

Bellaire General Hospital, LP, d/b/a Bellaire Medical Center and Dannie Denise Coleman and Linda A. Coleman and Iolene V. Williams. Cases 16–CA–22556, 16–CA–22557, and 16–CA–22558

September 30, 2006

ORDER REMANDING PROCEEDING TO
ADMINISTRATIVE LAW JUDGE

BY CHAIRMAN BATTISTA AND MEMBERS SCHAUMBER
AND KIRSANOW

On September 25, 2003, Administrative Law Judge Margaret G. Brakebusch issued her decision in this proceeding. The Respondent filed exceptions, a supporting brief, and a reply brief, and the General Counsel filed an answering brief.

On September 29, 2006, the Board issued its decisions in *Oakwood Healthcare, Inc.*, 348 NLRB No. 37, *Croft Metals, Inc.*, 348 NLRB No. 38, and *Golden Crest Healthcare Center*, 348 NLRB No. 39, in light of the Supreme Court’s decision in *NLRB v. Kentucky River Community Care*, 532 U.S. 706 (2001). *Oakwood Healthcare, Croft Metals*, and *Golden Crest*, specifically addresses the meaning of “assign,” “responsibly to direct,” and “independent judgment,” as those terms are used in Section 2(11) of the Act.

The National Labor Relations Board has delegated its authority in this proceeding to a three-member panel.

The Board has decided to remand this case to the judge for further consideration in light of *Oakwood Healthcare, Croft Metals*, and *Golden Crest*, including allowing the parties to file briefs on the issue and, if warranted, reopening the record to obtain evidence relevant to deciding the case under the *Oakwood Healthcare, Croft Metals*, and *Golden Crest* framework.¹

IT IS ORDERED that this proceeding is remanded to the administrative law judge for appropriate action as noted above.

IT IS FURTHER ORDERED that the administrative law judge shall prepare a supplemental decision setting forth credibility resolutions, findings of fact, conclusions of law, and a recommended Order, as appropriate on re-

¹ No exceptions were filed to the judge’s dismissal of the complaint allegation that the Respondent unlawfully terminated Dannie Coleman. The judge found that the Respondent satisfied its burden to demonstrate that it would have discharged Dannie Coleman even in the absence of her protected concerted activities. *Wright Line*, 251 NLRB 1083 (1980), enf’d. 662 F.2d 899 (1st Cir. 1981), cert denied 455 U.S. 989, approved in *NLRB v. Transportation Management Corp.*, 462 U.S. 393 (1983). The Respondent, however, excepts to the judge’s finding that Dannie Coleman was not a statutory supervisor. Even assuming arguendo that she was found to be a statutory supervisor under *Oakwood Healthcare, Golden Crest*, and *Croft Metals*, supra, the dismissal of the complaint allegation would not change. Therefore, we do not remand the portion of the proceeding concerning Dannie Coleman.

mand. Copies of the supplemental decision shall be served on all parties, after which the provisions of Section 102.46 of the Board’s Rules and Regulations shall be applicable.

Art Laurel, Esq., for the General Counsel.

Brad Hancock, Esq., *Teresa Neet, Esq.*, and *Jonathan Navarro, Esq.*, for the Respondent.

DECISION

STATEMENT OF THE CASE

MARGARET G. BRAKEBUSCH, Administrative Law Judge. The charge in Case 16–CA–22556 was filed on February 11, 2003,¹ by Dannie Denise Coleman (Dannie Coleman). The charge in Case 16–CA–22557 was filed on February 11, 2003, by Linda A. Coleman (Linda Coleman). The charge in Case 16–CA–22558 was filed on February 12, 2003, by Iolene V. Williams (Williams). Based upon the allegations contained in Cases 16–CA–22556, 16–CA–22557, and 16–CA–22558, the Regional Director for Region 16 of the National Labor Relations Board (the Board), issued an order consolidating cases, consolidated complaint, and notice of hearing on April 30, 2003. The consolidated complaint alleges that Bellaire General Hospital, LP, d/b/a/ Bellaire Medical Center (Respondent) discharged Dannie Coleman, Linda Coleman, and Williams because they engaged in concerted activities and to discourage employees from engaging in concerted activities and thus violated Section 8(a)(1) of the National Labor Relations Act (the Act).

A hearing on these matters was conducted before me in Houston, Texas, on June 30, July 1 through 3, and 8 through 9, 2003, at which all parties had the opportunity to present testimony and documentary evidence, to examine and cross-examine witnesses, and to argue orally. The General Counsel and Respondent filed briefs, which I have duly considered. On the entire record, including my observation of the demeanor of the witnesses, and after considering the briefs filed by the General Counsel and Respondent, I make the following

FINDINGS OF FACT

I. JURISDICTION

Respondent, a Texas limited partnership, with an office and place of business in Houston, Texas, has been engaged in the business of providing health care services. Annually, Respondent, in conducting its business operations, derived gross revenues in excess of \$250,000 and received at its Houston, Texas facility goods valued in excess of \$50,000 directly from points outside the State of Texas. Respondent admits and I find that it is an employer engaged in commerce within the meaning of Section 2(2), (6), and (7) of the Act.

II. ALLEGED UNFAIR LABOR PRACTICES

A. Background

Respondent’s executive officers include Stephen Selzer, chief executive officer; Buddy Whiddon, chief financial officer; and Martha Susan Long, who serves as chief nursing officer as well as vice president of patient services. Long testified that

¹ All dates are 2003, unless otherwise indicated.

when she came to the 349-bed hospital in September 2002, she understood that her charge was to make the nursing staff more productive, more efficient, and more customer friendly.²

Reporting to Long are eight nursing unit directors and three full-time nursing house supervisors. As a direct report to Long, Selzer, and Whiddon, Carolyn Washington is Respondent's director of human resources.

Prior to December 2002, 12 nurses working 12-hour shifts staffed Respondent's emergency room (ER). Based upon the staffing schedule, there were always three nurses scheduled in the ER on any given shift. One of the three nurses was responsible for triage, which involved making the initial assessment of the patient. The other two nurses were responsible for the ER patients' direct patient care following their initial assessment. In December 2002, Long restructured the staffing of the ER nurses from three to two for the period between 11 p.m. to 11 a.m. Long acknowledged that the ER nurses were not happy with this change and discussed the change among themselves. Long recalled that she not only had daily conversations with the day-shift nurses about their dissatisfaction with the change, but she also received e-mails from the nurses. Long explained that the nurses insisted that she could not make the changes because they believed that State regulations required that there be three nurses in ER at all times. Long admitted that Linda Coleman, Dannie Coleman, and Williams were among the nurses who complained to her about the staffing change.

B. Iolene Williams

1. Complaint paragraphs 9, 10, 13, 15, 16(b), and 17

The General Counsel alleges in complaint paragraphs 9 and 10 that about December 26, 2002, Williams engaged in protected concerted activities by invoking the Safe Harbor Act because of inadequate staffing levels and by informing Respondent that the staffing levels were unsafe. In complaint paragraph 13, the General Counsel alleges that Williams engaged in concerted activities on January 14, by responding to Respondent's e-mail regarding the invocation of the Safe Harbor Act because of inadequate staffing levels. The General Counsel further alleges in complaint paragraph 15 that on January 23, Williams engaged in concerted activities by complaining about the staffing levels. The General Counsel alleges that because of Williams' concerted activities, Respondent terminated her on January 29, 2003.

2. Background

Iolene Williams has been a licensed registered nurse for 28 years. She began working for Respondent in its psychiatry department in April 2001 and in March 2002, she transferred to the ER. Williams worked approximately three to five nights a week on the 11 p.m. to 7 a.m. shift. On weekends, Williams filled in as a house supervisor. As a house supervisor, Williams served as the administrative representative between the hours of 11 p.m. to 7 a.m. As house supervisor she was responsible for assuring staffing coverage and obtaining needed supplies, medications, and pharmaceuticals for nurses. She testified that

she did not have the authority to hire, fire, suspend, transfer, layoff, or discipline employees. If there was a problem with an employee, she tried to work out a solution. If she could not work out a solution, she contacted Respondent's administrative officer on call and obtained instructions as to how to proceed. When Williams worked as a staff nurse in ER, she rendered direct patient care. She estimated that there were perhaps only two occasions, when by default, she served as a charge nurse in the ER. These were occasions when she was the only staff nurse working a particular shift and the other nurses were agency or contract nurses.

3. Respondent's reduction in staffing

Williams recalled receiving notification of the reduction in staffing on approximately December 19. Williams testified that she had been concerned with the reduction because she felt that it would be difficult for the nurses to render effective or safe patient care with only two ER nurses. Williams explained that even though patient flow may be less from 11 p.m. to 7 a.m., the reduction would leave only one nurse to handle patient triage, which is in an area that is set apart from the remainder of the ER. All of the other ER nursing responsibilities would be left to the remaining nurse. Hospital policy requires that the triage nurse first evaluates each patient who is seen in the ER. Williams explained that because the Emergency Medical Treatment and Active Labor Act (EMTALA) requires that a patient coming into the emergency room must be triaged or given an assessment within a timely manner immediately upon arrival, there must be a full-time ER triage nurse. Additionally, if one of the nurses has to take a patient to a hospital floor for admission, only one nurse is left in ER to handle both triage and all of the other responsibilities.

4. Williams' invocation of the Safe Harbor Act

While Williams was not originally scheduled to work on December 26, she worked an extra shift from 7 p.m. to 7 a.m. The other nurse on duty in the ER was Lydia Leyva. It was an unusually busy night in the ER. When Williams telephoned House Supervisor Cathy Oliver to get assistance in transferring two patients from ER to the medical-surgical floor, Oliver told her that she had no additional staff to provide to ER. As Williams prepared to take the two patients to the medical-surgical floor, there were already five patients in ER and ambulances arrived bringing two more patients to ER. After ascertaining that the first new ambulance patient was not in a life-threatening situation, she took a patient to the medical-surgical floor, leaving Leyva alone in the ER to handle both triage and the other ER patients. When Williams returned to the ER to take the second patient to the medical-surgical floor, she discovered that another patient had arrived with a seizure disorder. Again, Williams had to leave Leyva alone in ER to deal with triage and the remaining ER patients.

