

In the Matter of the Arbitration

between Washington State Nurses Association
("Association")

and

University of Washington Medical Center ("UWMC" or
"Hospital.")

Findings,
Discussion and
Award.

Case Numbers:	Arbitrator's case No. K53.
Representing the Association:	David Campbell and Schwerin Campbell Barnard Iglitzin & Lavin LLP, 18 W. Mercer Street, Suite 400, Seattle, WA 98119.
Representing the UWMC:	Otto G. Klein, III and Summit Law Group, PLLC, 315 Fifth Avenue S., Suite 1000, Seattle, WA 98104.
Arbitrator:	Howell L. Lankford, P.O. Box 22331, Milwaukie, OR 97269-0331.
Hearing held:	At the University on May 3-5, 2010, with a final witness by phone on June 25, 2010.
Witnesses for the Association:	Barbara Frye, Christine Himmelsbach, Sonya Nelson, Jude-Teddy Villamarin, Patricia Berry-Bell, Tara Goode, Anita Stull, Anne Piazza, and Linda Machia.
Witness for the Union:	Lorie Wild, Gigi Jurich, Sandyr Saltzer, Catherine Cordner, Sue Theiler, Debi Grace, Anne Bailey, Karen Odle, Chris Larsen, Daniel Kraus, and Nancy Dombrowski.
Post-hearing argument received:	From both parties on July 7, 2010.
Date of this award:	August 5, 2010.

This is a dispute over the interpretation and application of a “rest break” provision in the parties’ collective bargaining agreement. They stipulate that the issue presented in arbitration is: Did the Employer violate Article 7 of the parties’ agreement by failing to provide rest breaks, and, if so, what is the appropriate remedy? There are no preliminary issues of substantive or procedural arbitrability; and the parties agree that the Association must show, more likely than not, that the University violated the collective bargaining agreement as alleged. The hearing was orderly. Each party had the opportunity to present evidence, to call and to cross examine witnesses, and to argue the case. Both parties had the benefit of a hearing transcript in drafting their post-hearing briefs, and those briefs were timely filed.

The disputed contract language. Article 7 addresses “Hours of Work and Overtime” and provides for a variety of work schedules; but, without reference or limitation to any particular schedule, Article 7 provides for periodic rest breaks:

Nurses in the bargaining unit shall be granted a fifteen-minute rest period within each four hour period. Nurses working a twelve-hour shift will receive three rest periods. Each unit will establish guidelines to enable nurses to take their breaks. A nurse who does not receive a break is obligated to bring it to the attention of unit management immediately, or by the end of the shift.

The last two sentences were added two contracts ago, in the 2003 negotiations. The Association first proposed that Nurses “shall be paid 15 minutes at the overtime rate for each missed break.” The Hospital rejected that proposal, even in the face of the Association’s claim that such payment was legally required in any case, and the Association then proposed to add “Each unit will establish guidelines to enable nurses to take their breaks” and a final provision requiring Nurses to bring missed breaks to management’s attention. The parties then exchanged several proposals about the timelines for that “bring it to the attention,” and they ended up with the Hospital’s “immediately or by the end of the shift.” In the next, 2006 negotiations the Association again proposed pay for missed breaks, and the Hospital again rejected that proposal.

FACTS

This bargaining unit consists of the over 1,300 Registered Nurses employed at the 450 bed University of Washington Medical Center. UWMC is one of two academic medical centers attached to the University of Washington medical school. As a tertiary or quaternary medical facility it draws patients from the five state area of Washington, Wyoming, Alaska, Montana and Idaho.

UWMC has officially been designated as a “Magnet Hospital” since 1994 for its ability to attract and retain highly qualified nurses, and part of the generally recognized characteristics of magnet hospitals is the autonomy and discretion exercised by the nursing staff. As part of that pattern, the members of the bargaining unit have been FLSA exempt professional employees since at least 1977. Moreover, the CBA allows a Nurse to substantially self-schedule as long as

the Nurse puts in a total of 160 hours in a four week, 28 day period (with the Nurses and Managers collectively working out how to deal with the section's staffing needs throughout that period). And many employment and professional determinations are made more or less collectively on the work unit level through a process the Hospital titles "Unit-based Decision Making."

