UNITED STATES OF AMERICA
BEFORE THE NATIONAL LABOR RELATIONS BOARD
REGION 06

UPMC MAGEE WOMENS HOSPITAL

Employer

and **Case 06-RC-366344**

SEIU HEALTHCARE PENNSYLVANIA

Petitioner

DECISION AND DIRECTION OF ELECTION

I. INTRODUCTION

On May 27, 2025, SEIU Healthcare Pennsylvania ("the Petitioner") filed a petition ("the Petition") in this case under Section 9(c) of the National Labor Relations Act, as amended ("the Act"), seeking to represent all full and regular part time Registered Nurses ("RNs") including but not limited to CRNPs[1] and Lactation Consultants employed by UPMC Magee-Womens Hospital ("the Employer") who work at 300 Halket St., Pittsburgh, PA 15213 ("the Employer's facility"), the only facility involved herein

At the hearing, the parties stipulated the exclusion of several classifications including the CRNPs and that the Lactation Consultants would vote subject to challenge.[2] The parties were unable to reach agreement regarding the eligibility of the rotating Charge Nurses[3]. In this regard, the Employer contends that RNs who serve as Charge Nurses should be excluded because they are statutory supervisors.[4] The Employer alleges that more than 20% of the proposed unit should be

[1] Certified Registered Nurse Practitioners.

[2] The parties stipulated to exclude the following positions from the bargaining unit: all office clerical employees, managerial employees, confidential employees, directors, Advanced Clinical Education Specialists, Clinical Education Specialists, Clinical Research Coordinators, Women's Health Coordinators, Improvement Specialists, Senior Improvement Specialists, Nurse Educators, OP Nurse Coordinator I and II with direct employee reports, Senior Infection Preventionists, Quality Nurse Coordinator Intermediates, Discharge Plan Managers, Discharge Plan Associates, Discharge Planning Coordinators, Expert Discharge Plan Managers, Senior Discharge Plan Managers, Senior Infection Preventionists, CRNPs, and guards, and supervisors as defined in the Act. The parties also stipulated that Lead Lactation Consultants, Lactation Consultants, and Expert Lactation Consultants will vote subject to challenge. During the hearing, the parties stipulated to exclude Clinicians. (TR 232:5-18.) The parties verbally stipulated that the performance of transport work, alone, is not relied on by the Employer in its assertion that Charge Nurses are supervisors as defined by Section 2(11) of the Act. (TR 506:24-507:6)

[3] The record reflects that the Employer does not employ any permanent Charge Nurses.

[4] Throughout the course of the hearing, there was testimony about Team Leads and Patient Flow Coordinators ("PFC."). The Employer did not raise the issue of Team Leads or PFCs in its Statement of Position, however the

excluded because they spend more than 10% of their time performing supervisory functions in the role of Charge Nurse.[5] The Petitioner contends that none of the RNs who serve as Charge Nurses are supervisors within the meaning of the Act and should be included in the petitioned for unit.

A Hearing Officer of the Board conducted a hearing from June 9 to 12, 2025, and the Employer and the Petitioner each filed briefs. I have considered the evidence and arguments presented by the parties and I find that the Employer did not meet its burden to establish that Charge Nurses are statutory supervisors. Therefore, I direct an election pursuant to the petition, as modified by the parties' hearing stipulations ("Unit").

II. FINDINGS OF FACT

1. Overview of Operations

The Employer is a Pennsylvania non-profit corporation and health care institution. The Employer's Magee-Womens Hospital ("Magee" or "Hospital") provides medical care including women's health and maternity services, intensive care for newborns and infants, an emergency department, general medical/surgical services, operating room care, and oncology services. There are 940 RNs at the facility who are not in managerial nursing leadership. The Hospital has six floors and about 100 departments.

Nurses serve as Charge Nurses on a rotating basis in the following units: Women's Care Birth Center, Medical/Surgical ("Med/Surg"), Neonatal Intensive Care Unit ("NICU"), Oncology, Orthopedics, Operating Room, Intensive Care, Transitional Care, Wound Care, Emergency, Medical, Surgery, and Telemetry Stepdown Units.