Upon Williams return to ER, she told Leyva that they really needed some help and suggested that they invoke the Safe Harbor Act. The Texas Occupations Code (the Code) provides protection for nurses who have been asked to engage in conduct which the nurse in good faith believes would violated the nurse's duty to a patient. By invoking the Code, the nurse requests that a peer review committee review the assignment that

² Prior to Long's arrival at the hospital, the facility had not only been closed for a period of time because of a flood, but the facility had also been for sale for 2 years prior to its purchase by American Trust.

the nurse believes would cause him or her to violate his or her duty to the patient. Long testified that when a nurse invokes Safe Harbor, the nurse is saying that there is insufficient staff and the nurse's license is in jeopardy and appropriate patient care cannot be provided.³ Williams contacted House Supervisor Cathy Oliver and told her that if they were not able to get some additional help in ER, they were invoking Safe Harbor. Just after talking with Oliver, the Houston fire department brought in a heart attack patient requiring CPR. Williams contacted Oliver again and asked her to come to the ER. Once the heart patient was stabilized, Williams and Leyva again spoke with Oliver about invoking Safe Harbor. Oliver asked them to identify the time in which they had invoked Safe Harbor and she asked the number of patients and the nature of their complaints at the time of their invoking Safe Harbor.

Later that same evening Oliver returned to ER and informed Williams and Leyva that she had called Long at home and Long wanted to meet with them at the end of their shift. Williams testified that when they met with Long at approximately 8 a.m. the next morning, they explained the events of the previous night and why they felt that they had to invoke Safe Harbor. Long told Williams and Leyva that the supervisor had called her in the middle of the night to inform her of the Safe Harbor discussions. Long initially testified in this proceeding that the supervisor had not told her that the nurses were invoking Safe Harbor, but were only discussing Safe Harbor. Long acknowledged, however, that in the affidavit that she had given the Board during its investigation of the unfair labor practice charge, she had stated, "I don't remember exactly what nurses invoked the Safe Harbor Act. I asked why the ER nurses were asking for Safe Harbor." Long acknowledged that she had taken the invocation of Safe Harbor as a threat that patients would not get the care they required and she restored the original ER staffing schedule the next day.

In response to questions from counsel for the General Counsel, Long testified that she could not remember what nurses attempted to invoke the Safe Harbor. Long admitted that she had "probably" asked Oliver at the time and Oliver had "probably" told her their names. While Kathy Oliver testified in the proceeding, she did not deny that she told Long the names of the nurses who invoked or threatened to invoke the Safe Harbor Act on December 26. When asked on cross-examination whether she had a discussion with Williams and Leyva about invoking Safe Harbor, Long replied that she did not recall. She acknowledged that it was "possible" that she had such a discussion. Respondent's staffing coordinator, Diana Curry, testified that Long talked with her about the nurses' complaints and the Safe Harbor incident. In that conversation, Long described the Safe Harbor complaint as either silly or ridiculous.

On January 2, 2003, an agent of the Texas Department of Health (TDH) conducted an inspection of the ER and met with Long. In response to the surveyor's request, Long provided

³ Respondent's Staffing Coordinator Diana Curry testified that she understood that Safe Harbor is a protection for nurses in which they can declare that the situation isn't safe for them or the patients.

specific ER patient records for review.⁴ Although Long denied that the State surveyor identified the source of the complaint, she understood that the inspection resulted from a complaint of inadequate staffing. Long admitted that while the surveyor never told her that the inspection was a result of a Safe Harbor complaint, she suspected that it was. By letter dated January 8, 2003, Respondent received a report from the Texas Department of Health, finding that Respondent's facility was in compliance with Federal regulations.

5. Long's reinstatement of the staffing reduction

On January 9, 2003, Long sent an e-mail to all ER staff. In the e-mail, Long informed the staff that as of January 10, ER would revert back to the reduced staffing level that had been originally instituted in December. In the e-mail, Long further explained that all 13 charts were reviewed for the night that the "Safe Harbor" complaint was made. Long acknowledged that the State surveyor indicated that two of these charts could have been determined to be an EMTALA violation, however, the surveyor did not document those against Respondent. Long further asserted in the e-mail that the State surveyor found the "Safe Harbor" complaint to be unsubstantiated. She also added: "A prudent nurse would not file a ridiculous complaint with the TDH." Long testified that while she had not known who had filed the complaint with the State, she suspected someone in ER of having done so.

After receiving Long's January 9 e-mail, Williams testified that she was surprised and a little bit angry. She discussed with the other nurses that apparently there was some misunderstanding on Long's part as to how things occurred in the ER. Williams recalled discussing this concern with fellow employees Linda Coleman, Dannie Coleman, Fred Phillips, Lydia Leyva, Dulce Bulsig, Kimberly Burt, and Mike Marcos. In an e-mail dated January 14, Williams responded to Long. Williams began the e-mail by stating:

I was very surprised and disappointed when I received your e-mail because it seem(s) as though Lydia and I are under attack and being blamed for something we did not do. I think your assumption is that since we invoked Safe Harbor, we must be the ones who called the State. I was not even aware that TDH was called until you told me in your e-mail.

Williams continued by addressing the various issues raised by Long in her e-mail and stated: "Anyone who would say that the Safe Harbor was unsubstantiated evidently does not understand the purpose of the process of Safe Harbor." Williams also pointed out that in their meeting with Long, they had not stated that the staffing was in violation of EMTALA, only that when the ER is busy, the triage nurse may leave triage unattended to assist in the other portions of ER. Williams also requested to know what violations were found by the State. She added: "Unless we know what they were we will more than likely continue to commit those violations out of ignorance. Please let me know the names of the patients so that I can re-

⁴ Long testified that despite the fact that she pulled the patient charts requested by the surveyor, she did not know the timeframe that was being investigated by the State.

view the charts.” Long acknowledged that she received and read Williams’ January 14 e-mail.

In early 2003, Long hired Michael Davis as Respondent’s director of ER and the intensive care unit. He remained in the job, however, only from January 20 until February 3, 2003.⁵ Davis recalled that in a conversation with Long on or about January 15, she told him that two nurses had declared Safe Harbor in the ER and she had called them into her office the day after the incident. While she had not identified them by name she told him that the incident had been without merit. Davis also recalled that during his first 4 days of employment, Long told him that some of the employees had problems and the hospital needed to clean house. Davis also recalled that during one of his initial conversations with Long, she stated that she was going to try to get rid of some of the ER nurses before he arrived at the hospital.

Williams testified that when Davis became director, she and other nurses talked with him about the staffing difficulty. Davis agreed that there was a problem and he told her that he would discuss the problem with Long and that he would also recommend hiring an emergency medical technician for the ER. Davis recalled that during his first week at the hospital, he received a “lot of complaints” from the nurses. He recalled that the nurses complained about staffing, pay, working conditions, but specifically about the reduction of staff on the night shift. Davis recalled that the night shift in particular complained about the reduction in staffing. Davis acknowledged that while he personally thought that the nurses were just “being babies” and “whining,” staffing seemed to be extremely important to the nurses. Davis recalled that they always presented the issue from the standpoint of a patient care standard and not so much a work standard. Davis discussed the nurses’ complaints about the schedule change with Long.

6. The events of January 28

On January 28, Williams worked an extra shift with Charge Nurse Dulce Bulsig. Williams recalled that it was a rather slow night in the ER. At one point, there was only one patient in the ER and Bulsig was working triage. A pregnant patient came into ER and was seen by Bulsig in triage. Williams explained that hospital policy requires that any pregnant patient who presents to the ER who is over 20 weeks of gestation and is having abdominal pain should be taken to the labor and delivery department for evaluation. Patients who are less than 20 weeks of gestation will remain in the ER and be treated as ER patients. When Bulsig called labor and delivery to notify them of the patient’s presence, she was initially told that there were no clean beds. It was Williams’ understanding that labor and delivery later called and told Bulsig that the bed was ready for the patient. When Bulsig took the patient to the floor, she was told that the patient could not be admitted to the floor and had to be returned to ER. At some point later in the evening, Bulsig instructed Williams to take the patient back to labor and delivery. Prior to that time, Williams had not had any involvement with

treating or assessing the patient. Williams recalled that her attention had been given to an elderly patient with diabetes, hypertension, and a severe nosebleed.

After Williams returned home from her shift, she received a telephone call from Davis. He stated that he had received an e-mail from Bulsig and he wanted to know what had happened. Davis told Williams that the situation that occurred the evening before with the pregnant patient presented an EMTALA violation. Williams told Davis that she felt that any violation occurred at the point in which the patient was turned away from labor and delivery. She explained to Davis that if ER were going to be required to monitor the labor and delivery patients, there needed to be training and equipment in the ER to deal with that kind of situation. Williams testified that while she had delivered babies years ago in Jamaica, she had not practiced midwifery for many years and she had no training in the use of fetal monitors. Williams testified as of January 28, there was not a fetal monitor, baby warmer, or incubator in the ER.

Davis called Williams at home a second time that same day. He told her that the previous night’s incident had snowballed and there was an investigation. Davis told her that rather than coming into work that evening, she was to report to his office the next morning at 9:30 a.m. to meet with administration. Williams then called Bulsig and learned that she had received a similar telephone call from Davis. Later, Bulsig telephoned Williams to share the news that Dannie Coleman had been terminated.

After learning of Dannie Coleman’s discharge, Bulsig and Williams discussed the situation and decided that they did not want to have a termination on their record. They decided that rather than being terminated, they would resign. Later that same day, Williams telephoned Human Resources Director Carolyn Washington and told her of her concerns that she was going to be terminated. Williams also told Washington that she planned to resign rather than to be terminated. Washington did not contradict Williams’ conclusion concerning the expected termination. Rather than going to Davis’s office on January 29, Williams went instead to Washington’s office. Williams again told Washington that she thought that she was going to be terminated and she would rather resign. Williams had prepared two resignation letters; one giving 14 days notice and the other effective immediately. Washington told her that she was glad that Williams had made the decision to resign and she recommended that she submit the resignation that was effective immediately. Washington explained that if Williams provided 2 weeks notice, she could still be terminated within the 2-week period. Once Williams handed Washington the resignation letter, Washington gave Williams her final paycheck.

Washington testified that she had not been involved in the investigation of the January 28 incident involving Bulsig and Williams. Washington admitted however, that she had known that Williams and Bulsig were going to be terminated and she had requested that the final checks be prepared on January 28.

7. Respondent’s account of the events of January 28

Long testified that Supervisor Cathy Oliver contacted her at home during the night shift that ended on January 28. Oliver told her that a pregnant patient had come into the ER at term

⁵ Long testified that she did not know why Davis resigned after only 2 weeks as ER director. She recalled that she walked into her office one morning and found his beeper and badge on her desk. He left a note stating that: “I can’t take this anymore.”

and her water had broken. Long explained that hospital policy is for a patient to be taken directly to labor and delivery if she greater than 20 weeks pregnant. Long also confirmed that on the night in question, there was no fetal monitor or incubator in the ER. Long explained that it was her understanding that it was Bulsig who took the patient to labor and delivery. At the time that Bulsig and the patient arrived on the labor and delivery floor, the nurses were delivering a breech baby and the doctor was stuck in traffic. It was Long's understanding that the labor and delivery charge nurse asked Bulsig to take the patient back to ER and keep her there until labor and delivery completed delivery of the breeched baby. Long explained that Bulsig had taken the patient back to ER and had left her in the waiting room. Because the patient was in pain and her water had already broken, her husband began calling an ambulance to take her to another medical facility. Long acknowledged that Williams' involvement in the entire incident had been transporting the patient to labor and delivery once that department was ready for the patient. The next morning, Long visited with the patient and determined that the baby had been delivered without incident and "everything was fine." Long was asked at what point Williams had done something wrong. Long replied that at the point in which she allowed the patient to be rolled into the waiting room where she could not be seen. Long asserted that Williams had to have known that Bulsig took the patient into the waiting room because there were only two nurses on duty in a small ER.