Staffing levels. This is not a staffing level dispute per se, but some Nurses have long insisted that rest breaks are difficult or impossible at their unit's current staffing level. The record does not suggest any basis for concluding that UWMC is *generally* understaffed. Compared to other academic medical centers across the US, UWMC's staffing has consistently ranked above the top 75th percentile. The Hospital and the Nurses have a joint "Nurse Staffing Committee," required by RCW 70.41.410 to 70.41.420 since 2008, composed of five management Nurses and five bargaining unit Nurses. In April, 2009, that Committee chose the data it would collect and examine during the coming year. Those included, e.g., falls, retention, med errors, linen use, etc. Missed meal breaks—which are documented through the payment process—are included, but missed rest breaks are not. The bargaining unit Nurses proposed the inclusion of missed rest breaks, but the management members objected that there was inadequate documentation and that missed meal breaks should be addressed in the Joint Conference Committee.¹

Hospital-wide Rest Break Data. Each party offers its own wall-to-wall data with respect to breaks. The Association did a survey in response to the Hospital's claim, at Step 3 of the grievance process, that there was not much of a problem. The Association sent survey forms to the entire bargaining unit of over 1,300 Nurses, but it got back only 144 responses. A response rate of barely over 1% is too thin to be significant. (A second, State-wide on-line survey produced only 99 responses from this bargaining unit.)

On the employer's side, the Hospital offers some wall-to-wall data, but the record in arbitration was well summarized by the Director, Professional Practice and Patient and Family Centered Care who noted to the members of the Staffing Committee, "I think we are all in agreement that it is important for nurses to take their breaks. We also agree that there is not a good tracking mechanism in place right now." The Hospital later made some attempt to develop data. On June 12, 2008, the Chief Nursing Officer announced a new emphasis on rest breaks:

UWMC believes that employees who take breaks have improved well being and are better able to meet quality and safety goals. Our aim is that employees take regular breaks. We also realize that taking breaks has been a challenge in some areas in our culture.

1. The *current* CBA includes a method for bringing staffing concerns to the attention of the parties' Joint Conference Committee, and that contract provision specifically includes concerns over "the ability to receive rest periods and lunch breaks." (§11.3.) That language was not in the contract that was in effect when the grievance was first filed.

We'd like to start changing that.

As of today, we ask that you make taking a break a part of your work flow—coordinating with each other to make sure that you and your colleagues have the opportunity to take a break. If you are unable to coordinate with your charge nurse or peers to take a break, we ask that you document that via your unit's system.

Thank you! We appreciate your support for each other in this important endeavor.

The data offered by the Hospital as a summation of the missed breaks wall-to-wall for FY 2009 shows a total of 3,434 missed breaks out of approximately 283,200, which shows a missed rest break rate of barely over a tenth of one percent. The Association examined the source material supposedly underlying that conclusion and demonstrated that that result and the data from which it was extracted are not credible.²

The absence of credible numerical data leaves me with the much less satisfactory anecdotal data derived from testimony of individual Nurses' and supervisors' experience in individual units. There are more than eighteen major nursing units (the Hospital's data presentation broke the workforce down into 65 different units) working around the clock, and there does not seem to be much dispute that the nature and pressure of the work may vary substantially from shift to shift. The anecdotal record does not come close to covering all the resulting unit-by-shift combinations. Moreover, in many if not most instances, it appears that each party quite understandably provided data about the units/shifts where rest break administration best supported its case. The following findings, therefore, are a partial summary of a series of not-necessarily-representative selective snapshots.

5SE: Cardiovascular ICU. This 22 bed unit serves acutely ill patients following cardiac and thoracic surgery, heart and lung transplants, valve replacements, heart failure, etc. With all 22 beds filled, the unit is staffed by 16 Nurses. (One Nurse assigned to this unit also functions as the "Stat" nurse for the entire Hospital from 21:00 to 09:00.) As far as this record shows, day shift Nurses in this unit manage to take all three breaks only about 5% of the time, manage to take two of the three roughly 15% of the time, and get even one of the three breaks substantially less than half the time. Nurses sometimes apply to the Charge Nurse for missed meal breaks but seldom for missed rest breaks. In part, that stems from a unit culture that focuses on devotion to the patients and dismisses the importance of rest breaks. The following testimony describes the problem of getting breaks in this unit (2 Tr. 184ff.):

2. From high school onward, one is encouraged to pay attention to whether one's results *make sense*. Here, the Hospital has inexplicably embraced, *inter alia*, the incredible conclusion that there were only 50 missed rest breaks in the Cardiovascular ICU throughout the entire fiscal year. The Hospital argues that the "issue becomes whether UWMC has made a good faith effort to provide rest breaks for nurses." (Post-hearing Brief at 37.) The Hospital's inexplicable acceptance of these survey results calls its good faith into question.

[T]he initial relief comes from the charge, and then from what we're told is either try to find a pod partner, someone that's next to you, to relieve you for a 15 minute break.