Within units, Charge Nurses report to Clinicians who report to Unit Directors. Clinicians are advanced care providers who directly supervise RNs and it is undisputed that they are statutory supervisors. Unit Directors report to Chief Nursing Officer and Vice President of Patient Care Services Dawndra Jones. There is always an Administrator on Duty ("AOD") who checks in with leadership and Charge Nurses across the hospital. The AOD tracks staffing for the entire hospital.

RN position titles progress in accordance with a clinical ladder. The RN job titles are Staff Nurse, Professional Staff Nurse I, Professional Staff Nurse II, and Professional Staff Nurse Expert. The Hospital has no Charge Nurse job classification or position description. Anchors are RNs who are not assigned any specific patients but are essentially "floats" who can assist anywhere they are needed.

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parties verbally stipulated that in the NICU department, the titles team lead and Charge Nurse are used interchangeably. (TR 112:5-18.) The parties verbally stipulated that Non-clinician PFCs act in a Charge Nurse role. (TR 328:24-329:5) With respect to any departments where the terms team lead and charge nurse are not interchangeable, it was not timely raised that team leads or PFCs have supervisory status under the Act, and as such will not be addressed herein.

[5] The Employer removed 13 RNs from its exclusion list during the hearing.

The Employer uses the payroll system Kronos and scheduling system ShiftSelect. Up-staffing refers to when additional RNs are needed to come in for a shift at the last minute. Down-staffing is when RNs can be released from their shift if there is a surplus of staff for the patients.

The Employer's use of the rotating Charge Nurse

At the hearing, the Employer provided a spreadsheet that contains names of RNs, as well as other classifications, it proposed to exclude from the Unit based on the percentage of time the RN may have served in the Charge Nurse role during the preceding one-year period. Specifically, the Employer's spreadsheet (Employer exhibit 7) contains the names of 754 RNs whom it employed at Magee during the period June 1, 2024, through May 31, 2025, and in the columns following each RN's name it shows their total hours worked, total hours worked as Charge Nurse, and the percentage of hours that they worked as Charge Nurse. Human Resources Director Jaclyn Betts testified that "payroll" created the spreadsheet by pulling records via ShiftSelect for RNs who were paid the Charge Nurse differential from June 1, 2024 through May 31, 2025 and that information flowed into the Employer's payroll system called Kronos which then flowed into HRdirect. During her testimony, Betts admitted that the data that was pulled also includes other classifications besides RNs such as Licensed Practical Nurse (LPN), OPS Coordinator and at least one Clinician, Anna Furnival, who transitioned from a professional staff nurse to Clinician during the specified period. Additionally, Betts testified that the payroll code utilized pulled in information for time the RNs worked at other facilities in the UPMC system, so it is not an accurate reflection of time spent as a Charge Nurse at Magee. As the testimony from Betts and Women's Care Birth Center Unit Director Rebecca Lavezoli confirmed, people who perform anchor duties and people who perform transport duties receive the same pay differential as Charge Nurses and those hours were also included in the column for total number of hours worked as a Charge Nurse. Betts testified that looking only at the spreadsheet, she cannot determine who received the differential for work performed in a non-Charge Nurse role and how many of their differential pay hours were worked at Magee. The Employer provided Daily Staffing Sheets for the medical/surgical 5300 unit for the month of May, 2025 (Employer Exh. 3) which show that Clinicians served as the Charge Nurse during the daylight shift and RNs were assigned the Charge Nurse role on the night shift. Out of 13 night shifts where a Charge Nurse was designated, this assignment was divided among nine different RNs. Also, it is not clear how reliable these Daily Staffing Sheets are as there were some shifts that do not reflect a Charge Nurse assignment.

2. Duties of the Charge Nurses

The record contains no evidence that the Charge Nurses play any role in hiring, transferring, laying off, recalling, promoting, rewarding employees, issuing discipline, or resolving grievances, or that they can effectively recommend such action. Thus, those functions are not at issue here. Rather, the evidence provided at the hearing centered on whether Charge Nurses have

a role in assigning and responsibly directing RNs or other employees and exercise independent judgement in doing so.