Long denied that she made any decision to terminate Williams and Bulsig on January 28. She insisted that she only made a decision to talk with them and to hear their side of the story. She further denied that she told Davis to terminate Williams and Bulsig. Long maintained that her only instructions to Davis were to set up a meeting for her to talk with them and she never discussed their termination with anyone. Long went on to explain that had the nurses come to talk with her as scheduled on January 29, they might only have received a suspension. When asked why their final paycheck was prepared on January 28, she responded: "We do that with everybody that we talk to."

During the Board's investigation of the underlying unfair labor practice charge, Respondent provided a position statement dated March 20, 2003. In the statement, counsel for Respondent states that Bulsig and Williams voluntarily resigned due to the incident that occurred on January 28. Counsel further states that Davis investigated the matter and it was his recommendation that Williams be terminated as well as Bulsig. Additionally, counsel added that although termination was a possible course of disciplinary action for Bulsig and Williams, Respondent left open the option of placing either nurse on corrective counseling that may have included suspension. Williams and Bulsig had preempted any discussion of this option by resigning.

Davis testified that on the morning of January 28, he met Long and Director of Women's Services Donna Marino as he was coming out of the elevator. Davis recalled that his conversation might have been as early as 7:45 a.m. One of them began the conversation by saying that he was just the person they were looking for. When he asked what was going on, Long

replied: "We are about to get rid of a couple of your night nurses." Throughout the day, Davis conducted an investigation of what had occurred. He spoke not only with Williams and Bulsig, but also with the labor and delivery nurse, Marino, and the ER physician who had been on duty the previous evening. Davis confirmed from the physician that Williams had been with an elderly patient with epistaxis during the incident with the pregnant patient. Davis determined that when the pregnant patient's husband became upset and began calling 911 from the waiting room that it had been Williams who had intervened and called the house supervisor. As a result of his investigation, Davis recommended to Long that Williams receive a suspension. Long responded that it was a good opportunity to get rid of both of them. In response, Davis recalled saying: "I'll give you Dulce but I don't think—I don't think I should give you Iolene." Davis recalled that upper management from Med Trust was present in the hospital that day. Long responded by telling Davis that the management official from Med Trust "doesn't want these types of people working here." Davis testified that Long made the decision to terminate both Bulsig and Williams on January 28.

C. Linda Coleman

1. Complaint paragraphs 7, 8, 11, 12, 14, 16, and 17

Complaint paragraphs 7, 8, 11, 12, and 14 allege that on various dates between late December 2002 until January 22, 2003, Linda Coleman engaged a number of concerted activities concerning unsafe staffing levels. The complaint alleges that this matter was brought to Respondent's attention by directly informing Respondent as well as by sending an e-mail, requesting to meet with Respondent, and by discussing these concerns with other employees. Complaint paragraphs 16(c) and 17 allege that Respondent terminated Linda Coleman on February 7, because she engaged in such concerted activity.

2. Background

Linda Coleman has maintained a registered nurse (RN) license for 25 years. Coleman worked for Respondent for 9 years prior to her discharge in February 2003. When Respondent first employed Coleman in 1994, she worked as a house supervisor on weekends. From 1996 to 1998, she worked as a staff nurse in ER and from 1998 to 2001 as a charge nurse in ER. From 2001 until March 3, 2002, Coleman served as nurse manager under the chief nursing officer. From March 3, 2002, until her termination in February 2003, she again worked in the ER. When not working overtime, she served as charge nurse on her scheduled shift. When working overtime, she worked as a staff nurse.⁶ When working as a charge nurse, Coleman was responsible for making the assignments for the nurses present on the shift. She was also responsible for checking the refrigerator, defibrillator, emergency cart, and for ordering the supplies that were needed. Additionally, she was responsible for making sure that there was appropriate flow of patient care within the ER. When there were three nurses in the ER, Coleman designated one nurse for triage and she and the third nurse

⁶ Coleman estimated that she worked overtime one 12-hour shift every 2 weeks.

would split the eight-patient beds in ER. In splitting the number of beds between the two nurses who were not handling triage, she tried to rotate the bed assignments. Coleman testified that as a charge nurse, she had no authority to hire, fire, transfer, suspend, or layoff employees. Coleman further testified that she had no authority to recommend hiring, firing, transferring, or suspending employees. Coleman confirmed that she did not have the authority to allow an employee to leave work early and she had never done so.

3. Respondent's staffing reduction

Coleman testified that when she first learned of the staffing reduction in ER in December, she was dismayed. She was concerned about patient safety when there were only two nurses covering the ER. She and fellow employees discussed this concern on their respective shifts and with employees on other shifts. On the first weekend that Coleman worked with the reduced staffing, Coleman called House Supervisor Janie Cook and asked for additional help in the ER. When Cook came to ER to talk with Coleman and the other ER nurse, Tarana Smith, Coleman explained that they were "socked" with so many people coming in and it was unsafe for patients. Coleman told Cook that even the doctors were trying to help the nurses with their work. Cook told her that she would report the problem to Long.

Coleman recalled that on or about December 24, she discussed the decreased staffing with nurses Fred Phillips and Linda Walker. Although Coleman called administration and asked that someone come to ER to talk with them about staffing, there was never any response. After December 24, Coleman recalled discussing the staffing reduction problem with Long when she visited the ER. Long told her that when she had those kind of problems, she should call Long at home. Coleman told her that she didn't have the authority to call Long at home and she had to go through Cook. Coleman also recalled that sometime at the end of January or the first of January, she sent an e-mail to Long, requesting that someone talk with the ER nurses about the staffing. Coleman received no response.

On or about January 8 or 9, Coleman, accompanied by nurse Barbara Nicholas, again requested that Long talk with her about the staffing situation in the ER. Long suggested that Coleman wait and discuss it with Mike Davis who was scheduled to come in as ER director. Coleman recalled that she and Barbara Nicholas spoke with Davis about the staffing concerns the first day that he came into the ER. In response to their concerns, Davis offered to be the third nurse in ER when he was in the building after 7 a.m.

In late January 2003, Coleman received a telephone call from Davis while she was off duty. He told her that he had heard rumors that she was leaving the hospital. Coleman told him that she had been thinking of leaving. She explained that she felt that her job was on the line because other people had been dismissed and she thought that she was going to be the next person to be discharged. Davis assured her that he was not thinking of terminating her. He added that he was trying to not only get more money for the staff, but also to make it better to

work in the ER. He asked her not to leave but to stay with him. Coleman agreed.

4. The events of February 7, 2003

Coleman and Barbara Nicholas were the first to arrive in the ER for the morning shift on February 7. Around 2 to 2:30 in the afternoon, Coleman received a call from Long, asking Coleman to come to her office. Upon entering the office, Long told Coleman that Respondent had received a complaint for something that occurred on February 6. Long stated: "You have problems with rudeness and patient dissatisfaction." Coleman was not aware of any complaint and recalled that the staffing coordinator had even given one of the nurses permission to leave work early on February 6. Long did not explain the circumstances of the complaint and asked that Coleman turn in her keys, pager, and badge. When Coleman returned to ER, security was waiting to escort her from the building. Coleman testified that at no time prior to her discharge was she aware of any complaint that had been made on February 6.

5. Respondent's reasons for discharging Linda Coleman

Counsel for the General Counsel asked Long to explain the basis for Coleman's discharge. Her responses were as follows:

Q. Ms. Long, isn't it true that you terminated Ms. Linda Coleman?

A. Yes, I did.

Q. Isn't it also true that Ms. Coleman was terminated for having a bad attitude?

A. Among other things, yes.

Q. Would you please tell me why Ms. Linda Coleman was terminated.

A. Ms. Linda Coleman was the charge nurse/supervisor, whatever you—leader of the ER when she was there. She worked three days a week. They all worked 12-hour shifts, so they worked three days one weekend four days the next. Ms. Coleman's records back to 1994—here valuations indicate that she, even at that time, had problems with her cooperation and patient care, her friendliness, her customer service, if you will, even her relationship with the employees in the department she could not manage.

Q. So, Ms. Long, is it your testimony that you terminated Ms. Linda Coleman because of bad performance appraisals going back to 1994?

A. That played into it, simply because I had had so many—had received so many complaints about her in my short tenure at Bellaire.

Long further testified that Linda Coleman was terminated for poor performance. When asked to explain what she meant by poor performance, Long described Coleman as having the worst possible customer service that she had ever seen in a nurse. Long maintained that Coleman could not get along with her patients or coworkers and could not show any kind of customer service to her patients. Long recalled that there were instances when Coleman did not "say good morning" to her when she visited ER. Long added, "She wore leather jackets to work." Long acknowledged that in her affidavit given to the Board during the investigation of the underlying unfair labor

practice charge, she stated that she did not remember the incident that led to Coleman's discharge.

On October 12, 1999, Respondent instituted a corrective counseling policy setting out the progressive discipline schedule for employees. The policy provides that when an employee's conduct or performance is below standard, employees are subject to a progressive system of counseling and discipline prior to discharge. The progressive system provides for an initial verbal counseling. The second step of the progressive discipline provides for a formal written counseling. If the employee continues to exhibit below standard conduct or performance, the employee is subject to suspension and ultimately discharge. Long testified that from the minute that she walked through the door at Bellaire, she received complaints about Coleman. Long testified that Coleman's level of misconduct was of such a level that discipline would be administered under the corrective counseling policy. While she testified that she received complaints concerning Coleman from September 15, 2002, until February 7, 2003, she admitted that she never gave Coleman any discipline as set out in the existing corrective counseling policy. Counsel for the General Counsel asked Long if there was any specific action by Linda Coleman that precipitated her termination. Long replied, "[H]er everyday attitude, her rudeness, her superiority, her—she would not recognize authority of any kind."

Long acknowledged however, that Coleman's performance evaluations for 2001 and 2002 reflected that all identified competencies either met the standard of performance or exceeded the standard of performance. On November 18, 2002, Coleman received an increase in pay based upon her level of performance. Long did not dispute that Coleman's personnel file contained two letters from visitors to the ER in which Linda Coleman was commended for her services in 1996 and 1997. Coleman's personnel file also contains documentation of two incidents in which fellow employees commended her work performance and patient care.

