IN THE MATTER OF THE ONTARIO *LABOUR RELATIONS ACT, 1995*

-and-

IN THE MATTER OF AN ARBITRATION

BETWEEN:

INTERNATIONAL CARE CORPORATION,
Carrying on business as CHATEAU PARK NURSING HOME
- The Employer

-and-

SERVICE EMPLOYEES' UNION, LOCAL 210
- The Union

AND IN THE MATTER OF a grievance of Venis Green

Arbitrator: Howard Snow

Appearances:

On behalf of the Employer:

John J. Barrack	- Counsel
Jim Feyerer	- Vice-President Human Resources, International Care Corporation
Patricia Bruckman	- Administrator, Chateau Park Nursing Home
Barbara Lewis	- Director of Resident Care, Chateau Park Nursing Home

On behalf of the Union:

E. R. Durham	- Union Representative
Roger Renaud	- Union Representative
Lorna Coulter	- Steward
Venis Green	- Grievor

Hearings held November 5 and December 12, 1996; January 10, February 19, February 20, February 21 and April 4, 1997, in Windsor, Ontario.

AWARD

I. INTRODUCTION

Venis Green (the grievor) was a health care aide at Chateau Park Nursing Home from 1989 until her dismissal in September 1996. The grievor was terminated for a series of incidents which occurred during a short period in early September 1996. In this grievance she sought reinstatement.

II. THE EVIDENCE

On September 13, 1996 the grievor was discharged from her employment by letter which indicated six incidents as the grounds for dismissal. In the dismissal letter several residents of the nursing home involved in the complaints against the grievor were identified by their initials. The parties are aware of the names of the residents and their names were used throughout the hearing. However there was a concern expressed regarding the privacy of the residents and I have therefore deleted their initials from the dismissal letter. With those alterations, the letter reads in part as follows:

1. On August 31st 1996 your punch card was altered concealing that you arrived at work late.
2. On September 2nd 1996 you used a hoyer lift with resident [Mr. A], who is a 2 person transfer. The resident was frightened and asked you repeatedly not to do this but you ignored his wishes.
3. Also on September 2nd 1996, you jeopardized the safety of a resident, [Ms. B] by leaving her alone in her room half nude in bed, with the bedside down. During this time you were in the staff room.
4. On September 3rd 1996, as reported by resident [Ms C], you did in a public area of the home and in the presence of residents, engage in a loud quarrel with a co-worker.
5. Also on September 3rd 1996, you refused to assist a resident [Mr. A] to the washroom when he requested. You advised the resident that you would provide a diaper instead. Your actions humiliated and offended the resident.
6. On September 6th 1996, a resident, [Ms D], demonstrating extreme distress,

> complained of your care as rough and mean, and refused to have you care for her again.

The Employer led evidence with respect to the six grounds listed in the letter. In addition, considerable evidence was led with respect to the Employer's investigation of the six items and its internal decision-making process prior to the dismissal. All of the oral evidence came from Employer witnesses. The Union called no witnesses.

No issues of credibility arose among the witnesses. In these circumstances, rather than reviewing the evidence given by each witness, I will simply set out the facts as the witnesses, or as the documents, disclosed them. I begin with the facts which relate to the six grounds listed in the dismissal letter reproduced above.

1. The punch card:

   On August 31 the grievor called prior to the start of her 2:30 p.m. (or 14:30) shift and advised the Employer that she would be late arriving for work. Her punch card was, however, punched at 14:31 and then again at 14:54. The card had been altered with the apparent intent of changing 14:54 to 14:34. However, I heard no evidence to suggest who might have punched the card at 14:31, assuming the grievor arrived late as she indicated in her telephone call, or who may have altered the punch card from 14:54 to 14:34.

   In his opening statement, Employer counsel indicated the Employer acknowledged that the punch card incident was minor. In closing argument he indicated that the Employer did not rely upon this incident.

