Attention is drawn to the order given in paragraph 2 prohibiting publication of certain evidence.

Determination Number: AA 125/08
File Number: 5082428

Under the Employment Relations Act 2000

BEFORE THE EMPLOYMENT RELATIONS AUTHORITY
AUCKLAND OFFICE

BETWEEN	LAN ZHAO (Applicant)
AND	THE MARIANNE CAUGHEY SMITH PRESTON MEMORIAL REST HOMES TRUST BOARD (Respondent)
REPRESENTATIVES	Patricia Cole for Applicant Greg Bennett for Respondent
MEMBER OF AUTHORITY	Leon Robinson
INVESTIGATION MEETING	23 July 2007
SUBMISSIONS RECEIVED	30 July 2007
DATE OF DETERMINATION	2 April 2008

DETERMINATION OF THE AUTHORITY

The problem

[1] The applicant Ms Lan Zhao ("Nurse Zhao") says her dismissal from her employment with The Marianne Caughey Smith Preston Memorial Rest Homes Trust Board ("the Board") was unjustifiable. The Board says Nurse Zhao was dismissed for serious misconduct that was unable to be remedied. The parties were unable to resolve the problem between them by the use of mediation.

[2] The dismissal concerns Nurse Zhao's care in relation to residents of the Trust and principally one resident in particular. The parties know who that principal resident is and I shall refer to the resident as "resident F". **I order that the evidence given in relation to particular residents gathered in this investigation be prohibited from publication. No person may have access to the Authority's file without order by a Member of the Authority and after hearing from the parties.**

The facts

[3] Nurse Zhao is a registered nurse and was employed by the Board in August 2006 at its aged care facility known as the Caughey Preston Hospital at Remuera. At the time of her dismissal, Nurse Zhao was employed under the terms of the prevailing collective employment agreement known as *The Marianne Caughey Smith-Preston Memorial Rest Home Trust Board Collective Employment Agreement 1 October 2006 to 30 September 2007* ("the Collective").

[4] The Board's General Manager Ms Gloria Budgen ("Ms Budgen") wrote to Nurse Zhao by letter dated 13 February 2007. Ms Budgen wrote:-

> *I am writing to advise that we have received a number of detailed verbal complaints from the family of [resident F]. A meeting was held with [resident F's daughter and her husband] last Friday and the minutes of that meeting are attached for your review as Part One.*
>
> *We have conducted an initial investigation into the issues raised by [resident F's daughter] and a copy of that initial findings are also attached for your review as Part Two.*
>
> *During the course of the investigation we have identified a number of important issues which appear to be not only related to the underlying issues from [resident F's daughter] but also prevalent in a more generalised sense. These are the issues of incomplete assessment process, poor documentation and problematic communication particularly with staff. A list of those issues is attached for your review as Part Three.*
>
> *Lan, I wish you to have an opportunity to read the attached documentation and then an opportunity to respond to the matters raised and the findings of the investigation, together with the more generalised issues.*
>
> *As these matters are potentially high risk to Caughey Preston Trust I request you to attend a formal meeting to provide your feedback and clarification of the events documented. As this is potentially a serious matter, this meeting will take the form of a disciplinary meeting. Please feel free to bring a support person with you to the meeting.*
>
> *Please confirm that you are able to attend such a meeting on Thursday February 15th at 3.15pm. The meeting will be held in the Administration Centre and will be attended by myself and Greg Bennett – HR Advisor.*
>
> *Yours faithfully*
> *Gloria Budgen*
> *General Manager*
> *Caughey Preston Trust*

Annexed to the advice were the referenced reports endorsed Part One, Part Two and Part Three. I shall refer to this advice and the annexed reports collectively as the allegation letter. I note that Part Three is stated to set out the "issues" for Nurse Zhao's review.