Davis testified that when he first began his employment, he had discussions with Long about the need to "clean house" in the ER. He recalled that Linda Coleman's name was mentioned specifically as one of the employees that had to go. Davis recalled that he had suggested to Long that if there were problems in ER, all of the employees in ER could be laid off and they could start from scratch. Long told him that the hospital did not have enough money to pay severance packages. She added, however, that the hospital had enough information gathered to terminate individual employees. Davis testified that when he started to work he had a preconceived idea that Linda Coleman was a troublemaker. He said that he had heard not only from Long but from other people that Long had a bad attitude. He explained that he found Coleman to be very passionate about patient care. She was also very vocal about the people around her pulling their load in patient care. During Davis's second week of employment he told Long that he was not going to invent a way to get rid of Linda Coleman because she was the strongest nurse they had.

Davis testified that he resigned on February 3, 2003. He explained that he had known from the third day that he worked there that the job was not for him. He recalled the specific

problems that he had with agencies not providing nurses because the hospital had not paid their bills. As a further example of the financial problems, he recalled that he had been told that the lock on his office door could not be changed because there wasn't money for the new lock. He explained that he felt bad for abandoning Long. He testified: "—I couldn't do it. I couldn't stay."

D. Dannie Coleman

1. Complaint paragraphs 6, 16, and 17

Complaint paragraph 6 alleges that Dannie Coleman engaged in concerted activities by sending an e-mail regarding the change in working hours and schedule changes. Paragraphs 16(a) and 17 allege that Respondent terminated Dannie Coleman because she engaged in concerted activities.

2. Background

Dannie Coleman has been a licensed registered nurse (LPN) since 1991. Prior to receiving her nursing license, Coleman was also a psychiatric technician, phlebotomist, and a hospital unit clerk. Coleman began her employment with Respondent in 1987. She was a nurse in ER from 1994 until her discharge in 2003. Coleman testified that she was told that she was terminated because of gross misconduct and job abandonment.

During the period between December 2002 and January 2003, Coleman's hours were from 7 a.m. to 7 p.m. Normally, Coleman worked this shift for 3 days 1 week and 4 days on alternating weeks. Coleman worked as both staff nurse and charge nurse on her shifts. As charge nurse, she was responsible for maintaining the flow of the patients and assigning the required nursing responsibilities for the nurses on that shift. The tasks that required assignment were counting narcotics, passing out linen, checking the temperature of the refrigerators, cleaning the utility room, and checking the emergency (crash) cart. Coleman testified that the primary difference between the charge nurse and the staff nurse is responsibility for completing the assignment sheet. Coleman testified that on those occasions when she served as charge nurse, it was by agreement with the other RN who worked that same shift. She explained that when the shift is composed of all regular employees, the charge nurse normally splits the responsibilities evenly. Coleman testified that if the staff included an agency nurse that was not a regular hospital employee, she would normally not assign that person the responsibility of counting narcotics or checking the emergency cart. The agency person might only be assigned to such tasks as cleaning the utility room or checking the linen. She recalled that she served as charge nurse approximately 50 percent of her scheduled shifts.

3. Dannie Coleman's response to the schedule change

Coleman recalled that she had been concerned with the December 2002 staff reduction in the ER. She explained that she was concerned not only for patient safety but she was also concerned about her license if there was not adequate staff to cover the ER. The 2002 staffing reduction also reduced her overtime and required that she change hours and work evenings as well as days. She discussed this concern with fellow employees Fred Phillips, Barbara Nicholas, Linda Coleman, Tarana Smith, Lydia Leyva, Dulce Bulsig, and Iolene Williams when she saw

them during shift changes. On an unspecified date in December, Phillips, Nicholas, and Dannie Coleman called Staffing Coordinator Curry and complained about the schedule changes and the hours. The same three employees also sent an e-mail to Curry addressing their concerns about the schedule change. Coleman did not identify the specific content of the e-mail nor did she produce a copy of the e-mail. Long acknowledged that Dannie Coleman had been one of the nurses who sent her an e-mail concerning the reduction in staffing level. Long admitted that when the nurses wrote to her, she had the impression that they were writing on behalf of all nurses on the night shift.

Coleman recalled that on January 9, Tarana Smith and she had been present in the ER when Linda Coleman called administration to request that Long come to ER to talk with them about their concerns. Coleman did not know why, but she knew that Long did not do so. Coleman recalled that sometime in January, she had a conversation with Long regarding the schedule change. Coleman did not identify the specific substance of the conversation with Long.

4. Respondent's basis for terminating Dannie Coleman

Long testified that the decision to terminate Dannie Coleman on January 28, was made by CEO Seltzer, Human Resources Manager Carolyn Washington, ER Director Michael Davis, and her. Long explained that the incident resulting in Coleman's discharge involved imminent danger to patient care. Long recalled that when she first found out about the incident from Nursing Supervisor Janie Cook, the incident had already occurred.

Janie Cook has been a nurse for 31 years. Cook teaches nursing at San Jacinto College and also works as Respondent's weekend nursing supervisor. As nursing supervisor or house supervisor on weekends, Cook serves as the administrative representative. Cook explained that as administrative representative, it is her responsibility to know the hospital policies and to consult with the administrator that is out of the building on call as well as the individual managers when there is a decision regarding a patient or any situation. Cook testified that the hospital policy provides that if an employee works at least 5 hours, the employee is allowed to take a 15-minute break. If employees take their break on hospital premises, they are not required to clock out. If they leave the premises for their lunchbreak or for any break, they are required to clock out. Swiping their badge at the timeclock does this. As a nursing supervisor, Cook was familiar with Dannie Coleman prior to January 2003. Cook described Coleman as someone who came in when scheduled to work and was competent to take care of the patients in ER. Cook did not recall receiving any complaints about Coleman's behavior in the ER from patients or from physicians. When Cook made rounds, she recalled that she often saw Coleman's personal items such as her cell phone, personal day planner, checkbook, and envelopes on the desk in the ER. Cook also recalled that she had observed Coleman entering the building during her shift carrying bags as though she were returning with purchases. Cook recalled two instances prior to Coleman's discharge when she was aware that Coleman left the facility during her scheduled shift. Cook testified that on one occasion, Cook waited for an hour for

Coleman to return to the hospital. When she noticed that Coleman appeared to be gone from ER, Cook inquired of the other nurse on duty as to the whereabouts of Coleman. Nurse Fred Phillips told her that he believed that she had gone to Walgreen's. When Cook saw Coleman entering the building, she told Coleman that she had been gone for some time and she inquired as to whether Coleman had clocked out before leaving. Coleman admitted that she had not. Cook testified that she told Coleman that such an absence was not only a violation of the payroll policy because she was being paid for her absence, but it was also abandoning her patients and her peers in the ER. Cook told Coleman that she was not to leave the premises without asking Cook or letting her know that she was leaving. She also told Fred Phillips that he needed to impress upon Coleman the significance of her leaving without anyone knowing it.

Fredricka Hall is a registered nurse employed with Temporary Health Care. As an "agency" nurse, she goes to various hospitals in the Houston area to fill in where a nurse is needed on any scheduled shift. Hall identified six hospitals in addition to Bellaire Medical Center where she has worked during the past year. Hall recalled working in the Bellaire Medical Center ER from 7 a.m. to 7 p.m. on January 4. Although Hall did not recall their last names, the record reflects that Dannie Coleman and Tarana Smith were the other two nurses who were scheduled to work with Hall on January 4. Hall recalled that she had been assigned to work four of the patient beds in ER and Coleman was responsible for the remaining four beds. Smith was responsible for triage on that shift. Hall testified that she observed Coleman leaving the ER twice during the scheduled shift. She recalled that she first saw Coleman leave around 7:30 a.m. and Coleman was gone for about an hour. When Coleman returned, she had someone with her. Hall didn't know if the woman with Coleman was affiliated with the hospital, although she did not believe that she was. Upon her return, Coleman appeared to be looking for something in her locker and in her purse. Although Coleman introduced the woman, Hall could not recall the name. Coleman and the other woman then left the ER.

Hall recalled that around 10 or 11 a.m., the ER became busy with more and more patients coming in for treatment. When Smith completed the triage assessment for the incoming patients, the patients went into the back area of the ER where Hall was responsible for caring for the patients and following the doctors' orders. Hall recalled that at one point there were at least six to seven patients under her care in the ER treatment area. Hall testified that during this time period, Coleman was not physically present in the ER. Hall testified that she did not look for Coleman because she didn't have time. She said that all that she could think about was taking care of the patients. Hall recalled that sometime after both she and Smith had eaten lunch, Coleman returned to the ER. Hall estimated that Coleman was gone for about 2 hours the second time that she left. Hall did not tell anyone at Bellaire that day about Coleman's leaving the ER. She recalled that when she left she was frustrated, angry, and tired. She had not really known who to tell or even who was the supervisor on duty that day. She testified that she had just wanted to leave the hospital when her shift

ended. She also added that as an agency nurse, she just didn't think that it was her place to say anything to anyone.

When she returned home that evening, Hall contacted her agency's staffing coordinator because she was so frustrated. Hall shared with her coordinator what had occurred and they discussed the length of time that Coleman had been away from the ER. At that time Hall decided that she would never go back to Bellaire Medical Center. When Hall's agency called her a couple of weeks later and asked if she was available to work a shift in Bellaire's ER, she told her agency that she did not want to go. Hall recalled that when her agency reported her response to Bellaire, a great deal of discussion followed between Bellaire administration and her agency. She estimated that she might have received two to three phone calls that morning asking her to come to Bellaire. Finally, Hall agreed that she would go back to the hospital if Dannie Coleman were not working.

When Hall arrived at the Respondent's facility that same day, a nurse named Cathy and who Hall believed to be the night supervisor, asked her why she had not wanted to come back to Bellaire. Hall explained that she did not want to work with Dannie Coleman anymore and explained about Coleman's absence when Hall had last worked a shift at Bellaire. Nursing Supervisor Cathy Oliver recalled that Hall's telling her about Coleman's absence was the first information that she had about this incident. Later that same shift, the ER physician, Dr. Evans, asked Hall to describe what occurred with Coleman. He suggested that Long would probably talk with her about the incident as well. Hall recalled telling the doctor that she really didn't want to talk with anyone about the incident. She told him that she didn't want to get Dannie Coleman in trouble or to report Coleman. She explained: "I just don't want to work with her anymore."

Hall testified that someone from Bellaire whose name was "Mike" later contacted her. When she returned his call, she assumed that this was the same "Mike" who was the new manager or director of the ER. When she spoke with him, he asked her to also describe the circumstances of Coleman's leaving and she did so just as she had with Dr. Evans. Hall told Mike that he shouldn't just take her word for Coleman's leaving, but he could pull the charts and determine her absence for himself.