2. The use of the hoyer lift with Mr. A:

   Residents in this nursing home are classified according to the type of assistance they

require to get in and out of bed. Some residents are able to get in and out of bed without any assistance. Other residents require one person to assist them and some residents require two people to assist them. In addition, the Employer has available a mechanical lift referred to as a "hoyer" lift which can be used to move residents in and out of bed. The hoyer lift requires the resident to be suspended in a sling which then often swings back and forth as the lift is used to move the resident from the bed to a chair or the reverse. A resident who has never been transferred in a hoyer lift would in all probability find the experience upsetting.

Mr. A was classified by the Employer as a "two-person transfer", indicating that he required two people to help lift him into and out of bed. On September 2, 1996 the grievor used the mechanical hoyer lift to put Mr. A into bed. Mr. A was frightened by the lift and asked the grievor not to use the mechanical lift. Nevertheless the grievor used the lift in putting Mr. A into bed. Mr. A continued to express his concerns during and after the lift was used.

The grievor's technical use of the hoyer was correct; it was the fact that the grievor used the hoyer lift with Mr. A that the Employer viewed as improper.

3. Jeopardizing the safety of Ms B:

Also on September 2 the grievor was involved in the early part of her shift with assisting resident Ms B out of bed. Ms B was classified by the Employer as a resident who should be helped into and out of bed by means of the hoyer lift. The grievor took the hoyer lift into Ms B's room and made some arrangements in preparation for lifting Ms B out of bed. The grievor then left Ms B's room and left the bedside rail down. When Ms B was next observed by another health care aide the bedside rail was down and Ms B's abdomen was exposed. There was no evidence that Ms B's

abdomen was exposed when the grievor left the room. There was evidence that Ms B has a skin condition which prompts her to scratch herself and it is possible that Ms B may have uncovered herself in this manner. Thus the evidence did not indicate that the grievor left Ms B partially undressed, as was alleged. Although the letter of dismissal indicates that the grievor was in the staff room, I am unable to make any finding as to where the grievor was, beyond the fact that she had left Ms B's room. I do, however, find that the grievor left Ms B in bed with the bed rail down.

4. The quarrel:

On September 3, 1996 the grievor and a co-worker, Jackie Cushman, were engaged in a discussion in the common area of the nursing home and in the presence of some of the residents. While this discussion did not begin in a manner which would be described as a loud quarrel, it did become louder as time went on and I think it fair to describe it as a loud quarrel by the end of the discussion. In addition, while obviously there were two participants, I conclude that the grievor was more responsible for the escalation of the discussion into a quarrel. This quarrel upset some of the residents.

The evidence also indicated that one of the reasons for the discussion/quarrel was the grievor's desire to obtain assistance in lifting her residents into bed.

5. Assisting Mr. A to the washroom:

Also on September 3 the grievor was delayed in getting her residents into bed. The grievor was primarily responsible for Mr. A's care. When she was putting Mr. A to bed, Mr. A requested assistance to go to the washroom. Mr. A regularly needed assistance in the use of the washroom during the day. Mr. A regularly wore a diaper when he went to bed at night. The grievor indicated to Mr. A that she intended to put

him to bed and put a diaper on him. When Mr. A persisted in his request to use the washroom, the grievor advised that she would put a diaper on him. At that point a co-worker offered to, and did, take Mr. A to the washroom.

Mr. A was upset by this experience.

6. Complaints of "rough, mean" from Ms D:

On September 6, 1996 another resident, Ms D, approached the home's administrator, Patricia Bruckman, and complained of the treatment she had received from the grievor. Ms D has had a stroke and has difficulty communicating. Ms D did, however, indicate that "I don't want Venis to take care of me" and "rough, mean". Ms D demonstrated "rough, mean" with a motion of her one good arm. Ms D indicated that she did not wish to have the grievor care for her. I accept that Ms D was complaining of the treatment she had received from the grievor and that she regarded the grievor as having been rough and mean to her. Ms D was in considerable distress as she described her concerns.