Well, that nurse that's working next to you also has one to two critically ill patients. And to have that as a – to ask someone for a 15-minute break to watch my patient while I either step in the break room or get my rest break is pretty kind of unheard of.

A lot of nurses just don't feel like it's – I don't know. They don't want to have the burden of another nurse watching their two patients or one patient while they just, you know, take a 15 minute break.

* * * * *

[T]he process of even asking for a rest break for 15 minutes, you giving a report to the next nurse is almost ten minutes into your rest break because you have to be sure you're safe in terms of going down the system – you know, doing your system checks, making sure you let them know what types of drips they're on, and issues, any family members that you have to watch out for, anything that, you know, might be needed during the 15 minutes that they are gone.

Q: *** Is it possible to take a break in which you would be relieved of your duties while sitting at a nurse station on your unit?

A. No. *** [Y]ou're there at the substation charting, or you're talking with family members, or sometimes even teaching, like, residents... [or] physicians...

Beyond postings and emails, the record does not show any serious attempts by the unit Nurse-Manager to see that Nurses on the unit take their rest breaks. The Nurse-Managers apparently attempted to track missed breaks in the month of January-February, 2008. That attempt was announced by an email noting “that it is sometimes difficult to schedule a break in a busy unit so please be flexible and work closely with your peers to develop a ‘break plan’ for everyone on the unit.” The resulting data is not in the record before me, but the testimony suggests that the forms in question were not used at all, at least by some of the Nurses. Management made another data-gathering attempt in June, 2008, this time announced by an email which noted, “I know that [taking breaks] is going to take a lot of work on all of our parts, but taking breaks is essential to our well-being, mental health and patient safety. It may seem at times that you don't have the time or there is too much to do, but I strongly encourage you to take that break.” The instruction to “work with your sub-station partners for each other's breaks” and to document missed breaks “if all else fails” was reiterated later that month. But a rotating Charge Nurse in this unit (twice every 28 days) testified that both the instruction to work out breaks and the instruction to document missed breaks were ineffective.

Post Anaesthesia Recovery. This 17 bed unit receives patients from the operating rooms. Patient acuity and staffing vary. As far as this record shows, these Nurses get both of their rest breaks from a quarter to a third of the time and get at least one rest break about half the time.

7N: Psychiatry. This unit was reduced from 20 beds to its current 14 late in 2005, which reduced the staff from about 23-24 down to its current 18 (not counting the two RN3s). The only rest break problem addressed in the record arises on night shift, when the staff is down to two

Nurses.³ Those Nurses do half hour sleep reports, and most of the patients are sleeping most of the time through the night. One of the night Nurses objects to being required to take her breaks in the ward—there is apparently a chart room just off the ward where snacking is acceptable—and argues that a real break cannot include the Nurse being subject to call if there is an emergency.

8N: In-patient Rehabilitation. This is a 20 bed regional center for spinal cord injuries. The patient population all involves in-patient rehabilitation, but that may also include brain injury or oncology. Once again, the three shifts have come to different agreements about rest breaks. Night shift nurses now agree on specific break times at the beginning of each shift, while day and evening shift Nurses start the shift with more general agreements about, e.g., which Nurse of a pair will take break early and which will take break late.

As far as this record shows, the four Nurses staffing the night shift only rarely got lunch and both breaks at the time the grievance was filed and for some years thereafter. (The current situation for that shift is unclear.) These patients present a high risk of falling, and it is not uncommon for a patient to be in the process of moving off ventilation. Until sometime in 2009, the night shift generally consisted of two to three Nurses, but the addition of a Patient Care Technician in 2009 has made rest breaks for the Nurses more likely.

Inpatient Obstetrics and Mother-Baby. These units include nine labor/delivery rooms and two operating rooms and a total nursing staff of about 150 Nurses. An additional assistant was added to the staffing pattern in 2008 (the record does not show what shift). Since then, as far as the record shows, these Nurses frequently get the rest breaks required by the contract. Breaks are taken in different patterns based on the preferences of each shift, with the day shift (07:00 to 15:30) taking a half hour morning break and a half hour meal break and the evening shift taking 45 minutes at mid shift and another 15 minutes during the second half. Nurses are assigned with an eye to rest break pairs; assignments each day are posted on a board in the Mother-Baby unit, and both rest breaks and meal breaks are shown on that board as they are taken. That makes it easy for the Charge Nurses and for the Nurse Manager to see who has not had a break; and the Nurse Manager specifically asks the Charge Nurses about Nurses getting their breaks. The topic of breaks and coverage comes up frequently in the unit's Charge Nurse Council, and there is frequent attention to strategies for covering breaks in different work load situations. Finally, the Nurse Manager for these units understands that it is her responsibility to staff to cover rest breaks. On the other hand, the Nurse Manager of the Mother-Baby unit testified that the break-partner system works well in her unit due to that unit's lower acuity than the Obstetrics unit.