Davis testified that he first learned about the incident with Coleman on January 20 when he received a note written by Staffing Coordinator Curry. The note stated that Curry had contacted Hall's agency and asked specifically for Hall to cover a particular shift. The agency reported that Hall would not return to the hospital because of an incident that occurred on January 4. It was his understanding that Curry had given the note to Long. Long gave him the note and asked him to investigate the matter. During the investigation, Davis contacted Tarana Smith. It was his recollection that Smith denied that Coleman left the facility, however she had not elaborated as to whether Coleman was or was not in the ER. Davis contacted Hall and she explained to him the time period when Coleman was gone and discussed the number of patients who required attention in her absence. In addition to talking with Hall and Smith, Davis also reviewed the patient charts for those patients who were seen during the morning of January 4. The records that were introduced into evidence reflect that from 7:45 until

11:30 a.m., seven patients were triaged and treated in the ER. Davis's examination of the records reflected that only Hall and Smith made entries on the patient charts and Hall was shown to have discharged all the patients during this time period. Davis found no documentation on any patient by Dannie Coleman until 12:45 p.m. Davis testified that nurses normally document such things as vital signs, medications given, interventions, and nursing assessments in the patient charts. He explained that while it might not be unusual for a nurse to fail to make a chart entry for a period of 2 to 4 hours for one patient, it is unusual for a nurse to fail to make even one entry for such a period of time for a group of six to eight patients.

5. The General Counsel's proof

Coleman denied that she ever left the ER on January 4. Coleman maintained that she had taken a patient to the intensive care unit around 8 a.m. and that there had not been any patients for the next 2-1/2 hours. Although Coleman denied leaving the hospital on January 4, she maintained that if she had done so it would not be against hospital rules. Coleman testified that it was the "general consensus" of the hospital staff that employees could leave the premises during their shift. Coleman admitted however, that she left the hospital for about 20 to 30 minutes on January 11 without clocking out. When she returned Nursing Supervisor Cook told her that she could not do so.

Tarana Smith testified that she worked with Dannie Coleman in the ER on January 4. Coleman was the charge nurse for that shift. Smith did not recall that the day was busy in ER. She recalled that at some point after January 4, Davis called her to ask her questions about that day. Smith testified that when Davis asked her if Coleman had left the hospital, she had told him that Coleman had "absolutely" or "definitely" not left the hospital that day. During examination by counsel for the General Counsel, Smith testified that Coleman left the ER but did not leave the hospital on January 4. She explained that Coleman was outside the ER using her cellular telephone. Smith estimated that Coleman might have been outside using her cellular phone for as much as an hour "off and on." Smith maintained that if Coleman had left the hospital, she would have known about it and Coleman would have told her if she were leaving.⁷ Smith admitted, however, that because she was working triage, Hall would have been the person who would have more contact with Coleman.

III. FACTUAL AND LEGAL CONCLUSIONS

The General Counsel argues that Respondent terminated the employment of Dannie Coleman, Linda Coleman, and Iolene Williams because of their concerted activities in protest of Respondent's December 2002 implementation of a staffing reduction. While the General Counsel has established by record evidence that each of these nurses took some concerted action in response to the staffing reduction, Iolene Williams's actions appeared the more pronounced and vocal.

⁷ Smith admitted that the hospital has a policy that requires all employees to clock out when leaving the hospital premises. She acknowledged that neither she nor Coleman adhered to the policy.

Section 7 of the Act guarantees employees “the right to self-organization, to form, join, or assist labor organization and to engage in other concerted activities for the purpose of collective bargaining or other mutual aid or protection.” Employees are engaged in protected concerted activities when they act in concert with other employees to improve their working conditions. *Eastex, Inc. v. NLRB*, 437 U.S. 556 (1978). An employer violates Section 8(a)(1) of the Act when he discharges an employee for engaging in protected concerted activity. *Rinke Pontiac Co.*, 216 NLRB 239, 241, 242 (1975). There is no dispute that Dannie Coleman, Linda Coleman, and Iolene Williams engaged in concerted activity. All three employees engaged in some form of activity to protest Respondent’s staffing reduction for the ER. Whether through e-mail or in person, these employees made their complaints and concerns known to Respondent. Although these employees had no bargaining representative, their individual and collective actions were taken in furtherance of improving the working conditions of all of the ER nurses. It has long been recognized that the Act protects unorganized employees’ efforts to improve the terms and conditions of their employment. See *NLRB v. Washington Aluminum Co.*, 370 U.S. 9, 14 (1962).

The Board has frequently held that in order to prove a violation of Section 8(a)(1), once it is established that employee activity is concerted, the General Counsel must also establish that (1) the employer knew of the concerted nature of the employee’s activity; (2) the concerted action was protected by the Act; and (3) the employer’s adverse action was because of, or motivated by, the protected concerted activity. *Meyers Industries*, 268 NLRB 493, 497 (1984) (*Meyers I*), remanded sub nom. *Prill v. NLRB*, 755 F.2d 941 (D.C. Cir. 1985), on remand *Meyers Industries*, 281 NLRB 882 (1986) (*Meyers II*), enfd. sub nom. *Prill v. NLRB*, 835 F.2d 1481 (D.C. Cir. 1987), cert denied 487 U.S. 1205 (1988). In cases involving an employer’s motivation, the Board will normally require an analysis under *Wright Line*, 251 NLRB 1083, (1980), enfd. 662 F.2d 899 (1st Cir. 1981), cert denied 455 U.S. 989 (1982). In cases where the employer does not dispute that the employee is discharged for concerted activity, the Board has found the *Wright Line* analysis to be inappropriate. See *Phoenix Transit System*, 337 NLRB 510 (2002). In this case however, Respondent denies that any of these employees were terminated because of their protest of unsafe staffing levels or any other concerted activity. Accordingly, the General Counsel must make a prima facie showing that the concerted activity of Linda Coleman, Dannie Coleman, and Iolene Williams was a motivating factor in Respondent’s decision to terminate their employment. Once that burden has been met, Respondent must then demonstrate that it would have taken the same action in the absence of the employees’ protected concerted activity.

A. Whether Responded Unlawfully Terminated Iolene Williams

In its brief, Respondent asserts: “The evidence showed that Iolene Williams was terminated for gross misconduct arising from her abandonment of a pregnant patient who presented at the ER on January 28, 2003.” Counsel for Respondent adds that while Williams actually resigned before being terminated,

Respondent had already determined that termination would be justified.

There is no dispute that Williams and Leyva attempted to invoke the Safe Harbor Act during their 7 p.m. to 7 a.m. shift on December 26. They telephoned Nursing Supervisor Cathy Oliver and explained that if she could not provide more staff to help them in the ER, they were invoking Safe Harbor. Oliver communicated this information to Long and Long directed Williams and Leyva to meet with her at the end of their shift the next day. While Long admitted that she met with the two employees, she testified that she could not recall their names. Although Long never admitted that Williams and Leyva were the two nurses who invoked the Safe Harbor Act, the record reflect that she clearly knew that Williams and Leyva were involved. Not only did she admit to meeting with the two nurses, she also admitted that she had addressed the Safe Harbor Act complaint in her e-mail to the ER staff on January 9. Long further admitted that she received Williams’ e-mail of January 14, wherein Williams memorializes Long’s meeting with Williams and Leyva as well as the content of their discussion in the meeting. Staffing Coordinator Curry also testified that Long had talked to her about Williams’ and Leyva’s invocation of the Safe Harbor Act and during the discussion Long described their complaints as either silly or ridiculous. It is incredible that Long would have felt strongly enough about the Safe Harbor complaint to address it in her January 9 e-mail and yet not know or seek to know the identify of the nurses who lodged the complaint. Long’s contention that she had not remembered the names of the two nurses who made the complaint is suspect and undermines her overall credibility.

Based upon Long’s e-mail of January 9, it is apparent that she believed that the Safe Harbor complaint was the basis for the Texas Department of Health inspection. In the e-mail, Long specifically states that the State surveyor reviewed all thirteen charts for the night that the “Safe Harbor” complaint was made. Long adds in the e-mail that a “prudent nurse would not file a ridiculous complaint with the TDH.” Based upon the wording of the e-mail, there can be no mistake that Long credited the individuals in the Safe Harbor complaint for also reporting Respondent to the Texas Department of Health. Her reference to such a complaint as “ridiculous” further reflects her dissatisfaction with these individuals.

It is logical that Williams’ e-mail of January 14 in response to Long’s e-mail of January 9, only further antagonized Long. If there had been any doubt that Williams was one of the nurses who invoked Safe Harbor, Williams clearly acknowledged that she and Leyva had been the nurses involved. Williams further requested to know the violations that had been found by the State during their inspection and requested to review the names of the patients involved in order that she could review their charts.

Thus, the evidence reflects that Williams was clearly engaged in protected concerted activity. By invoking the Safe Harbor Act, Williams and Leyva effectively communicated to Respondent their concerns about their existing working conditions. While Williams was not involved in the complaint to the State, Long nevertheless believed that she was. Additionally,

Williams' January 14 e-mail further addressed the working conditions and concerns of the ER nurses.

Counsel for the General Counsel submits that Respondent seized upon the incident of January 28, as a reason to justify terminating Williams. The overall evidence supports such a conclusion. Because Long had again reduced ER staffing, Williams and Bulsig were the only ER nurses on duty on the 7 p.m. to 7 a.m. shift that began on January 27. There is no evidence that Williams had any involvement in assessing or treating the pregnant patient who reported to the ER that evening. Dulce Bulsig was the charge nurse who was also performing triage that shift. It is undisputed that Bulsig made the determination to take the patient to labor and delivery and that she was the nurse who was attending to the patient when labor and delivery did not initially allow the patient to be admitted. The first time that Williams had any contact with the patient was when she transported the patient back to labor and delivery for actual admission to that department. Nursing Supervisor Cathy Oliver confirmed that Bulsig was the nurse who initially brought the pregnant patient to labor and delivery and that Bulsig was the nurse who returned the patient to the ER's waiting area. Oliver testified that she had approximately seven telephone conversations that evening with ER or labor and delivery concerning this matter. In one of the conversations, Oliver told Bulsig that if she needed direction in taking care of the patient, she should call Director of Labor and Delivery Donna Marino. Oliver had no doubt that the call had been made to Marino because Marino later called Oliver and demanded to know why Oliver had directed ER to call her. Oliver recalled that Bulsig had then called her again and was upset because Marino had reprimanded her for the telephone call. Oliver recalled having only one telephone conversation with Williams. She recalled that after repeated telephone conversations with Bulsig, Williams called to report that the patient's husband had called 911. Oliver recalled that at that point, she made the matter a priority. Oliver contacted labor and delivery and told them that the patient's husband was very upset and told them that they had to make room for the patient. Thus, Oliver's testimony is consistent with Williams and supports her testimony that she was not involved with the patient until the time when the patient was actually admitted to labor and delivery.