As a health care aide the grievor was responsible for providing assistance to residents. The position description for a health care aide provides, in part, the following:

POSITION SUMMARY

Assists registered staff in providing personal care to residents in assigned area in accordance with individual resident care plans. . . .

MAJOR DUTIES AND RESPONSIBILITIES

1. Under the direction of registered nursing staff, provides personal care to promote the comfort and safety of residents. . .
3. Assists in the maintenance of a clean, safe environment . . .
5. Assists in providing restorative care for residents. . .
9. Provides emotional and social support to residents.
15. Uses only specified transfers, lifts and mechanical lifts for residents as designated at all times.

As a nursing home, the Employer is subject to what is know as the "Residents' Bill of Rights". The Bill of Rights is incorporated into the Ontario *Nursing Homes Act*. The Bill of Rights reads in part as follows, beginning with the preamble:

> These facilities are primarily the home of their residents. As such they are to be operated in such a way that the psychological, social, cultural and spiritual needs of each resident are met. Furthermore, each resident should be given the opportunity to contribute, in accordance with his or her ability to the physical, psychological, social, cultural and spiritual needs of others. The following rights of residents are to be fully respected and promoted:
>
> 1 Every resident has the right
> To be treated with courtesy and respect and in a way that fully recognizes the resident's dignity and individuality and to be free from mental and physical abuse.
>
> 2 Every resident has the right
> To be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
>
> 7 Every resident has the right
> To receive reactivation and assistance towards independence consistent with his or her requirements.
>
> 18 Every resident has the right
> To live in a safe and clean environment.

Health care aides at this nursing home, including the grievor, have been advised by the Employer of the Residents' Bill of Rights, of the expected treatment of residents, and of the proper approach to lifting residents.

III. PROVISIONS OF THE COLLECTIVE AGREEMENT

The following are the relevant provisions of the collective agreement:

ARTICLE 3- MANAGEMENT RIGHTS

3.01 The Union acknowledges that the Employer retains all historical rights of management (except where modified by this agreement) and without limiting the foregoing, it is the

function of the Employer:

. . .

c) To . . . discharge or otherwise discipline for just cause, provided that a claim of ... discharge or discipline or a claim that an Employee who has completed her probation has been discharged without just cause, may be subject of a grievance and dealt with as hereinafter provided;

ARTICLE 8- DISCHARGE, SUSPENSION, DISCIPLINE

8.01 A claim by an Employee that she or he has been unjustly discharged shall be treated as a grievance if a written statement of such grievance is lodged . . .

IV. POSITION OF THE EMPLOYER

The Employer submitted that the discharge should be upheld. The Employer suggested that it is necessary to consider:

1) the residents,
2) the higher standard of care expected of health care workers in a nursing home who are in a position of trust vis-a-vis the residents,
3) the legislative imperative which includes the Residents' Bill of Rights included in the *Nursing Homes Act*,
4) the reputation of the home in the community, and
5) most importantly, the facts of the case itself.

With respect to the six incidents in the discharge letter, the Employer indicated it was not relying on the time card incident (number 1). The Employer argued that there were five other incidents which had taken place in a short period of time and justified dismissal.

With respect to the use of the hoyer lift in putting Mr. A into bed, the Employer submitted that this was improper. Mr. A was clearly classified as requiring two persons to assist him

into bed. It was the grievor's obligation to use the designated lift and thus to obtain help from another employee. The grievor's actions were unacceptable.

With respect to leaving Ms B somewhat undressed and with the bed rail down, the Employer argued this violated both the dignity and safety of the resident. The grievor was required to respect the needs of the resident. The grievor had failed to properly care for the needs of Ms B in this case.

With respect to the quarrel in the lobby, the Employer submitted that the grievor was primarily responsible for this, and that quarrelling in the middle of what is the residents' home is inappropriate conduct and indicative of the grievor's approach to the residents.