[5] Nurse Zhao met with Ms Budgen and the Board's HR Advisor Mr Greg Bennett ("Mr Bennett") on 15 February 2007. Nurse Zhao submitted a written response to the matters raised in Mr Budgen's advice of 13 February 2007 and attached reports. Nurse Zhao spoke to her written notes by way of responding, in the meeting.

[6] A further meeting was held with the same participants the following day on 16 February 2007. Nurse Zhao was advised that her employment was terminated immediately. She was provided with a letter from Ms Budgen of the same date setting out the basis for the immediate termination ("the dismissal letter").

The merits

[7] The dismissal letter articulates four key areas of concern as justification for Nurse Zhao's immediate termination. I scrutinise those key areas now.

Relationship management

[8] The first key area was headed "relationship management". The ultimate finding leading to dismissal in this regard was that Nurse Zhao's communication manner had placed the relationship between Caughey Preston and resident F's family and between the Board, and a contracted medical practitioner, in "doubt".

[9] That conclusion was founded on these stated findings:-

> *In your communications with Dr Hodder on January 31st regarding [resident F], you did not request him specifically to review [resident F]. Instead you had a conversation with Dr Hodder about [resident F] but at no time did you clearly and emphatically request him to review [resident F]'s condition. As a result Dr Hodder did not review [resident F] on your shift. He was not aware that this was required. It was the afternoon registered nurse who requested Dr Hodder's attendance which occurred at 6pm and resulted in [resident F]'s immediate admission to Auckland City Hospital with a suspected CVA.*

[10] Between 2.00pm and 3.00pm on 31 January 2007 Resident F's daughter approached Ms Budgen concerned generally about her father Resident F's care and specifically, that he had had a stroke. As a result of the daughter's distress, Ms Budgen telephoned Dr Murray Hodder ("Dr Hodder") and requested that he visit Resident F as soon as he could. When Dr Hodder saw Resident F at around 6.00pm he arranged for Resident F to be transferred to Auckland City Hospital.

[11] Resident F's daughter had communicated to the Board that:-

> *… communication with [Nurse Zhao] is a problem and is not sure that there is full understanding whenever she raises concerns about her father and states that [Nurse Zhao's] English is poor. She feels this may be why she has noticed some staff are caring for her father with no understanding of his current condition.*
>
> *[Resident F's daughter] and her husband are concerned that a pattern is emerging whereby the PM and Night staff are requesting Dr's visits for [Resident F], as his condition changes over a 24hr period, but these requests are not being actioned by [Nurse Zhao] the following morning e.g. the incident with the blisters and paralysis.*

[12] In response, Nurse Zhao rejected the criticisms of her English. She said she would not be a registered nurse if her English was poor. She regarded the criticism of her in this regard as degrading of her personal values and devalued the quality of standards of the New Zealand nursing counsel.

[13] While Ms Budgen gives evidence to the Authority that she *"became aware from Dr Hodder that there had been a conversation between himself and [Nurse Zhao] in the morning regarding [Resident F] but at no time had [Nurse Zhao] specifically requested Dr Hodder to attend [Resident F]"*, Dr Hodder does not give that evidence to the Authority.

[14] But it was not specifically communicated to Nurse Zhao that the particular circumstances ought to have put her on notice and were sufficiently serious enough that she ought to have appreciated an urgent and specific need to make request that a doctor visit Resident F.

[15] The suggestion that Resident F had had a stroke and that the Board had not urgently arranged a medical assessment was of course a serious concern for the Board as Ms Budgen gives evidence. Ms Budgen was primarily concerned about that and the potential consequences for the Board and also the management of Resident F's family distress.

[16] But the Board's own enquiry disclosed that Resident F's family had been advised on the evening of 30 January 2007 by a registered nurse Heather Jones that she would request a doctor's visit the following morning.