In brief, Respondent argues that because the patient was not triaged and was not medically assessed, Williams deprived herself of having any knowledge about the patient's acuity or the progression of the labor. Respondent argues that as a result, Williams placed the lives of the ER patient and the unborn child at unnecessary risk. Respondent further argues that Williams' refusal to treat a patient that presented to the ER came precariously close to violating the Emergency Medical Treatment and Active Labor Act (EMTALA). Despite these assertions, however, Williams testified without rebuttal that while Bulsig was the nurse involved with the presenting pregnant patient, she had been involved with an elderly patient with diabetes, hypertension, and a severe nosebleed. Davis testified that during his investigation, he confirmed with the ER physician that Williams had been involved with the elderly patient.

Counsel for the General Counsel submits that Williams was terminated for the very reason that she and other Charging Par-

ties complained about—"two nurses in the emergency room are not enough to provide adequate patient care." The entire record evidence supports a finding that Williams was discharged because she protested Respondent's reduction in staffing and the inadequacy of the assigned staff to cover patient care. I find Respondent's reliance upon the events of January 28 as clearly pretextual. When the reasons advanced by an employer for an employee's discharge either did not exist or were not in fact relied upon, an inference of wrongful motive is established. *Limestone Apparel Corp.*, 255 NLRB 722 (1981), enf. 705 F.2d 799 (6th Cir. 1982). Further, the fact that Williams may have submitted her letter of resignation before Respondent could terminate her does not exonerate Respondent from the unlawfulness of its action. Williams reasonably believed that she was going to be terminated on January 29, based upon the circumstances and Respondent's actions. Such a preemptive resignation must still be deemed as a discharge. *MDI Commercial Services*, 325 NLRB 53 (1997).

Davis testified that Long discussed with him the fact that ER nurses had invoked Safe Harbor. He also credibly testified that approximately 45 minutes after Williams' shift ended on the 28th, Long told him that she was planning on getting rid of a couple of the ER night nurses. After Davis had an opportunity to investigate the matter, he recommended that Williams only receive a suspension. Long rejected his recommendation and on the same day, Long ordered the preparation of Williams' final paycheck. The record establishes that Respondent terminated Williams because of her protected concerted activity. Respondent has not demonstrated that it would have taken this action in the absence of such concerted activity and, thus, has not met its burden under *Wright Line*.

Accordingly, I find that Respondent terminated the employment of Iolene Williams on January 29, in violation of Section 8(a)(1) of the Act.

B. Whether Respondent Unlawfully Discharged Linda Coleman

In its posttrial brief, Respondent asserts that Linda Coleman was terminated for her documented history of poor patient relations and poor supervisory skills. Based upon the total record evidence, I find that Respondent's basis for terminating Coleman is pretextual and that the true motivation for terminating Coleman was her protected concerted activity.

Michael Davis was hired by Respondent in early 2003 to serve as director of ER and ICU. He worked in this position only from January 20 until February 3. He testified that after the third day in the job, he had known that the job was not for him. He testified that after talking with his family and giving the matter much consideration, he decided that his only option was to resign. He testified that he had felt that he had abandoned Long and felt bad for doing so. I found Davis to be a totally credible witness. Although no longer employed by Respondent, Davis' testimony reflected no apparent animus toward Respondent. He testified consistently and without apparent bias toward either Respondent or the Charging Parties.

Davis credibly testified that in his initial discussions with Long, she told him of her desire to get rid of some of the ER nurses. She specifically mentioned Linda Coleman as one of

those nurses who was targeted for discharge. Davis explained that based upon what Long had told him, he had a preconceived idea that Linda Coleman was a troublemaker. He credibly added that he had also heard from others that Coleman had a bad attitude. Upon meeting and working with her, however, he concluded that she was very passionate about patient care. She was also someone who was vocal about the people around her pulling their load in patient care. During his second week of employment, he told Long that he was not going to invent a way to get rid of Linda Coleman because she was the strongest nurse they had. Davis's testimony that Coleman was targeted for termination is supported by the fact that she was terminated only 4 days after he resigned.

The most compelling evidence of pretext in Coleman's discharge is the absence of any precipitating event. Coleman's February 7 termination notice includes a section designating February 6, as the date on which the violation occurred. The violation is described as "Ineffective leadership performance in the areas of customer service. Employee has been reported as rude, hostile, unfriendly, not courteous to pts. or employees. This has been an ongoing problem that has been documented in her evaluations for the last two years. We have received written documentation and phone calls to administration of multiple complaints in reference to poor, inadequate patient care in the ER." The termination notice provided no additional information as to any specific complaint on February 6, or any other date. Coleman credibly testified that while Long mentioned a February 6 complaint, no further information was given to her at the time that she was discharged.

During the course of the hearing, Long was asked if there was any specific action by Linda Coleman that precipitated her termination. Long replied: "Her everyday attitude, her rudeness, her superiority, her—she would not recognize authority of any kind." The only examples that Long provided in which she personally observed Coleman's poor performance were Coleman's failure to say good morning to her and Coleman's having worn a leather jacket to work. Human Resources Manager Carolyn Washington testified that on February 6, Long told her that she had received complaints about Linda Coleman. Washington admitted that when she later read the three complaints, there was no specific mention of Linda Coleman. Washington admitted that Linda Coleman had simply been the charge nurse on duty during the time period of the complaints. I find it also significant that Long admitted that when she had initially given an affidavit to the Board she testified that she did not remember the incident that let to Coleman's discharge.

Because there was apparently no triggering event upon which to base Coleman's discharge, Respondent has relied upon performance evaluations given to Coleman over the period from 1998 to 2002. A performance evaluation contains an appraisal of an employee's competencies in a range of areas including administrative, technical, interactive, customer service, performance of duties, safety, and adherence to hospital attendance policies. Respondent asserts in its brief that Coleman's assessments for 1998, 1999, and 2000 document Coleman's problems with attitude and customer relations. While there are certainly references to improving customer relations' skills and reducing complaints on rudeness and attitude, I also

note that in each of these evaluations, Coleman was rated as meeting or exceeding the standards of performance for all competency areas assessed. Coleman's March 11, 2002 performance evaluation reflects that she was rated as exceeding the standard of performance in 62 of the 77 identified competencies. For the remaining identified competencies, Coleman was rated as meeting the standard of performance. Coleman's December 2, 2002 performance evaluation rated her as exceeding the standard of performance in 71 of the 79 identified competencies. Coleman was determined as meeting the standard of performance for the remaining 8 identified competencies.

In its brief, Respondent also points out two written warnings that were given to Coleman in 1997. One warning involves Coleman's refusal to allow a physician to perform a minor procedure in the ER because she did not have time to recover the patient. The second warning is documented as Coleman's failure to complete assessment of an unstable patient, inappropriate patient assignment by delegating care to an LVN, and inappropriate room assignment for a patient. In its brief, Respondent asserts that these documents reflect that Respondent chartered Coleman through each of the steps in its disciplinary policy, providing her with repeated opportunities to change her behavior. I find however, that Respondent's reliance upon these prior warnings as further suggestive of the pretextual basis for her discharge. Carolyn Washington testified that when she reviewed Linda Coleman's personnel file, she found only one write-up that had been issued to Coleman during the 2 to 3 years before her discharge. The writeup, which was issued in 2002, involved Coleman's failure to hang IV equipment so that it would flow downward. This discipline however, was never offered into evidence. While Long testified that she received numerous complaints concerning Coleman from September 15 to the time of her discharge, Long admitted that no discipline was given under the corrective counseling policy.

During the course of the trial, Respondent presented Human Resources Manager Washington and Nursing Supervisor Cook to testify concerning their own personal experiences with Coleman when they had occasion to visit the ER as patients or employees requiring ER procedures. Although Cook contended that Coleman refused to give her a mandatory TB test and Washington described Coleman as failing to act toward her as a patient advocate, there is no evidence that either of these incidents were reported to higher management or provided the impetus for Coleman's discharge.

There is thus no evidence of any precipitating event that triggered Coleman's discharge nor is there evidence that Respondent followed its corrective counseling procedures in discharging Coleman. Rather than basing Coleman's discharge on any one specific incident, Respondent provides a litany of reasons ranging from her attitude to her choice of clothing. The only evidence suggesting that Coleman's discharge had been considered prior to her actual discharge was Davis' testimony concerning Long's plan to get rid of Coleman. Crediting Davis' testimony over that of Long, there is no reasonable basis for concluding that Respondent discharged Coleman for an accumulation of offenses as asserted by Long. See *Becker Group, Inc.*, 329 NLRB 103, 106 (1999).

Respondent's explanation for Linda Coleman's discharge is inherently implausible and is based upon evidence that is either discredited or unpersuasive. Specifically, I find Long's testimony concerning Coleman's discharge as unpersuasive and lacking credibility. Although Long testified that her mission was to improve the ER, as well as other areas of the hospital, Respondent has simply provided no legitimate business justification for Coleman's discharge on February 7. Finding Respondent's asserted reasons for the discharge to be pretextual, I find that Linda Coleman's concerted activity was a motivating factor in her termination. *La Gloria Oil & Gas, Co.*, 337 NLRB 1120, 1126 (2002), *Limestone Apparel Corp.*, 255 NLRB 722 (1981), *enfd.* 705 F.2d 799 (6th Cir., 1982). Respondent has not demonstrated that it would have discharged Coleman in the absence of her concerted activity. Accordingly, finding that Respondent has not met its burden under *Wright Line*, I conclude that Coleman's discharge was motivated by unlawful considerations and is violative of Section 8(a)(1) of the Act.

*C. Whether Respondent Lawfully Discharged
Dannie Coleman*

Respondent asserts that based upon the initial information gained from Fredricka Hall and Davis' ensuing investigation, Respondent determined that Dannie Coleman abandoned her patients for as long as 4 hours on January 4. Because of what Respondent determined to be gross misconduct, Coleman was discharged on January 28. Counsel for the General Counsel maintains that Coleman was fired because of her complaints and critical e-mail concerning the December 2002 staffing reduction. Long recalled that she received a number of e-mails from nurses, voicing their concern and complaints about the staffing reduction. Long admits that one of those e-mails came from Dannie Coleman. The record, however, contains no evidence of any individual animus from any manager or supervisor directed toward Coleman for her complaints or her e-mail.

The General Counsel argues that the Board allows a finding of animus to be based solely on indirect evidence in appropriate cases. Counsel argues that timing alone may support animus as a motivating factor in an employer's action. Certainly, in this instance, timing is the only factor that lends any support to the argument that Dannie Coleman's concerted activity was a motivating factor in Respondent's decision to terminate her. While her discharge came suspiciously close in time to the discharges of Linda Coleman and Iolene Williams, I find the circumstances far different and totally distinguishable.