With respect to the refusal to assist Mr. A to the washroom, the Employer submitted the key element here was the grievor's uncaring treatment as she had no intention of helping Mr. A to the washroom but rather she intended to simply put a diaper on him. One of her co-workers helped out by taking Mr. A to the washroom. The Employer argued that the grievor's care fell below the expected standard. The Employer and the employees have an obligation to assist residents in maintaining their comfort and safety and to assist them in maintaining as full a lifestyle, including the use of the washroom, as possible. The grievor's refusal to assist Mr. A to the washroom was unacceptable.

Finally with respect to the treatment of Ms D, it was clear that the grievor had treated Ms D in a rough and mean fashion and that Ms D no longer wished to be cared for by the grievor. Residents ought not to be afraid of the people who are responsible for providing them with care, and thus the grievor's conduct was unacceptable.

In relation to all of the above five incidents the Employer noted that there had been no

evidence from or on behalf of the grievor, there had been no apology made by the grievor and there had been no explanation provided for the grievor's conduct.

The Employer submitted that it had communicated the standards which it expected from the grievor as a health care aide. Health care aides were knowledgeable with respect to the Residents' Bill of Rights and aides knew their responsibilities under the job description. In addition it was clear that the grievor knew of the various lifts and knew of her responsibility to use only the type of lift designated for use with each resident.

The Employer had fully and properly investigated the allegations and had given the grievor an opportunity to put forward her position.

Finally the Employer noted the grievor's failure to testify and the failure of the Union to call any evidence. In the circumstances the Employer suggested there could be no argument of mitigating factors and nothing to prompt me as arbitrator to review the penalty imposed.

The Employer relied upon the following authorities: *Hogarth-Westmount Hospital and The Service Employees Union, Local 268*, (January 9, 1990), unreported (Phillips)*; Re Kennedy Lodge Nursing Home and Service Employees International Union, Local 204* (1991) 18 L.A.C. (4th) 38 (Davis); *Canadian Union of Public Employees, and its Local 1565, and Barton Place Nursing Home* (April 27, 1988), unreported (Franks); and Brown and Beatty, *Canadian Labour Arbitration*, 3rd edition, Section 7:4422.

The Employer relied upon the above authorities in asserting that there was a higher standard expected of workers in the health care sector. This was particularly the case where, as here, workers are in charge of the care of people who are unable to fully care for themselves. Such people can be harmed very easily. Thus what is acceptable behaviour in some other sectors,

such as in manufacturing, is not to be tolerated in a nursing home. There is an element of public trusteeship in this environment. The grievor's cavalier behaviour violates that duty. The Employer thus argued that the grievor had violated the expected standard of conduct and that there was no basis upon which I might reasonably conclude that the penalty of discharge ought to be altered.

V. POSITION OF THE UNION

The Union submitted that no inference ought to be drawn from the failure of the grievor to testify. Rather, the Employer had to satisfy its onus in proving just cause for dismissal.

The Union then reviewed the six complaints against the grievor in the letter of discharge.

1. The Punch Card:
   The Union submitted that the altered punch card suggested that some other employee was attempting to undermine the grievor's employment.

2. The use of the hoyer lift with Mr. A:
   The Union submitted that the use of the hoyer lift had always been admitted, but that Mr. A's safety had not been jeopardised in this situation. During the investigation, the grievor had indicated that she had used the mechanical lift as no other aide would help her lift Mr. A into bed.

3. Jeopardising the safety of Ms B:
   With respect to the safety of Ms B, whom the Employer alleged the grievor had left half nude in bed with the bed rail down while she was in the staff room, the Union submitted there was no evidence the grievor was in the staff room, that the evidence

did not demonstrate the resident was left in a half nude state, and that it was unclear whether the bed rail was down.