[17] I do not agree that the very serious issues of concern were properly and sufficiently put to Nurse Zhao for her response. I do not discern the necessary communication to Nurse Zhao of the specific issue for her to respond to. While indeed very comprehensive, I cannot agree that the particular allegation and essential issue was put sufficiently and appropriately to Nurse Zhao. I do not and nor could Nurse Zhao have appreciated the particular circumstances the Board relied on as imposing upon and requiring her to have specifically sought a doctor's intervention. Because the allegation was not sufficiently and appropriately specified, Nurse Zhao was not in a position to address the concern.

[18] I particularly note that this allegation is not communicated either explicitly or generally in the Part Three annexure said by the allegation letter to set out the issues for review.

[19] I conclude that I do not agree that the Board could justifiably find that Nurse Zhao had placed the relationship between the Board and Resident F's family and the Board and a medical practitioner in doubt. That finding or conclusion would not be what a fair and reasonable employer would have found.

Team accountability

[20] The second key area was headed "team accountability". The accountability specified in the dismissal letter was a responsibility by a registered nurse on morning shift to carry out any requests put forward by either the afternoon or night registered nurse from the previous day.

[21] The ultimate finding leading to Nurse Zhao's dismissal in this regard was this:-

> *Your actions in regard to [Resident F] however show clearly that this critical team approach did not occur as you failed to action the notes left by afternoon and night Registered Nurses to get medical attention to [Resident F] the next day on the basis of their observations during their relevant shifts. Your failure to action their request has undermined the imperative clinical team collaborative approach and put our clinical process in question.*

[22] The Board concluded Nurse Zhao had failed to action notes left by afternoon and night registered nurses that mediation attention for Resident F be obtained. There is a note in a diary on the pages for Wednesday 31 January 2006 entered at 7.00am *"Doctor [Resident F]? TIA see notes"*. The Multidisciplinary progress notes do not disclose any express reference to a need for a doctor's attention.

[23] The Part Two report annexure to the allegation letter states this:-

> *POINT 1: Documented in Diary by H. Jones (RN) on 30/01/07 that [Resident F] required a Dr's visit on 31/01/07.? T.I.A. Also documented in Multidisciplinary notes 30/01/07 @ 21.30 by H. Jones (RN)(photocopies attached).*

[24] But the concern in this instance is not that she failed to obtain the appropriate medical assistance, but rather she failed in terms of "team accountability". I am not persuaded on the evidence gathered that Nurse Zhao had failed in the contended respect and nor am I persuaded that she was properly notified of the allegation she was required to answer.

[25] While the allegation was specifically directed at Resident F at the end of January 2007, the Board went on to refer to earlier examples of deficiencies under this head relating to November 2006 and another resident in February 2007. The ultimate finding in respect of all these matters was this:-

> *Registered Nurses are a key component of the wider care and service delivery team - in your own words - Registered Nurses are the bridge, yet these three examples alone demonstrate you inability to work effectively as part of a larger team which presents an operational risk to Caughey Preston Trust.*

[26] That finding should have been properly specified as the concern in advance so that Nurse Zhao was on notice that she would have to address it.

[27] The other mentioned instances were not specified to Nurse Zhao in advance. It was unfair to take those matters into account without informing Nurse Zhao that the Board would do so. As well, Nurse Zhao was summarily terminated and this was not a dismissal on notice. Nurse Zhao had not been disciplined for the other instances. They ought not have been considered without Nurse Zhao's input.

[28] I particularly note again that this particular allegation is not communicated either explicitly or generally in the Part Three annexure said by the allegation letter to set out the issues for Nurse Zhao's review.

[29] I am not persuaded Nurse Zhao was fairly put on notice of the precise allegation or concern against her. I find the Board failed to do so sufficiently and appropriately.

[30] I do not agree that the Board could justifiably and fairly conclude that Nurse Zhao was unable to work effectively as part of a larger team which presented the Board with an operational risk. That finding or conclusion would not be what a fair and reasonable employer would have found.

