ought to be imposed will have to await the parties' submissions unless they otherwise agree upon a lesser penalty.

DATED at Toronto this 22nd day of February, 2017.

Jesse Nyman
Sole Arbitrator