Neo-natal ICU. Most of the approximately 90 Nurses in this 36 bed unit work 12 hour shifts. The Nurse Manager has worked with Charge Nurses to make sure that Nurses get their

3. The Nurses assigned to this unit respond to "Code Grey" calls, 20 times a year or less, when there is a psychiatric emergency anywhere in the Hospital.

breaks and has taken steps to improve the performance of at least one of the Charge Nurses in that regard.

Medical-Surgical Orthopaedics. The Nurse Manager who testified about this Unit for the Hospital took over that position in October, 2006 (after the grievance was filed). Since that time, she has added an additional Nurse three days a week at 11:00 to help with rest and meal breaks in the face of higher surgical output on those three days. Four years after taking over, she testified there has been a clear improvement in rest break administration over that time, that night shift now does the best job of getting rest and meal breaks, and that evening shift continues to be the most demanding in that regard.

Surgical Services. These units currently comprise 22 operating rooms, divided between two buildings, along with 16 recovery beds.⁴ Like Obstetrics, these units use a board to show nursing assignments, and each Nurse's breaks are shown on that board as they are taken. The record does not clearly show the dependability of rest breaks in the operating rooms. The work schedule there can be superseded by patient needs, and it takes at least 15-20 minutes for a Nurse to scrub out and scrub back in when leaving the operating room.

DISCUSSION

Preliminary matters. The subject matter here is complex, but part of that complexity can be stripped away by isolating five preliminary matters.

(1) The age of the grievance and the focus of the record. The Association has been pressing its concern over breaks since at least 2003 both in contract negotiations and in the Labor/Management Committee. But the formal grievance from which this arbitration arises was finally filed early in May of 2006 by a Nurse in the In-patient Psychiatric Unit. After the grievance was filed, the parties apparently held lengthy discussions as the dispute moved through the grievance process, and the arbitration hearing was not scheduled until late November, 2009, three and a half years after the filing of the grievance. On the day scheduled to begin the hearing, the parties spent all day in settlement discussions and decided to continue those discussions; but settlement again eluded them, and the hearing was rescheduled for three days in May, 2010, almost exactly four years after the formal grievance had been filed.

The time that elapsed between the filing of the grievance and the eventual hearing caused some inevitable problems in the record. There is no dispute that the narrow question presented in arbitration is whether or not the Hospital had violated the rest break provision *as of the date the grievance was filed*. But much of the testimony in the record describes the various units' administration of that provision in the more recent past. In fact, the record includes numerous descriptions by Hospital managers of how much the administration of the rest break provision

4. The record shows that that composition has changed since the grievance was filed in 2006, but it does not show the former arrangement.

has improved over the last four years. The admission implicit in such testimony, of course, is that the Hospital fell substantially short of the contractual requirement at the time the grievance was filed; and the proper consequences of the subsequent improvements are addressed as part of the remedy issue.

(2) Lunches. A separate provision of the contract requires “a 30 minute meal period to be taken on the nurse’s own time if relieved of his/her duties during that period. Nurses required to remain on duty during their meal period shall be compensated for such time at the overtime rate of pay.” That provision is not at issue in the case at hand, but the record includes numerous references to problems in assuring that Nurses get their “breaks,” meaning by that term both lunch and rest breaks, and in several units it appears that improvements have come in the order of lunch breaks first and rest breaks second.

(3) Applying break language to exempt employees. If these Nurses were covered by the FLSA, I would have the benefit of extensive regulatory and case law discussions of just what the statutory language requires when it comes to the administration of rest breaks.⁵ For example, FLSA work breaks cannot be combined or stacked. But these Nurses are FLSA exempt, and the record demonstrates eloquently that the parties have never understood their contract to include the restriction against combining rest breaks or rest breaks and the lunch break.

(4) Arbitrability / Damage to the Named Grievant. The Hospital argues that “Much like in civil litigation, in order to establish the ability to pursue a class action, the named individual must have a valid claim. Here the WSNA has failed to meet that requirement.” (Post-hearing Brief at 32.) But, quite apart from the question of whether or not the Association established that the named grievant had individually suffered damage, this proceeding is unlike civil litigation in an important aspect. Under the CBA the parties here are not the Hospital and the individual grievant “et al,” but the Hospital and the Association. Section 18.1 specifically recognizes the Association’s right to “allege” a grievance; and nothing in the record suggests that the parties ever considered this grievance to be about the filing grievant. For example, the Hospital’s Step Three response did not point to a dispute about individual damage; instead, it argues that “much of the information available regarding nurses taking their rest breaks, is anecdotal. Until more reliable data are available, it is difficult to determine the degree to which the issue of not taking rest breaks is a frequent, or incidental problem.” In short, this was always understood to be an action of the Association on behalf of the entire bargaining unit, and establishing damage to the filing grievant is not a necessary part of the Association’s burden.