4. The quarrel:

With respect to the quarrel, the Union conceded the existence of a quarrel, but submitted that the grievor and Ms Cushman had been equal partners in the quarrel. The Union further submitted that the quarrel had ensued after the grievor had asked for assistance in putting those residents for whom she was responsible into bed. All witnesses had indicated that it was necessary to obtain assistance in getting those residents who are classified as two-person transfers into bed. In light of that, the Union suggested that the grievor ought not to be singled out for discipline.

5. Assisting Mr. A to the washroom:

With respect to the alleged refusal to take Mr. A to the washroom, the Union submitted that at no point had the grievor actually refused. Instead, the Union submitted that Mr. A always wore a diaper at night and that the grievor had merely indicated he would have to have a diaper for the night. In the circumstances, then, the Union submitted there had been no clear refusal to assist the resident to the washroom and similarly there had been no clear evidence that the resident was humiliated or offended.

6. Complaints of "rough, mean" from Ms D:

Finally, with respect to the "rough, mean" complaint from Ms D, the Union submitted that it was improper to conclude that Ms D was complaining clearly about the grievor. Ms D suffered from some measure of impairment and although there was a complaint about a rough manner it was impossible, suggested the Union, for me to conclude that this was a clear complaint about the grievor.

In summary, the Union submitted that there was not clear, cogent or convincing evidence of the incidents other than the grievor's use of the hoyer lift and the argument with a fellow employee. The Union referred me to the following authorities: *Beacon Hill Lodges and Service Employees' Union, Local 210* (April 22, 1996), unreported (Williamson); *Re Chedoke-McMaster Hospitals and Canadian Union of Public Employees, Local 839* (1987), 29 L.A.C. (3d) 82 (Brunner); *Re University of Western Ontario and Canadian Union of Public Employees, Local 2361* (1988), 35 L.A.C. (3d) 39 (Dissanayake); and *Re Municipality of Metropolitan Toronto and Canadian Union of Public Employees, Local 79 (DaSilva)* (1992), 28 L.A.C. (4th) 160 (Gray). The Union relied upon these authorities to submit that where, as here, the Employer alleges a violation of legislation, the Employer must demonstrate a violation of that legislation with clear, cogent and convincing evidence. The Union submitted the Employer had not done so.

VI. CONCLUSIONS

There are three questions to be considered in this case. They are:

1. Did the grievor do that which she is alleged to have done?
2. If so, do her actions justify a disciplinary response?
3. If so, in the circumstances of this case, is the Employer's selected form of discipline appropriate?

I address each question in turn.

1. Did the grievor do that which she is alleged to have done?

I begin with the standard of proof. The Union submitted that I should use a standard of clear, cogent and convincing evidence. I cannot agree with the Union's submission that the

standard of proof in this case should be different from the normal standard of "balance of probabilities" generally used in labour arbitration. The grievor is not alleged to have committed a criminal act. The higher standard urged upon me may well apply in, for example, a case of theft or other criminal misconduct. However I find no legal or policy reason to apply a higher standard of proof here where it was alleged that the grievor's work performance was inadequate and that her care for the residents was below the expected standard.

Applying the "balance of probabilities" standard, I find that the Employer has proven the substance of each of the five allegations in the dismissal letter numbered 2 through 6 and reproduced earlier. I find that:

a) The grievor improperly used the hoyer lift in getting Mr. A into bed, causing Mr. A to be upset and concerned.

b) The grievor left resident Ms B in bed with the bed side down, thus jeopardizing Ms B's safety.

c) The grievor engaged in a quarrel with a co-worker. I find that the grievor was primarily responsible for the discussion becoming a loud quarrel. The quarrel caused upset among some of the residents who heard it.

d) The grievor refused to assist Mr. A to the washroom when Mr. A requested. I find that she intended instead to simply provide Mr. A with a diaper for the night. It was only the intervening actions of a co-worker which caused this not to take place. I find that the resident was upset by this treatment.

e) Finally, I conclude that Ms D found the treatment she received from the grievor to be rough and mean, that Ms D declined to have the grievor continue to care for her, that Ms D complained of the grievor's treatment, and that Ms D was emotionally distressed by the grievor's care of her.