Based upon all of the record evidence, I do not find Dannie Coleman to be a credible witness. Her blanket denial that she did not leave the hospital on January 4, is incredible. While she asserts that she was not absent on that particular day, she admits that she has previously left the hospital without clocking out and was reprimanded by having done so. I also found the testimony of Tarana Smith to be equally lacking in credibility. While Smith acknowledges that she told Davis during the investigation that Coleman was definitely or absolutely not away from the hospital, she testified at the trial that Coleman was outside the ER for as long as an hour using her personal cellular telephone.

I find Fredricka Hall's testimony to be totally credible. As an agency nurse, Respondent's facility is but one of seven hospitals where she has occasion to work. The General Counsel has shown no basis to conclude that Hall has any personal or vested interest in the outcome of this matter. There is no reason to conclude that she has any personal loyalty to Respondent or any personal bias or prejudice toward Coleman. Her candid testimony indicates that she would have never pursued the matter further if Respondent had not insisted that she return to work at its facility. After working her January 4 shift, Hall simply didn't want to come back to Respondent's facility and bear the risk of finding herself responsible for Coleman's ER patients. I credit Hall's testimony that Coleman left twice on January 4, leaving Hall and Smith responsible for all the patient care for up to 4 hours.

The patient records further substantiate Coleman's absence for the period of time in which she is alleged to be absent. As Davis so credibly explained, it might be possible to fail to chart one patient, but the failure to chart six to seven patients is another matter. There is no documentation to support that Coleman dealt with any patient before 12:35 p.m. Smith confirmed that Coleman had her own assigned patients for the morning of January 4. It is illogical that she was present and treated these patients without making any chart entries for the period of time in question. Kimberly Burt serves as the registered nurse who is Respondent's risk manager. In her position, she is responsible for dealing with the prevention of injury to patients and dealing with any lawsuits regarding any injuries. Burt has also worked as both a staff and charge nurse in ER. Burt testified that based upon her own experience in the ER, the triage nurse assigns alternating patients to the other ER nurses. Burt explained that based upon the patient records for January 4, Coleman would have been assigned patients prior to 12:35 p.m. Burt also explained that a nurse is expected to chart his or her assessment of each patient as soon as the assessment is complete. The nurse charts the assessment with date, time, and signature. I find that the patient records substantiate Hall's testimony that Coleman was absent from the ER from for approximately 4 hours on January 4.

The General Counsel has demonstrated that Dannie Coleman engaged in concerted activity by making complaints and sending an e-mail containing her complaints and concerns. Respondent does not dispute her concerted activity inasmuch as Long admits that she received Coleman's e-mail. Thus, Coleman's concerted activity and Respondent's knowledge of such activity is without dispute.

The General Counsel argues that the discriminatory motive in terminating Coleman is established through the testimony of Davis. In his brief, counsel for the General Counsel argues that Davis testified that Long told him to fire the emergency room nurses because they complained of the staffing reduction that initially began in December 2002. While Davis credibly testified that Long told him that she was going to get rid of some of the ER nurses before he arrived, Davis recalled only that he and Long discussed that a lot of the nurses in the ER had bad attitudes and the patient numbers did not merit as many nurses on duty. I find no specific admission that Long told Davis that she was going to clean house because of the nurses' complaints

about the staffing reduction. As discussed above, Davis recalled that Long specifically mentioned that Linda Coleman was one of the nurses to go. Davis also recalled that in one of his initial conversations, Long also told him about the ER nurses who declared Safe Harbor. Davis did not, however, testify that Long or any other management official told him that Dannie Coleman was specifically slated for termination. Citing *Ferguson*, 118 NLRB 235 (1957), *enfd.* 257 F.2d 88, 90 (5th Cir. 1958), and *Columbus Marble Works*, 111 NLRB 1162 (1955), *enfd.* 233 F.2d 406, 409, 410 (5th Cir. 1956), counsel for the General Counsel argues that the form, content, and context of a management representative's words, if credited, may eliminate all doubt of motive. While I credit Davis's testimony, I do not find that Davis's testimony clearly establishes Long's admission that she was going to terminate Dannie Coleman because of her concerted activity.

Despite the fact that there is no direct evidence of animus toward Coleman, the very timing of her discharge evidences that a discriminatory motive may be a factor in the decision to terminate her employment. Dannie Coleman was terminated only one day before Iolene Williams and 10 days before Linda Coleman. Even without direct evidence, the Board may infer animus from all circumstances. *Electronic Data Systems Corp.*, 305 NLRB 219, (1991); *Mistletoe Express Service*, 295 NLRB 273 (1989). Based upon the timing and Long's statement to Davis in January that she planned to get rid of some of the emergency room nurses, I find there to be sufficient evidence to warrant an inference of Respondent's unlawful motive.

Under the Board's ruling in *Wright Line*, 251 NLRB 1083, (1980), 662 F.2d 89 (1st Cir. 1981), cert. denied 455 U.S. 989 (1982), and approved by the Supreme Court in *NLRB v. Transportation Management Services*, 462 U.S. 393 (1983), the General Counsel bears the initial burden to establish by a preponderance of the evidence a prima facie showing that the alleged discriminatee (1) engaged in concerted protected activity; (2) the employer had knowledge of that activity; and (3) the employer based its discriminatory action upon, at least in part, the fact that the discriminatee engaged in concerted activity. Finding sufficient evidence to warrant an inference of an unlawful motive, I find that the General Counsel has met its burden to establish a prima facie showing of Coleman's discriminatory discharge. After the General Counsel has made its prima facie case, the burden shifts to Respondent to show that it would have taken the adverse action without consideration of the employee's protected activity. *American Gardens Management Co.*, 338 NLRB 644, 645 (2002). I find that Respondent has clearly met its burden and demonstrated that it would have terminated Dannie Coleman in the absence of any concerted activity. Based upon the credited testimony of Fredricka Hall and the patient records supporting Hall's testimony, the evidence reflects that contrary to her denial, Coleman left the ER on January 4, 2003. Respondent has established that it had a reasonable belief that Coleman abandoned her duties on January 4. Respondent's corrective counseling policy and procedure provides that an employee may be subject to a verbal counseling, written counseling, probation, and discharge prior to termination. The policy also provides, however, that an employee's incompetence, inefficiency, or negligence including

abandonment of post or patient where a patient's welfare is jeopardized is serious misconduct sufficient to cause termination. Although Respondent did not discipline Coleman under the progressive discipline policy, Coleman's conduct was of such gravity that Respondent could reasonably believe that termination was appropriate. There was no evidence that Respondent had allowed other employees to engage in the same or similar conduct without discharge. Additionally, I find no credible evidence that Respondent has allowed employees to leave the premises without clocking out or obtaining supervisory approval. It is simply incredible that Respondent would otherwise tolerate an ER nurse to leave the premises for 4 hours, without regard to the impact upon patients and fellow staff members. Accordingly, I find that the record is insufficient to demonstrate that Respondent unlawfully terminated Donnie Coleman.

D. Supervisory Status in Dispute

Respondent argues that none of the charging parties in this matter are "employees" as defined in Section 2(3) of the Act. Respondent contends that Dannie Coleman, Linda Coleman, and Iolene Williams are all supervisors and, thus, outside the scope of the protection of the Act. Respondent argues that Linda Coleman was considered to be a "full-time charge nurse for the 7 a.m. to 7 p.m. shift and that Dannie Coleman regularly served as charge nurse. Respondent contends that Iolene Williams was employed on weekends as a "house supervisor" and occasionally worked as a charge nurse.

1. Charge nurse

Section 2(11) of the Act defines a "supervisor" as:

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

It has long been recognized that the supervisory definition is phrased in the disjunctive. Thus, possession of any one indicia of supervisory status provides a sufficient basis for finding supervisory status. See *Ohio Power Co. v. NLRB*, 176 F.2d 385, 387 (6th Cir. 1949), cert. denied 338 U.S. 899 (1949). The burden of proving supervisory status, however, is on the party alleging that it exists. *Bennett Industries*, 313 NLRB 1363 (1994).

Respondent argues in its brief that any nurse that assumes the charge nurse position, either on a full-time or part-time basis, has the authority to adjust patient and staff grievances, carry out short-term discipline, make assignments, transfer employees, effectively recommend suspension and/or termination of staff employees, and responsibly direct the emergency room's employees. Respondent asserts that to successfully carry out these duties, the charge nurse relies on his or her independent judgment. To demonstrate this independent judgment, counsel cites a number of responsibilities.

Respondent argues that charge nurses handle and direct patient relations and deal with patient, family, and visitor complaints. Respondent, however, cites no authority for finding that such responsibility constitutes supervisory status. Ascribing this responsibility to the charge nurse begs the question as to whether a staff nurse has no responsibility to address or to concern herself or himself with these complaints. Removing such responsibility from the staff nurse would appear to be not only inconsistent with patient care, but beyond sound business practice.

Respondent further argues that staff and agency nurses complain to the charge nurse about the behavior of their nurse colleagues. Respondent further maintains that because charge nurses adjust staff grievances, it follows that disciplining staff nurses is part of the charge nurse's duties. The Board, however, has found that the resolution of minor employee complaints regarding workload, lunch and break schedule conflicts, or personality conflicts is insufficient to establish supervisory status. *Ohio Masonic Home*, 295 NLRB 390 (1989).

Respondent submits that the charge nurse has the authority to enact short-term discipline, such as verbal and/or written warnings. Full-time charge nurse Fred Ford testified that he was the first step to disciplinary action. He acknowledged, however, that he had never formally verbally counseled any employee while at Respondent's facility. Kimberly Burt, a former staff nurse and part-time charge nurse, testified that she regularly observed full-time charge nurse Linda Coleman issuing informal verbal warnings to her staff. For reprimands or warnings to reflect supervisory authority, however, the warnings must not only initiate or be considered in future disciplinary action, but they must also be a basis of later personnel action without independent investigation or review by the employer. *Passavant Health Center*, 284 NLRB 887, 890 (1987). The record reflects no evidence of any charge nurse's verbal or written warning that was issued without further independent investigation or review.

Respondent maintains that charge nurses assign and transfer nurses to various stations in the ER and responsibly direct other employees. The record reflects that the number of nurses on any given shift varied from two to three depending upon the staffing level in place. If three nurses were on duty, one nurse worked triage and the other two nurses split the eight beds in the ER to provide the care following triage. Linda Coleman testified that she normally just rotated patient assignments to the ER nurses. Dannie Coleman testified that when she served as charge nurse she simply split the responsibilities for counting narcotics, passing out linen, checking the refrigerators' temperature, cleaning the utility room, and checking the emergency cart. The Board has determined that the exercise of some supervisory authority in a merely routine, clerical, perfunctory, or sporadic manner does not elevate an employee to a supervisor. The "test must be the significance of his judgment and directions." *Hydro Conduit Corp.*, 254 NLRB 433 (1981). Consequently, an employee does not become a supervisor merely because he gives some instructions or minor orders to other employees. *NLRB v. Wilson-Crissman Cadillac*, 659 F.2d 728 (6th Cir. 1981); *NLRB v. Doctors' Hospital of Modesto*, 489 F.2d 772 (9th Cir. 1973). In this case, charge nurses' assign-

ment of ordinary tasks appears to be ordinary and routine and did not require the use of 2(11) judgment. See *Illinois Veterans Home at Anna L.P.*, 323 NLRB 890, 891 (1997). Although Fred Ford testified that he recommended that an ER staff nurse be transferred to Respondent's ICU based upon his observations of her nursing skills and capabilities, there is no evidence that the transfer was completed without an independent investigation and review by management. Ford acknowledged that while a charge nurse's opinion might carry a little more weight, nursing administration would still investigate the matter.