(5) The Association did not agree to submit this dispute to the Joint Conference Committee. The *current*, 2007-2009 Agreement amended Section 11.3 by adding “ability to receive rest periods and lunch breaks” to the list of “continuous or potential workload/staffing

5. The Hospital quite reasonably points out that if these Nurses were covered by the FLSA, their work experience would probably be quite different, involving substantially less professional autonomy and, perhaps, substantially less job satisfaction overall.

problems” which would be brought to the Joint Conference Committee. No such agreement existed at the time the grievance arose. Moreover, on this record there is no room for dispute that the bargaining unit members of the Staffing Committee have failed in their attempts to get that committee to gather and consider missed rest break data; and there is no room for dispute that the Joint Conference Committee has repeatedly considered particular missed rest break claims, without ever coming to grips with the overall problem. The Association was not obliged to submit this dispute to the Joint Conference Committee or to exhaust that process.

On the merits: What does the contract require as a “rest break?” The term, “rest break” is not defined in the contract, and the record does not suggest that the parties discussed the exact meaning of that term during negotiations. The burden of proof is on the Association, of course, and the Association did not show that the Hospital was incorrect in its many posted explanations of its understanding of the meaning of this contract term:

UWMC will define a break [as used in section 7.12 of the collective bargaining agreement] as time (15 minutes) when the employee is completely relieved of all duties. The employee may be required to stay on the work premises.

In case of emergency, the employee may be called back from their break. The unit or department Charge RN or manager determines if the employee needs to be called back emergently. If the employee break is interrupted for an emergency, the employee may arrange to take break at another time, if a break is not taken, the employee will be paid for the break time.

Individual Units/Departments may agree to combine breaks with meal times as part of their unit/department specific meal/rest guidelines.

Nothing in the record suggests that either UWMC or the Association ever contemplated that the term “a fifteen minute rest period” might actually be several different smaller periods all adding up to fifteen minutes, which the Hospital now characterizes as an “intermittent break.”⁶ On the other hand, nothing in the record suggests that the parties shared an understanding that these breaks—unlike breaks for employees who are covered by the FLSA—could not be required to be taken on the floor or off the floor at the Hospital’s discretion or for the Nurse to be on call. (See *White v. Salvation Army*, 119 Wn.App. 272, *rev denied*, 151 Wn.2d 1028 (2004).)

On the merits: Have Nurses gotten their rest breaks? The parties agreed that the issue here is whether the Hospital “violate[d] Article 7 of the parties’ agreement by failing to provide

6. The Hospital’s Director of Patient Care Services seems to have agreed to that general understanding during the grievance process. The Hospital points to an 2005 award by Eric Lindauer (NAA) in *WSNA Good Samaritan Hospital* allowing intermittent breaks. But that conclusion was based on the contract’s incorporation of WAC 296-126-082, which specifically allows intermittent rest breaks. There is no such reference in the contract here, as the Association points out.

rest breaks.” The first part of that issue is whether the Nurses have gotten their rest breaks, or, more particularly, whether they *had* gotten their rest breaks as of the date of the written grievance four years ago.

The record makes it unmistakably clear that substantial numbers of Nurses were not generally getting their rest breaks as of the date of the grievance. It is not necessary to weigh conflicting testimony to reach that conclusion: it is inescapable even considering the testimony of only Hospital management witnesses. One after another, unit managers testified that things have gotten a lot *better* in recent years with respect to Nurses getting their breaks on *most* shifts. The inescapable implication of that testimony is that the reality of Nurses getting breaks in that unit used to be a lot worse and is still not good on some shifts. Manager after manager testified—again, by implication—that things did not *start* getting better in this regard until sometime in 2008.⁷ The testimony of the Nurse Manager of 8N (In-patient Rehabilitation) was fairly typical (3 Tr. 514):

Prior to 2008, discussions with staff around breaks were more focused on how's things going on the unit, how's it going with patient care, what are the things that you need in order to provide the best care. If breaks came up, that was something that we could talk about in that context.