I acknowledge that not all the details of the grounds for dismissal provided in the letter of dismissal have been proven. For example, I do not find that Ms B was left "half nude", nor that the grievor was in the staff room at that time. Nevertheless I find that the substance of five of the allegations relied upon by the Employer in the dismissal letter have been proven.

As the Employer indicated it was not relying on the first allegation, I will not pursue it in any detail. I would note, however, that the evidence does not lead me to the conclusion that a co-worker was attempting to undermine the grievor's employment, as was suggested by the Union.

In summary, on this first question I conclude that the grievor did, in substance, what she was alleged to have done in points 2 through 6 of the letter of dismissal.

2. *Do the grievor's actions justify a disciplinary response?*

I now consider whether the grievor's actions justify a disciplinary response. As a health care aide, the grievor was responsible for providing care for residents who were living in the nursing home. Most residents of this nursing home are elderly and they come to live in the nursing home because they are no longer able to manage independently. As such, the residents are in a vulnerable position. The residents are dependent on the care available to them in the nursing home. The expectations spelled out in the Residents' Bill of Rights and the expectations of this Employer, which have been clearly expressed to its employees, have to be considered in light of the nature of the nursing home itself in evaluating whether the grievor's conduct deserves a disciplinary response.

I accept the basic position advanced by the Employer that, in this workplace, conduct which might be acceptable elsewhere should not be tolerated. As an example, a quarrel such as the

one which the grievor participated in may be both common and acceptable in another work place, but it is not acceptable in most areas of a nursing home.

Those employees in a nursing home who are responsible for the direct care of residents have an obligation to care for those residents and both the Employer and the residents should be able to rely on those employees to meet that obligation.

The grievor's conduct in each of the five incidents described above fell below the standard expected. Each incident involved the grievor's relationship with residents. Four incidents involved direct care of a resident; the quarrel had a less direct impact on residents. In each incident the grievor's actions were inappropriate. A resident should not suddenly and without advance warning be lifted into bed by means of a mechanical device such as Mr A was. This is especially so when the resident (Mr. A) was designated as requiring another type of assistance in getting into bed, when the resident has never before experienced such a mechanical lifting device, when the resident protests, and when there was no other staff member present to allay the resident's fears, as was the situation here. Nor should a resident be left in an unsafe position as was Ms B, who was left alone in the midst of getting out of bed. Nor should the residents be subjected to a loud quarrel in what is, after all, their residence. In addition residents have a right to assistance with maintaining independence for as long as is possible and should thus be assisted in using the washroom, not told they will only be given a diaper as Mr. A was. Nor should any resident be subjected to rough treatment - residents should not live in a state of emotional distress brought about by the persons who are employed to care for them as Ms D was. In each of these five incidents the actions of the grievor involved residents for whom she was employed to provide care and in all the incidents the grievor provided inadequate or inappropriate care.

The grievor's conduct fell below the standard set by this Employer. It fell below the standard

set in the Residents' Bill of Rights. It fell below the standard which a reasonable employer would expect of a health care aide in a nursing home. The grievor treated residents who were entrusted to her care in a cavalier manner; she was rough and generally uncaring. I have no difficulty concluding that the grievor's actions justify a disciplinary response.

3. *In the circumstances of this case, is dismissal the appropriate form of discipline?*

The remaining question is whether, in all the circumstances of the case, the particular form of discipline chosen by the Employer - discharge - is appropriate.

I note that the Employer submitted that, in the absence of any evidence from the Union, there was no basis for me considering a lesser penalty. I also note that the Union made no submission that, if I found the grievor did what was alleged, I should nevertheless modify the penalty. However, I believe it is always incumbent upon an arbitrator to consider whether the penalty is appropriate in a just cause case.

