

**United States Government
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OFFICE OF THE GENERAL COUNSEL**

Advice Memorandum

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TO : Joseph P. Norelli, Regional Director
Region 20

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Subregion 37

FROM : Barry J. Kearney, Associate General Counsel
Division of Advice

SUBJECT: Sutter Health Pacific d/b/a
Kahi Mohala Behavioral Health
Cases 37-CA-7309, 7313, 7347

177-8520-0800
177-8520-2400
177-8520-4700

The Region resubmitted this Section 8(a)(5) and (1) case for advice on whether new evidence obtained during a supplemental investigation establishes that the registered nurses ("RNs") at the Employer's facility are statutory supervisors. Based on the analytical framework set forth in the prior Advice memorandum in this case,¹ we conclude that the RNs are statutory supervisors. We first conclude that, when the RNs order Mental Health Specialists ("MHSs") to perform interventions, conduct MHS led groups, and take patients on recreational group outings, the RNs assign significant overall duties, rather than direct employees by giving them ad hoc instructions to perform discrete tasks. We then conclude that, particularly with respect to patient interventions, the RNs use independent judgment when assigning MHSs to these duties.

FACTS

The Employer is an acute and residential mental health treatment facility for children, adolescents, and adults. Its operation, the history of its dealings with the Union, the management hierarchy, and the functions of RNs and MHSs are described in detail in the prior Advice memorandum in

¹ See Sutter Health Pacific d/b/a Kahi Mohala Behavioral Health, Cases 37-CA-7309, et al., Advice Memorandum dated January 28, 2008.

this case. The issue presented here is whether the RN assigned to each residential unit is a supervisor by virtue of his or her delegation of patient care duties to MHSs on the unit. The Region's supplemental investigation provided new information about the specifics of patient treatments administered at the facility, including interventions, group therapy sessions, and outings. These tasks are frequently included on the printed staff assignment sheet prepared by the RNs at the beginning of the shift, although circumstances may occur where an RN orders an MHS to perform one of these tasks mid-shift.

Concerning the daily tasks printed on the staff assignment sheet, some RNs who work with more experienced MHSs allow the MHSs to decide among themselves what tasks on the sheet they will perform. Other RNs will assign these tasks themselves. It appears that, in either situation, the RN on duty has final authority over which MHS will perform the tasks on the sheet.

A. Interventions

As discussed in the prior Advice memorandum, part of patient treatment at the facility is to "intervene" with patients who demonstrate some outward expression of their anxiety levels. The more extreme the patient's behavior, the more involved the intervention that is ordered. Thus, interventions may range from a "close watch intervention,"² which involves an MHS checking on a patient every 15 or 30 minutes, to the administration of physical restraint and/or medication. A doctor may order an intervention for a patient before a shift starts. Alternatively, an RN can order an intervention during a shift, because of an unexpected patient outburst, and then obtain a doctor's approval. Regardless, the RN on duty will decide which MHS will carry out the intervention.

While different forms of interventions were discussed in the prior Advice memorandum, the evidence at that time did not show the frequency and duration of these MHS tasks. New evidence now shows that patients regularly require some form of intervention and that this therapy lasts for extended periods of time. The frequency with which

² This intervention is also referred to as a "precaution."

interventions are used varies depending on the type of intervention and the RN involved. For example, RNs report ordering "refocusing" interventions, in which an MHS speaks with a patient to distract him or her from the stimulus that caused that patient's anxiety, at least once per shift and usually multiple times per shift. A refocusing can last anywhere from a few minutes to several hours depending on the patient's condition. Some RN's order close watch interventions only one or two times per month. However, one RN states that he places every new patient in his unit under a close watch order, and a former RN states that about half of the patients on her unit were under such an order. A close watch intervention can last up to one full day. One RN reports ordering "point-of-contact" interventions, which require a patient to direct all of his or her communications to one MHS, no less than once per month and another once per week. Such an intervention can last from one hour to an entire eight-hour shift. Finally, RNs order "one-to-one assignments," where an MHS constantly stays within two arms' lengths of a patient, generally at least once per month; they most commonly last for several hours during a shift. Such an intervention can be more common and continue longer, however. A former RN states that one-to-one interventions occurred several times per shift, and sometimes lasted for longer periods of time, up to one week.

The prior Advice memorandum listed several different factors that RNs consider when they decide which MHS on the unit will perform an intervention. These factors included the skill levels of the MHSs, the need and condition of the relevant patient, and the relationship between the MHS and the relevant patient. As an example, one RN previously had stated that he would assign an MHS who had experience as a certified nursing assistant to be a point-of-contact for an elderly patient who requires assistance with the activities of daily living.