Respondent's director of human resources, Carolyn Washington, testified that charge nurses have the authority to effectively recommend the hiring or firing of an employee. Ford testified that he had recommended the hiring of a nurse and that the nurse had ultimately been hired. The Board has consistently applied the principle that authority effectively to recommend generally means that the recommended action is taken without independent investigation by supervisors, not simply that the recommendations were ultimately followed. *Hawaiian Telephone Co.*, 186 NLRB 1 (1970). *Brown & Root, Inc.*, 314 NLRB 19, 23 (1994).

Fred Ford testified that as a charge nurse, he did not have the authority to hire, fire, suspend, layoff, or transfer nurses from one department to another. Ford confirmed that he had never recommended the suspension, layoff, or transfer of a nurse from one department to another. On one occasion, Ford recommended that a nurse be fired. He was told that a proper trail was needed before such action could be taken and the nurse was not fired.

In summary, I do not find that that Linda Coleman and Dannie Coleman as charge nurses exercised independent judgment in making their assignments or in directing the work of other nurses. *Ten Broeck Commons*, 320 NLRB 806 (1996), I do not find that the charge nurses effectively recommend hiring, firing, transferring, or laying off other nurses. If such supervisory powers are exercised only irregularly or sporadically, a sufficient basis to establish supervisory status cannot be found. *Meharry Medical College*, 219 NLRB 488, 490 (1975). The Board and the courts have determined that it is the exercise of independent judgment allied with the employer's interests, and not greater skill or responsibility, which sets apart a person as a supervisor. *Beverly Manor Convalescent Centers*, 275 NLRB 943, 946 (1985), *NLRB v. Lauren Mfg., Co.*, 712 F.2d 245 (6th Cir. 1983). Based upon the entire record evidence, I do not find that Linda Coleman and Dannie Coleman exercise independent judgment sufficient to establish supervisory status.

2. House supervisors

In addition to working in the ER as a staff nurse and occasional charge nurse, Iolene Williams worked as a house supervisor on weekends. Williams estimated that she performed house supervisor duties on a part-time basis, approximately 32 hours per month. Human Resources Manager Washington testified that Respondent's full-time house supervisors are exempt from the Fair Labor Standards Act, while part-time house supervisors are nonexempt. Respondent contends that a house supervisors' powers and duties are the same regardless of how frequently he or she is scheduled to work as a house supervisor.

In its brief, Respondent identifies a number of duties that would constitute supervisory authority.

Respondent asserts that the house supervisor makes personnel assignments by staffing nurses through the hospital depending on the hospital's changing staffing needs. Williams testified that if the staffing level was reduced to a designated level, the house supervisor could call in agency nurses to work in certain areas of the hospital without obtaining additional permission. If the staffing was not reduced to such a designated level, Williams needed permission to bring in any additional nurses on her shift. Williams acknowledged that she has had occasion on her shift as house supervisor to transfer a nurse from one department to another. She also testified that as a house supervisor, she was responsible for trouble shooting, which might involve directing nurses to do what they should be doing but otherwise are not. Williams testified that as a house supervisor, she had the authority to write a complaint about an employee, however, she had never done so. She acknowledged that as a house supervisor, she had the authority to recommend discipline for nurses.

The record contains testimony that full-time nursing supervisors or house supervisors exercise a relatively broad range of duties that may arguably require independent judgment. Williams' position of part-time house supervisor is a somewhat unique position. Clearly, at the time that Williams performed this function, she was the highest-level nurse in Respondent's facility. As a part-time house supervisor, she has occasion to direct employees in their work and to take actions that impact upon the nurses working that same shift. There is no record evidence, however, that Williams was functioning in her capacity as weekend house supervisor when she engaged in protected concerted activity. When she invoked Safe Harbor in the ER, she did so as an ER nurse. The very basis for invoking Safe Harbor was her concern that she could not provide the necessary direct patient care that was expected of her as a staff nurse. Had she been functioning as a house supervisor on that occasion, she may have been able to secure the additional staff that she was requesting on December 26. There is no evidence that at the time that she wrote her response to Long's e-mail or when she otherwise voiced her concerns about the reduced staffing level that she was acting as a house supervisor. Respondent does not contend that Williams was performing the functions of house supervisor on January 28, 2003, when she was alleged to have been negligent in her duties. Respondent contends that Williams was discharged for her actions taken as a staff nurse on January 28. Accordingly, the fact that Williams occasionally performed a different job that may have involved the exercise of supervisory indicia on isolated dates does not eliminate Williams from the protection of the Act when she is otherwise engaged in protected concerted activity or terminated for her actions as a statutory employee.

CONCLUSIONS OF LAW

1. Respondent, Bellaire General Hospital, LP, d/b/a Bellaire Medical Center, is an employer engaged in commerce within the meaning of Section 2(2), (6), and (7) of the Act.

2. Respondent violated Section 8(a)(1) of the Act by discharging Iolene Williams and Linda Coleman.

3. The foregoing unfair labor practices affect commerce within the meaning of Section 2(6) and (7) of the Act.

4. Respondent has not engaged in any unfair labor practice not specifically found herein.

REMEDY

It having been found that the Respondent has engaged in certain unfair labor practices, it is recommended that it be ordered to cease and desist and to take certain affirmative action designed to effectuate the policies of the Act.

Having found that Respondent discriminatorily discharged Iolene Williams and Linda Coleman, I shall recommend that Respondent offer them reinstatement and make them whole for any loss of earnings and other benefits, computed on a quarterly basis from date of discharge to date of proper offer of reinstatement, less any net interim earnings, as prescribed in *F. W. Woolworth Co.*, 90 NLRB 289 (1950), plus interest as computed in *New Horizons for the Retarded*, 283 NLRB 1173 (1987).

On these findings of fact and conclusions of law and on the entire record, I issue the following recommended⁸

ORDER

The Respondent, Bellaire General Hospital, LP, d/b/a Bellaire Medical Center, Houston, Texas, its officers, agents, successors, and assigns, shall

1. Cease and desist from

(a) Discharging or otherwise disciplining employees because they engaged in protected concerted activity.

(b) In any like or related manner interfering with, restraining, or coercing employees in the exercise of the rights guaranteed them by Section 7 of the Act.

2. Take the following affirmative action necessary to effectuate the policies of the Act.

(a) Within 14 days from the date of this Order, offer Iolene Williams and Linda Coleman full reinstatement to their former jobs or, if that job no longer exists, to substantially equivalent positions, without prejudice to their seniority or any other rights or privileges previously enjoyed.

(b) Make Iolene Williams and Linda Coleman whole for any loss of earnings and any other benefits suffered as a result of the discrimination against them, in the manner set forth in the remedy section of the decision.

(c) Within 14 days from the date of this Order, remove from its files any reference to the unlawful discharges, and within 3 days thereafter notify the employees in writing that this has been done and the discharges will not be used against them in any way.

(d) Preserve and, within 14 days of a request, or such additional time as the Regional Director may allow for good cause shown, provide at a reasonable place designated by the Board or its agents, all payroll records, social security payment records, timecards, personnel records and reports, and all other

⁸ If no exceptions are filed as provided by Sec. 102.46 of the Board's Rules and Regulations, the findings, conclusions, and recommended Order shall, as provided in Sec. 102.48 of the Rules, be adopted by the Board and all objections to them shall be deemed waived for all purposes.

records, including an electronic copy of such records if stored in electronic form, necessary to analyze the amount of backpay due under the terms of this Order.

(e) Within 14 days after service by the Region, post at its facility in Houston, Texas, copies of the attached notice marked "Appendix."⁹ Copies of the notice, on forms provided by the Regional Director for Region 16, after being signed by the Respondent's authorized representative, shall be posted by the Respondent immediately upon receipt and maintained for 60 consecutive days in conspicuous places including all places where notices to employees are customarily posted. Reasonable steps shall be taken by the Respondent to ensure that the notices are not altered, defaced, or covered by any other material. In the event that, during the pendency of these proceedings, the Respondent has gone out of business or closed the facility involved in these proceedings, the Respondent shall duplicate and mail, at its own expense, a copy of the notice to all current employees and former employees employed by the Respondent at any time since January 29, 2003.

(f) Within 21 days after service by the Region, file with the Regional Director a sworn certification of a responsible official on a form provided by the Region attesting to the steps that the Respondent has taken to comply.

APPENDIX

NOTICE TO EMPLOYEES
POSTED BY ORDER OF THE
NATIONAL LABOR RELATIONS BOARD
An Agency of the United States Government

⁹ If this Order is enforced by a judgment of a United States court of appeals, the words in the notice reading "Posted by Order of the National Labor Relations Board" shall read "Posted Pursuant to a Judgment of the United States Court of Appeals Enforcing an Order of the National Labor Relations Board."

The National Labor Relations Board has found that we violated Federal labor law and has ordered us to post and obey this notice.

FEDERAL LAW GIVES YOU THE RIGHT TO

- Form, join, or assist a union
- Choose representatives to bargain with us on your behalf
- Act together with other employees for your benefit and protection
- Choose not to engage in any of these protected activities.

WE WILL NOT discharge or otherwise discriminate against any of you for engaging in protected concerted activity.

WE WILL NOT in any like or related manner interfere with, restrain, or coerce you in the exercise of the rights guaranteed you by Section 7 of the Act.

WE WILL, within 14 days from the date of the Board's Order, offer Iolene Williams and Linda Coleman full reinstatement to their former jobs, or if those jobs no longer exist, to substantially equivalent positions, without prejudice to their seniority or any other rights or privileges previously enjoyed.

WE WILL make Iolene Williams and Linda Coleman whole for any loss of earnings and other benefits resulting from their discharge, less any net interim earnings, plus interest.

WE WILL, within 14 days from the date of the Board's Order, remove from our files any reference to the unlawful discharges of Iolene Williams and Linda Coleman, and WE WILL, within 3 days thereafter, notify each of them that this has been done and that the discharges will not be used against them in any way.

BELLAIRE GENERAL HOSPITAL, LP, D/B/A BELLAIRE
MEDICAL CENTER