I begin with two general comments.

1. First, I accept the principle that discipline should be designed to change behaviour. Under this approach discipline is viewed as a mechanism to correct employee's behaviour, not simply to punish the employee for some wrong(s). The essential purpose of discipline is thus to improve an employee's conduct. An Employer will ordinarily be expected to use increasingly severe forms of discipline with an employee both to indicate that the current behaviour is unacceptable and to draw the employee's attention to the fact that the conduct will have to change. This is part of the basic notion of just cause - that the punishment imposed should fit the employee's offence(s).

2. Secondly, there are several points about the evidence which in some circumstances might support a modification of the penalty.

   a) I note, for example, that the use of the hoyer lift in putting Mr. A into bed was conducted in a careful and technically correct manner. In addition the grievor indicated during the Employer investigation that she used the hoyer lift because no one would assist her in lifting Mr. A into bed. (However, the evidence which I heard did not support the refusal of co-workers to assist.)

   b) While there was a safety concern with respect to Ms B who was left with the bed rail down, it is clear that nothing happened to cause injury to Ms B nor was there any evidence that Ms B was in any way prone to falling out of bed.

   c) Regarding the quarrel, as I have already noted there were two employees involved. The evidence did suggest that one of the reasons the quarrel escalated in the way it did was a difficulty that the grievor had in obtaining assistance to get her residents into bed.

   d) With respect to the refusal to provide washroom assistance to Mr. A, Mr. A did receive assistance at the time he requested the assistance, although from another employee.

   e) Finally, while Ms D complained of "rough, mean" treatment, it was not clear what the grievor had done which caused Ms D to have reached this conclusion and to have become so distressed.

Thus given the grievor's conduct here, and considering that discipline should be used primarily to change behaviour, it might be possible in some circumstances to justify altering the penalty. However, before I could do so I would have to have some measure of confidence that a lesser penalty would still draw the grievor's attention to the fact that her conduct was inappropriate and that even with a lesser penalty the grievor's conduct in the future would change and that she would be likely to conform to the expected norms. In this

case, for the reasons which follow, I am unable to reach such a conclusion.

As I have noted, in this workplace residents are dependent on the care provided by employees. The essential nature of a nursing home is such that residents are unable to fully care for themselves. The residents are in a nursing home because they need the special assistance which is available to them there. The residents are, of necessity, dependent upon the staff for this assistance. The nursing home is also the home of the residents. The residents have a reasonable expectation to fair and considerate treatment, as well a legal entitlement to such treatment. If the grievor were to be reinstated would the residents receive from her the care to which they are entitled?

I have already found that in incidents 2 through 6 the grievor did not meet the expected standard of performance, did not provide appropriate care, that her approach was rough and uncaring, and that she treated residents entrusted to her care in a cavalier manner. These are serious matters. There is absolutely no reason for the residents to be subjected to such treatment and no reason for the Employer to have to continue to employ a health care aide whose work is of this nature. In the circumstances confronting me there is no basis upon which I can reasonably conclude that if the grievor were to be reinstated her work, her care for the residents, would improve. The position of the grievor throughout, and of the Union, has been that most of these incidents did not occur. There is no basis for me to think the grievor would change her view from her current position of denial. Acceptance of having acted improperly is, in my experience, generally required before real change can occur. I note as well that the grievor has made no apology and has shown no signs of remorse for even unintended treatment of residents. Thus I have no confidence that, if I were to reinstate the grievor, her work performance would improve. There is nothing which would suggest that the grievor accepts that her performance was inadequate, or that if she were reinstated she would change in any way, or that she would adopt a more caring and considerate

approach. In the circumstances of this case, then, I find no basis to justify my altering the penalty of dismissal selected by the Employer.

For the reasons given above, the grievance is denied.

Dated in London, Ontario, this _____day of April, 1997.

_____

Howard Snow, Arbitrator