In short, the record establishes by far more than a preponderance of the evidence that in May, 2006 Nurses were commonly not getting their breaks and that as of today some Nurses are still not getting their breaks.⁸

On the merits: Did the Hospital “fail to provide” the missed breaks? The Hospital argues that more is required to show a violation of this language than simply showing that Nurses had not been getting their breaks. The Hospital points to three important features of this CBA and of the bargained relationship between the Hospital and its Nurses. First, and most importantly, Nurses here are FLSA-exempt professional employees. They are not scheduled as FLSA-covered Nurses—they are not sent home when there is a low unit census, for example—

7. Employer exhibit 32 lists various efforts to address rest breaks from 2005. The record does not suggest that any of those efforts were substantially successful before 2008.

8. The Hospital argues (Post-hearing Brief at 32) that “None of the WSNA witnesses established a valid claim for rest breaks that occurred prior to [the filing of the grievance].” There are three problems with that argument. First, *WSNA*’s own witnesses established that the Hospital’s performance on rest breaks had been substantially improving since 2008, so it must have been substantially below standard before that time. Second, the objection is once again based on the non-CBA model of “class action,” in which there is no single contracting entity to contest a contract violation. And finally, that objection in the sense of “which Nurse, and when?” points to the Hospital’s failure to gather the data required to administer this provision of the contract, as addressed below under Remedy.

and they exercise substantial discretion and responsibility in their professional practice. Second, or possibly another side of the same coin, Nurses here are part of a unit-based decision-making process, responsible as a unit for making many of the decisions that supervisors might make at other hospitals.⁹ And finally, Article 7 clearly requires each unit to “establish guidelines to enable nurses to take their breaks” and requires a Nurse who has not received a break to inform management by the end of the shift.

This brings us to a central dispute in this case: the Hospital argues that it is the *Nurse’s* responsibility to organize the work in a way that insures breaks. There are two problems with that sweeping claim. First, as the Association points out, it somewhat runs into the language of Article 7 which requires that Nurses “*shall be granted*” a fifteen-minute rest break. It is hard to imagine that the bargainers of that language did not understand that it would be UWMC’s responsibility to “grant” the required breaks. Second, it runs into two features of the record. There is no dispute in the record that once Hospital management began to pay attention to rest breaks, rest breaks became substantially more common, which seems to show that Hospital management has an important role to play in providing breaks through (or despite) the unit-based decision making process. And second, more than one manager testified that rest breaks had become more common as the result of increases in staffing in the unit. Quoting only one of *several* examples (again with respect to 8N),

[I]n November-December, one thing that I noticed as we had our hospital assistants more in place, specifically on the night shift, is that patient work really was flowing better, staff seemed able to do their best work, they were able to get their breaks...(3 Tr. 518.)

Not only does the record show that breaks have been amenable to staffing changes, it also shows at least one instance in which the manager paid attention, realized that breaks were substantially more difficult to take under one particular Charge Nurse, and took steps with that Nurse to fix the problem. In short, neither the adoption of unit-based decision making nor the contract’s requirement to inform management of missed breaks turn managers into potted plants: shifting *some* responsibility onto the Nurses is quite different from removing *all* responsibility from the Hospital. The record shows, more likely than not, that UWMC still has substantial responsibility in this area and so violated Article 7 of the parties’ agreement by failing to provide rest breaks.

REMEDY

The most unfortunate feature of this dispute is the parties’ inability, so far, to work out a means of improving compliance with the requirements of Article 7 despite their professed identical interests. The Hospital insists that it wants its Nurses to take their breaks. Several

9. The Hospital objected to Nurses’ testimony about the rest break experience of their unit peers. But the Hospital insists that rest breaks are scheduled and administered cooperatively by the Nurses themselves, and therefore can hardly object to one Nurse’s general knowledge of the rest break experience of the other Nurses he or she is supposed to “work it out” with.

Managers testified to the importance of rest breaks. As the Manager for Obstetrics summarized the Hospital's interest: When Nurses do not take rest breaks they burn out, have more sick time and less staff satisfaction, and have less job pleasure and shorter retention. There is no dispute that rest breaks are also a safety issue for both Nurses and patients.

Similarly, although the Association proposes to require the Hospital to pay for missed breaks, it insists that it does not want the money; it wants the breaks. And it wants them for exactly the same reason the Hospital wants them, and probably for exactly the reason that the parties bargained this language into the collective bargaining agreement.

The Association offers two arguments for its proposal that the Hospital be required to pay for lost breaks. First, it argues that the Hospital would otherwise receive a "windfall" from its violation of the contract, i.e. 240 minutes' work for what amounts to 225 minutes' pay in every four hour period not containing a fifteen minute break. Second, it argues that only the requirement of overtime rate payment for missed breaks will wean the Hospital from its addiction to that additional free staffing bonanza.¹⁰

But that remedial proposal runs into two insurmountable obstacles. First, it would rewrite the parties' agreement and give the Association through arbitration exactly what it twice tried and twice failed to achieve in negotiations. Second, this record provides no basis for even making a rational *guess* about the magnitude of the appropriate award.