The new evidence is consistent with and further supports those prior findings. One RN states that in deciding which MHS will carry out an intervention, he considers the MHS's experience, skill level, rapport with the patient, and strength, size, and gender. A former RN states that when deciding which MHS was to perform a one-to-one assignment, she would have matched a "stronger" MHS

to a more volatile patient or patient group and a "weaker" MHS to a calmer patient or patient group.³

B. Group Therapy Sessions

Group sessions are also a regular part of patient treatment plans at the facility. Commonly referred to as "groups," these activities occur daily, are scheduled by the Program Manager, and generally last for about one hour. Group sessions are professionally led or MHS led.

Professionally led groups are conducted by occupational therapists, chemical dependency therapists, and other professional counselors. Some RNs stated that they assigned MHSs to these groups to monitor patients, to make sure that patients act in a safe and appropriate manner, to be able to remove a patient who becomes disruptive from the group, and to distribute and collect supplies. One RN stated that she would only assign an MHS to such a group if the therapist leading the session requested the assistance of an MHS.

There are three types of MHS led groups. At the beginning of the day shift, MHSs lead a "community meeting" where each patient discusses what his or her treatment goal is for that day. In the evening, around 5 P.M., MHSs lead another group that most often involves watching television news and then discussing current events.⁴ Finally, MHSs lead an evening shift wrap-up session, which may last less than an hour, at which patients discuss if they feel they have met their treatment goal for the day. During this session, patients also express their concerns and

³ The context of this RN's statements make clear that the terms "stronger" and "weaker" refer to the MHSs' experience levels and ability to manage patients, not physical strength. Moreover, "patient groups" include children, adolescents, acute patients, or residential patients.

⁴ MHSs are permitted to decide what activities the patients will engage in during this group session; MHSs are not required to have the patients watch television and discuss current events.

complaints to the MHSs, such as the air conditioning being too high or wanting more time for meals.⁵

In deciding which MHS will participate in either a professional led or MHS led group, a former RN stated that she would not assign an MHS to a group knowing that the MHS had a poor relationship with one of the patients in that group. Another RN stated that he considers the MHS's experience, skill level, rapport with the patients, and strength, size, and gender.⁶

C. Outings

MHSs regularly take patients away from the facility either to participate in group recreational activities or to go to medical appointments or court appearances. Group recreational activities involve taking a group of patients to the beach, to a movie, or to shop at a department store. In conducting recreational activities, MHSs have to keep track of, among other things, the amount of money given to each patient, which is based on the number of points the patient earned during the week, as well as the purchases that each patient makes. In general, all of these activities are referred to as "outings," and they are pre-planned.

At footnote 46 of the prior Advice memorandum in this case, we noted that there was conflicting evidence about the authority of an RN to decide which MHS will take

⁵ In addition to professional led and MHS led groups, there are also RN led groups at the facility. During such groups, RNs instruct patients on topics such as personal hygiene, taking medications, and other health-related topics. There is no evidence describing what role MHSs serve during those group sessions.

⁶ In setting out these factors, this RN stated that he broadly defined "groups" to include monitoring patients during professional led groups, taking patients to the cafeteria, organizing patients for chores, and taking one or more patients away from the facility for various reasons.

patients on an outing.⁷ The supplemental investigation revealed, however, that several RNs have exercised the authority to assign MHSs to outings where the Staffing Coordinator had not already made the outing assignment.

In deciding which MHS will lead an outing, one RN states that because activities away from the facility occur in a less controlled environment, he will order a more skilled or experienced MHS to go on the outing unless unit acuity level is high and such an MHS is needed within the unit. A former RN stated that she would order an MHS with more experience and a greater ability to handle patients to conduct the outing.⁸

ACTION

We conclude that the new evidence supplied by the Region establishes that the RNs are statutory supervisors. We first conclude that, when the RNs order MHSs to perform interventions, conduct MHS led groups, and take patients on outings, the RNs assign significant overall duties, rather than direct employees by giving them ad hoc instructions to perform discrete tasks. Second, we conclude that, particularly with respect to patient interventions, the RNs use independent judgment when assigning MHSs to these overall duties.⁹

⁷ For example, we noted that the Staffing Coordinator often already had assigned the outing to an MHS, and that one RN's MHS assignment had been countermanded by the Senior RN.

⁸ Another RN stated that he would rely only on gender when ordering an MHS to go on an outing.