Documentation

[31] The third key area was headed “documentation”. The dismissal letter stated:-

> *While you advised that you thought in the future you would write in the notes weekly in a summarised form, you also said that that would not be for all clients but only for specific clients whose condition had changed.*

[32] The finding from that statement by Nurse Zhao was this:-

> *This is unacceptable practice and you have failed to demonstrate or acknowledge the importance of Registered Nurses writing in the progress notes of all clients regularly. It is imperative that each Registered Nurse writes in the clients notes as to their observations, client condition, changes or lack of changes.*
>
> …

Your lack of attention to documentation has placed Caughey Preston at serious risk effectively putting us in breach of certification standards and of normal clinical practice.

[33] While that was the conclusion, once again, I do not consider it was properly notified to Nurse Zhao to answer. The notification to Nurse Zhao in the Part Three annexure to the allegation letter says only this:-

Mrs [S] (admitted 21/12/06) Initial care needs assessment incomplete. Communication, Pressure Risk, Skin, Body Map, Pain, Nutritional, Elimination and Personal hygiene assessments not completed.

Clients' notes show little evidence of documentation by L. Zhao (RN), [Resident F] & Mrs [S].

[34] That articulation was not sufficient in my view to inform Nurse Zhao that her documentation lacked attention. I am not satisfied the concern was properly set out before Nurse Zhao to answer.

[35] Quite apart from that deficiency, I am not persuaded that on its own, such an allegation even if established, was sufficient to justify summary termination.

Clinical accountability

[36] The fourth key area was headed “Clinical Accountability”. The dismissal letter stated:-

You failed to observe that [Resident F] had not eaten, stating that you were busy at the time. Therefore you failed to observe why he had not eaten as he had lost the ability to feed himself which had been noted by [Resident F's daughter].

You failed to respond to concerns being expressed by [Resident F]’s family and to requests from afternoon and night Registered Nurses to arrange a consultation with the doctor. You failed to take adequate precautionary clinical steps which raised the anxiety level of the family and seriously delayed necessary medical attention. Dr Hodder, on examining [Resident F], suspected a CVA and admitted [Resident F] to Auckland City Hospital immediately. This was not, as you stated, because of the family, it was because Dr Hodder, in his clinical opinion, queried a possible CVA. This would have happened earlier in the day if you had ensured Dr Hodder examined [Resident F] while conducting his ward round in the morning. Instead there was a delay of some 6 or 7 hours.

[37] Nurse Zhao said that she believed her nursing care had followed the necessary steps.

[38] The ultimate finding was this:-

> *However, you have failed to appropriately manage the broader clinical issues and family dynamics resulting in unacceptable risks for our client and for Caughey Preston. This is the highest possible risk and absolutely will not be tolerated.*

[39] While that was the conclusion, once again, I do not consider it was properly notified to Nurse Zhao to answer. I do not understand anything in Part Three annexure to properly inform Nurse Zhao of this allegation.

[40] Yet again I conclude that the documentation provided to Nurse Zhao was not sufficient in my view to inform her of an allegation that her clinical accountability was not acceptable to the Board. I am not satisfied the concern was properly set out before Nurse Zhao to answer.

[41] Quite apart from that deficiency, I am not persuaded that on its own, such an allegation even if established, was sufficient to justify summary termination. If the general allegation is distilled to the underlying actions of misconduct, I do not consider that it would be fair or reasonable to regard a single incident of failing to appreciate a patient had not eaten or failing to arrange a consultation could amount to serious misconduct. I repeat here again the comments I make at paragraphs [22] - [24] above.

[42] It must be remembered that English is Nurse Zhao's second language. While the documentation provided to her was lengthy, it was not as this determination makes clear, sufficiently helpful. The Board ought to have been particularly more careful than ordinarily so when specifying its concerns for Nurse Zhao accordingly.

[43] Ms Budgen wrote that Nurse Zhao's actions had exposed significant risks in terms of operational processes, certification compliance, legal liability and most

importantly client care. It seems to me the ultimate conclusion is that immediate termination was required because of serious risks Nurse Zhao exposed the Board to.