The record seems to show that there are two fundamental causes of missed breaks. The first is the Hospital's insistence that missed breaks are not its problem but are fundamentally the responsibility of the Nurses. The second is the lack of dependable data. The Hospital has made various forays into data collection over the years; but the management members of the Staffing Committee were certainly correct in pointing out that there simply *is* no dependable data source for missed breaks. That lack colors this dispute at every turn. It makes settlement difficult, because the parties have no solid grip on the extent or focus of the missed breaks. It makes a financial remedy in arbitration impossible, as indicated above. And it makes the day-to day administration of this contract language extremely problematic. The record includes a good example in the potential discipline (or almost discipline) of Nurse N for not managing her time well enough to allow her to take rest breaks.¹¹ The Hospital argues that "After additional staffing was added to the unit, [the Nurse Manager] found that Ms. [N] was generally the only nurse who

10. Tom Levak (NAA) granted such a remedy in *Sacred Heart Medical Center v. WSNA* (2006) under different contract language and bargaining history, and on a record that Nurses got breaks before a series of staffing reductions, and without the FLSA exempt status of the Nurses here.

11. There is a dispute about whether the Nurse Manager's response was disciplinary action. The Hospital does not address the potential chilling effect of the document delivered to Ms. N which ends with the note, "Please see attached WSNA Corrective Action, Progressive Discipline and Dismissal Information."

for some reason was unable to get a rest break.”¹² The Association argues that Ms N was disciplined after she pressed the issue of missed rest breaks on behalf of her shift and unit. Thus the underlying factual dispute is whether Nurse N was alone in not getting her breaks after the staffing increase—which would suggest that failure resulted from her performance—or whether she was merely the most clamorous of several Nurses who still got no breaks, which would suggest that the Hospital had allowed itself to shoot the messenger. This illustrates the day to day difficulty of administering this contract provision without dependable data showing who is getting rest breaks and who is not.

The Hospital explains its quandary this way (Post-hearing Brief at 43):

The UWMC recognizes that there is a possibility for tension between expecting employees to report missed breaks and holding open the possibility of counseling, and perhaps even discipline, on employees who do not take rest breaks. On the other hand, UWMC is placed in a bit of a Hobson’s choice. The UWMC is committed to having its RN s take rest breaks. UWMC expects its RN s to get rest breaks, and if for some reason they are unable to get a break, to immediately let their charge know so that they can get the rest break. When the UWMC finds out that an RN is missing breaks, the charge or nurse manager is expected to investigate and determine why that is occurring. Is there a systemic problem, or is it a function of the individual nurse? Whatever the answer, UWMC explores how to achieve the desired result: rest breaks for the nurse. Depending on the circumstances, it may be entirely appropriate for UWMC to engage in conversation with the nurse, and ultimately coaching and counseling, in order to fix the problem.

That summation is good as far as it goes. But it rests on a false assumption: I.e. the assumption that Management accurately *knows* who is getting rest breaks and who is not.¹³ And, as long as the Hospital insists that missed rest breaks are entirely the Nurse’s problem unless the Nurse informs management, it is simply not reasonable to have faith in the resulting data about who is missing breaks. The Hospital’s summation would be far more compelling if the record included any hint that any Nurse had ever been disciplined, counseled, or coached about *failing* to tell management about missed breaks. Without that missing piece, we are left with a policy that (1) seeks to make sure that Nurses get their breaks, (2) puts the responsibility for informing management of missed breaks entirely on the Nurse, (3) apparently restricts potential corrective action to those Nurses who do report missed breaks. With all due respect to the Hospital, that combination is administratively self-defeating.

12. This claim by the Hospital implies a tacit admission that *before* the addition the staffing of the unit made it difficult or impossible for most of the Nurses to get their breaks.

13. In some units, Management *does know* who is getting breaks and who is not because, for example, that unit shows breaks on the board every day. In other units it is clear that there is no similar oversight.