⁹ As a preliminary matter, we conclude that new evidence showing that the Employer changed how it operates the Lehua building and altered the duties of some of the RNs who work in that building is irrelevant to this case. Because these changes occurred after the Employer had already withdrawn recognition from the Union, they have no relevance in determining whether the RNs were statutory supervisors at the time the Employer withdrew recognition.

A. RNs "Assign" MHSs By Ordering Them to Carry Out Interventions, MHS Led Groups, and Recreational Group Outings

As explained in more detail in the prior Advice memorandum, Section I.A., "assign" and "responsibly direct" differ with respect to the nature of the duties they cover. The Board appears to distinguish between these two Section 2(11) functions based on the complexity and duration of the duties at issue. Thus, assignment encompasses giving significant overall duties; in the health care setting, assignment occurs when a charge nurse designates an employee to be the person who will regularly administer medications to a patient or group of patients, or designates which employee will care for specific patients over the duration of a shift.¹⁰ On the other hand, direction consists of ad hoc instructions to perform discrete tasks such as when a charge nurse orders an LPN to immediately give a sedative to a particular patient or tells a staff member to give a patient a bath, clip a patient's toenails or fingernails, empty catheters, or change an incontinent patient.¹¹

Applying these principles to the current case in light of the Region's supplemental investigation, we conclude, contrary to our preliminary conclusion in the prior Advice memorandum, that RNs assign MHSs to significant overall duties when they order them to perform patient interventions. New evidence establishes that carrying out a patient intervention often involves a complex set of duties occurring over a lengthy period of time and not a discrete task. Where an RN orders an MHS to perform an intervention at the beginning of a shift, the intervention is planned and not a duty that unexpectedly arises on an ad hoc basis as the work day progresses. But even if an intervention is unplanned, the frequency of interventions shows that they are part of routine patient care on each unit.

¹⁰ See Oakwood Healthcare, Inc., 348 NLRB 686, 689, 695 (2006).

¹¹ Id. at 689; Golden Crest Healthcare Center, 348 NLRB 727, 730 (2006).

Ordering interventions is a regular part of the RN's duties. Close watch assignments occur at least twice a month, in some units much more frequently; refocusing occurs at least once per shift, usually more frequently. One-to-one and point-of-contact interventions occur at least once per month. The duration and complexity of these interventions demonstrates that they amount to assignment of significant overall duties. Some interventions may last for several days. Certain interventions, such as a one-to-one or point-of-contact, commonly last several hours, and even lesser interventions, such as a refocusing, similarly last for hours. During those times, the MHS interacts with the patient in an effort to both lower the patient's anxiety level and prevent the patient from causing any harm to self or others. This complex interaction is more akin to assigning a staff member to generally care for a patient over the duration of a shift than it is to directing a staff member to perform the discrete task, such as giving a patient a sedative or clipping a patient's fingernails.

We also conclude that RNs assign MHSs to significant overall duties when ordering them to carry out MHS led groups.¹² As with interventions, this function involves a complex and lengthy set of duties rather than a discrete task. MHS led groups, most of which are about an hour long, are a planned part of the routine on each unit and do not arise on an ad hoc basis. The morning "community meeting" involves MHSs interacting with patients to assist them in setting personal goals for the day that are consistent with their treatment plans. The afternoon group session involves the MHSs engaging in some recreational activity with the patients, including watching television news and discussing current events. The evening wrap-up session involves patients' reflecting on their day and discussing with the MHS whether they have met their treatment goals for that day.

¹² However, we conclude that RNs direct, rather than assign MHSs when they order them to attend a professional led group. MHSs usually merely act as monitors during professional led group therapy sessions which is analogous to a discrete task.

In all of these group sessions, the MHSs basically serve as the primary treatment providers for the patients, and the patients interact exclusively with the MHSs. Moreover, the MHSs perform many of these duties by dealing with each patient on a one-to-one basis. In sum, more is required to complete these assignments than the simple tasks that the Board has identified when finding that a putative supervisor directs rather than assigns work.¹³

Finally, we conclude that RNs assign MHSs to significant overall duties when ordering them to conduct recreational group outings.¹⁴ When an MHS takes a group of patients on a recreational outing to the beach, or a movie, or a department store, the MHS is the only staff member interacting with and responsible for the patients. The MHS also has multiple interactions and responsibilities during these outings. The MHS must keep track of the amount of money given to each patient as well as the purchases each patient makes. The MHS must generally care for the group of patients over the duration of the outing, which would foreseeably be for an hour or longer. In sum, rather than performing a discrete task, MHSs are providing the patients with individual care and assistance over an extended period of time.