[44] The fact that any particular action may have serious consequences does not in itself render that action serious misconduct justifying summary termination. The conduct in question must be considered in context having regard to all the attendant surrounding circumstances. I am unable to say the conduct here has such a character. I do not agree that the matters put to Nurse Zhao were matters of misconduct serious or otherwise. I rather consider the correct response was appropriate and focused performance management and better communication of expectations.

[45] Nurse Zhao was not dismissed on notice. Although I accept she had been dealt with previously in relation to her performance, she had not been formally so by disciplinary warning or any form of notice that her continued employment was in jeopardy. She had not been given any previous warnings or formally disciplined so as to put her on notice. Rather, the Board on the occasion that she was dismissed, terminated her employment summarily. The conduct which justified that termination must be serious enough to warrant that immediate response. I am not satisfied that her conduct the subject of her immediate dismissal was sufficiently serious as to justify that response.

[46] I am also concerned with the timeframe in which the dismissal was effected. While she received the allegation letter of 13 February 2007, she was dismissed only days later on 16 February 2007. That minimal period is haste in my estimation. The Board's evidence which is not challenged is that Nurse Zhao did not raise any opposition and when asked, said she wished to proceed.

The determination

[47] Viewing matters objectively, I determine that a fair and reasonable employer would not have concluded Nurse Zhao's conduct amounted to serious misconduct. I further conclude a fair and reasonable employer would not have dismissed Nurse Zhao. I determine that Nurse Zhao was justifiably dismissed and she has a personal grievance. She is entitled to remedies in settlement of that personal grievance.

[48] Having made those findings and in considering both the nature and the extent of the remedies to be provided, I am bound by section 124 of the Act to consider the extent to which Nurse Zhao's actions contributed towards the situation that gave rise to the personal grievance, and if those actions so require, to reduce the remedies that would otherwise have been awarded accordingly. I cannot say that blameworthy conduct on Nurse Zhao's part has been established. I find that Nurse Zhao did not contribute to the situation that led to the unjustifiable dismissal such as would require a reduction in either the nature and extent of remedies to be awarded to her.

Reimbursement

[49] Nurse Zhao found other employment about 4 - 5 weeks after her dismissal at the Selwyn Foundation. That work was not full time but part-time for 32 hours per week. I award her lost income of five weeks gross wages. **I order the Marianne Caughey Smith Preston Memorial Rest Homes Trust Board to pay to Lan Zhao five weeks gross wages as reimbursement.**

Compensation

[50] I accept that Nurse Zhao suffered hurt and humiliation, loss of dignity, and injury to her feelings as a result of the personal grievance I have found. She says she feels particular aggrieved about the criticisms of her culturally and of her english. When the decision to terminate her employment was advised to her, Nurse Zhao was traumatized and would not leave the Board's premises. She began to cry and was very upset. She protested that what was happening was not right and that Ms Budgen could not do what she was doing. Nurse Zhao refused to hand over her name tag. She had to be escorted from the premises by a security officer - according to Nurse Zhao by the time he counted to ten or the Police would be called. That was humiliating and distressing for her. She says she lost her self esteem, personal dignity and her family's financial situation suffered. She says she could not face her mother for two weeks because she was embarrassed about her dismissal.

[51] Nurse Zhao claims $10,000.00. My assessment of her loss having regard to the length of her service, her evidence and the nature of her personal grievance is an award of $8,000.00. **I order the Marianne Caughey Smith Preston Memorial Rest Homes Trust Board to pay to Lan Zhao the sum of $8,000.00 as compensation.**

Costs

[52] In the event that costs are sought, I invite the parties to resolve the matter between them, but failing agreement, Ms Cole is to lodge and serve a memorandum as to costs within 14 days of the date of this Determination. Mr Bennett is to lodge and serve a memorandum in reply thereafter but within 28 days of the date of this Determination. I will not consider any application outside that timeframe without leave.

Leon Robinson
Member of Employment Relations Authority