I shall therefore require a remedy that will put the Hospital in a better position to fulfill its contractual duty to see that Nurses receive the breaks required by the contract and will simultaneously put the parties in a better position to negotiate about the realities of missed breaks and put the Association in a better position to seek compensation for missed breaks if the Hospital's administrative failure persists. To date, the Hospital has not met its administrative responsibility to find out how its many directives in this area are actually working out on the floor. As a remedy for the Hospital's violation of this contract provision, therefore, I shall require the Hospital to keep records, not of what breaks are *missed*, but of what breaks are *actually taken*. The Hospital shall indicate how many breaks a Nurse is entitled to, and the Nurses shall be required to sign or initial for the rest breaks actually taken. The record should also present the Nurse with an alternative something like "All 15 minutes? Yes/No." *A break that is not signed for shall be considered a break that was missed entirely.* And a break that was not shown to be for 15 minutes shall be considered a break that was substantially shorter. (Time spent briefing one's break replacement and being briefed upon return does not count as part of the break.) On the other hand, the manager or Charge Nurse may indicate that a break was offered and refused, and that shall count as a break taken (the Nurse should have an opportunity to show his or her disagreement). Consistent with the Hospital's explanation of its understanding of the rest break provision, an interrupted break does not count as any break at all unless that fifteen minutes is begun again from the beginning. Nurses may be required to stay on the floor or to leave it, and may be required to be on call during a break. Rest breaks may be combined or stacked with other rest breaks or with lunch as the Nurse or unit may decide. Individual units may decide on times requirements for management to be informed that a break has been missed, and if the Charge Nurse indicates that such an agreement was not complied with, the break in question shall be counted as taken (again, the Nurse in question should have an opportunity to show his or her disagreement).

I do not mean to suggest that pay for missed breaks—even pay at the overtime rate—is inherently improper as a remedy for the breach of such language. Rather, I take each party at its word that it genuinely wants to see Nurses take their breaks and understands that to be in that party's own interest. But I cannot determine the scope and intensity of the missed break problem on the basis of the available data. Neither can the Association. Neither can the Hospital. The remedy ordered here is designed to end that ignorance. If the resulting data show that there is a substantial missed rest break problem in some units and on some shifts, and if the Hospital ignores that data and continues to fail in its obligation under this section of the contract,¹⁴ that would certainly provide substantial support for the Association's argument that only a serious financial disincentive will lead UWMC to invest the attention—and possibly the expense—required to comply with this provision. The Association could certainly argue that such failure constituted an intentional and egregious breach of Article 7, and an arbitrator reaching that conclusion could certainly impose such payment as a remedy. That arbitrator would have damage data available, because every break not shown to have been taken will be considered

14. That administrative obligation may include taking corrective or disciplinary action in response to a Nurse's continuing failure to take rest breaks.

missed. On the other hand, on the record before me I cannot conclude that the UWMC's violation of this contract provision has been intentional, except, perhaps, for its perplexing preference for ignorance about the scope and intensity of the problem. That, I propose to end with the remedy required here.

AWARD

UWMC violated Article 7 of the parties' agreement by failing to provide rest breaks. The Hospital shall cease and desist from that violation. The Hospital shall also keep records of rest breaks missed and taken as follows: For each shift, the Hospital shall indicate how many breaks each Nurse is entitled to, and the Nurses shall be required to sign or initial after each rest break is actually taken. The form shall also present require the Nurse to initial an alternative showing whether the break in question was for "All 15 minutes. *A break that is not signed for shall be considered a break that was missed entirely.* And a break that was not shown to be for all 15 minutes shall be considered a break that was substantially shorter.¹⁵ Time spent briefing one's break replacement and being briefed upon return does not count as part of the break. The manager or Charge Nurse may indicate that a break was offered and refused, and that shall count as a break taken. The form shall give the Nurse an opportunity to show his or her disagreement with that designation, but the break shall still count as taken. Consistent with the Hospital's explanation of its understanding of the rest break provision, an interrupted break does not count as any break at all unless that fifteen minutes is begun again from the beginning. Nurses may be required to stay on the floor or to leave it, and may be required to be on call during a break. Rest breaks may be combined or stacked with other rest breaks or with lunch breaks as the Nurse or unit may decide. Individual units may decide on when management must be informed that a break has been missed, and if the Charge Nurse indicates that such an agreement was not complied with, the break in question shall be counted as taken. The Nurse shall have an opportunity to show disagreement, but that break will still count as taken. UWMC shall provide timely copies of these forms to the Association.

By stipulation of the parties, I retain jurisdiction for 90 days (or longer with good cause shown) in order to resolve disputes that may arise under the terms of this award. Those disputes may include the design of the form in question, the date for beginning its use, the timelines for providing copies to the Association, and other details. I leave it to the parties to work out what they can, with my retained jurisdiction available where agreement fails.

Respectfully submitted,



Howell L. Lankford
Arbitrator

15. Some units may actually prefer intermittent breaks totaling 15 minutes. Nothing in this award is intended to prevent the parties from bargaining over language enabling such an option.