In the prior Advice memorandum at footnote 46, we noted conflicting evidence on whether RNs had authority to assign MHSs to outings, because some outings assignments already had been made or RN outing assignments had been countermanded by a higher authority. New evidence from several RNs shows that, where an outing assignment has not already been made, the assignment was made by the RNs. The prior evidence showing that a Senior RN had countermanded an RN's patient transport assignment does not necessarily indicate that the RN had acted without authority. Rather,

¹³ See Oakwood Healthcare, Inc., 348 NLRB at 689, 694-695; Golden Crest Healthcare Center, 348 NLRB at 730.

¹⁴ However, we conclude that RNs direct, rather than assign MHSs when they order them to transport a patient to a medical appointment or court appearance. MHSs merely have to transport the patient which is analogous to a discrete task.

it may have indicated only that the Senior RN disagreed with the RN's judgment about who should perform the outing. In sum, the supplemental investigation now establishes that RNs have authority to assign MHSs to outings.

B. RNs Use Independent Judgment when Assigning MHSs to Significant Overall Duties

Recent Board decisions have made clear that in the health care setting, a putative supervisor exercises independent judgment if he or she makes assignments by matching the individualized conditions and needs of patients with the skills or special training of available staff members.¹⁵ General or conclusory evidence on this matter is not sufficient to establish the use of independent judgment. Rather, the party asserting supervisory status must present examples or details of circumstances where alleged supervisors engaged in the requisite matching.¹⁶

Applying these principles here, we conclude that the RNs exercise independent judgment when assigning MHSs to

¹⁵ See Barstow Community Hosp., 352 NLRB No. 125, slip op. at 2 (2008) ("in the healthcare setting, if an individual weighs the individualized condition and needs of a patient against the skills or special training of the available nursing staff, the resulting assignment involves the exercise of independent judgment"); Loyalhanna Care Center, 352 NLRB No. 105, slip op. at 2 (2008) (nurses must "make assignments that are both tailored to patient conditions and needs and particular [employees'] skill sets"); Lynwood Manor, 350 NLRB No. 44, slip op. at 2 (2007).

¹⁶ See Barstow Community Hosp., 352 NLRB No. 125, slip op. at 2 (testimony that alleged supervisor would consider patient's acuity or needs, and experience of available nurses when making assignments, lacked sufficient specificity to find use of independent judgment); Loyalhanna Care Center, 352 NLRB No. 105, slip op. at 2 (testimony that alleged supervisor determined residents' acuity level and reassigned staff accordingly was conclusory and did not establish use of independent judgment); Lynwood Manor, 350 NLRB No. 44, slip op. at 2.

perform patient interventions. The prior Advice memorandum noted that when RNs must select an MHS to perform an intervention, they consider, among other things, the available MHSs' respective skill levels and ability to deescalate situations as well as the type of assistance and intervention the relevant patient requires. One RN previously stated that he would assign an MHS who had experience as a certified nursing assistant to be a point-of-contact for an elderly patient who requires assistance with the activities of daily living. New evidence similarly includes a former RN stating that she would not assign a one-to-one intervention to an MHS who had a poor relationship with the relevant patient and that she would assign a "stronger" MHS to a more volatile patient and a "weaker" MHS to a calmer patient. This evidence establishes that RNs engage in the requisite matching of staff skills to patient needs that must be present to find the exercise of independent judgment in the health care setting.

The evidence that RNs use independent judgment when assigning MHSs to MHS led groups or recreational group outings is less specific. One RN stated that he would consider the available MHSs' experience, skill level, rapport with the patients, and strength, size, and gender when making these assignments. He stated that, barring high unit acuity level, he would order an MHS with more experience to go on an outing. A former RN similarly stated that she would have ordered an MHS with more experience and a greater ability to handle patients to conduct an outing. She also stated that she would not assign an MHS who had a poor relationship with a patient to an MHS led group that included that patient. While this evidence arguably lacks the specificity required by the cited cases,¹⁷ it nevertheless suggests that the RNs use independent judgment when making these assignments. Because we previously concluded that RN's clearly use

¹⁷ See Barstow Community Hosp., 352 NLRB No. 125, slip op. at 2; Loyalhanna Care Center, 352 NLRB No. 105, slip op. at 2; Lynwood Manor, 350 NLRB No. 44, slip op. at 2.

independent judgment when assigning MHSs to patient interventions, we conclude that the RNs are statutory supervisors.

B.J.K.