In most units Charge Nurses are selected based on their volunteering for the duties. The exception is In the NICU, where an RN applies for the Charge Nurse role and is selected after being interviewed for the position. In all units, RNs are permitted to perform Charge Nurse duties after going through an orientation of shadowing a current Charge Nurse for three to six shifts. There was no testimony regarding who determined when a Charge Nurse had completed orientation.

RNs are paid a $1-$1.50 per hour wage differential when working as a Charge Nurse. In addition to their Charge Nurse duties, in most units Charge Nurses provide direct patient care during their shifts. As the duties and responsibilities of Charge Nurses differ from unit to unit, each unit will be examined separately.

The Employer provided a position description for Professional Staff Nurse Expert. Clinical Director Lee Baron asserted that Professional Staff Nurse Experts make up the majority of his departments' Charge Nurses but acknowledged there are Professional Staff Nurse Experts who do not serve as Charge Nurse. RNs with as little as one year of experience can serve as Charge Nurses. Barron testified that the job description was a "fair starting point for what a Charge Nurse does." NICU Unit Director Roberta Bell testified that most of the NICU Charge Nurses have this title or equivalent BSN[6] but that there are also Charge Nurses who do not have this title. Bell and Barron testified that the specific requirements in the job description apply not only to Charge Nurses, but also to RNs who have the title of Professional Staff Nurse Expert, but do not work as Charge Nurses. As these position descriptions are for RN positions and the duties are those of an RN regardless of Charge Nurse status, I do not find these position descriptions indicative of a Charge Nurse's specific duties that would establish a Charge Nurse has supervisory status over an RN with the same duties.

Women's Care Birth Center Unit

The Birth Center is comprised of several units: triage, obstetrics operating room, Post-Anesthesia Care Unit ("PACU"), labor and delivery suite, and labor and delivery ICU. These units house 15 triage beds, 22 labor and delivery rooms, five operating rooms, ten PACU bays, and six OB ICU beds. There are about 180 RNs in the birth center and over 100 are trained as Charge Nurses. Unit Director Rebecca Lavezoli estimated that less than five of the 100 trained are never assigned as a Charge Nurse. There is not an RN who is permanently assigned as a Charge Nurse, team lead, or Patient Flow Coordinator ("PFC").

[6] It is presumed that this refers to a Bachelor of Science in Nursing degree.

PFCs are the Charge Nurses over the entire Birth Center. There is one PFC designated per shift. PFCs receive calls from RNs who are calling off for a shift and rearrange the schedule based on RN call offs. The PFC decides what bed to place incoming patients in based on the patient's clinical status. PFCs do not have to consult with anyone to assign patients to specific rooms. PFCs assign RN roles for the following shift by slotting people into the assignment sheet with no preference or order of how they should be slotted in. Clinicians make assignments in ShiftSelect, which then tells the PFC who will be the PFC, the OR Charge, Triage Charge, Anchor and who is qualified to be a team lead. PFCs do not see patients while performing PFC duties. The PFC does not assign individual patients to RNs but rather, assigns beds to RNs.

The Employer maintains a patient flow policy which provides instructions for down-staffing or up-staffing. PFCs can escalate the need for additional staff to a Clinician, Unit Director, or the AOD but the AOD ultimately makes the decision about up-staffing. PFCs cannot call anyone into the Hospital from the on-call list without approval from the AOD. A Clinician or Unit Director notifies the PFC when down-staffing is necessary and how many staff members will be sent home. There are in-unit protocols for determining the order RNs are down-staffed and the PFC has no discretion to change the order. The policy also mandates minimum staffing levels.

Senior Professional Level Staff Nurse Expert II Jean Stone is on the OB resource team. She works across labor and delivery, antepartum, high risk postpartum, mother-baby, and NICU step-down. Stone reports to Clinical Director and Unit Director of the Birth Center Leah Kelly. Stone has acted in the Charge Nurse role in the Birth Center, as a PFC, and as a team lead. If there are fewer staff than the minimum required by policy, Stone testified that she would always contact leadership.

Professional Staff Nurse Expert Jamie Miller works in the high risk postpartum department. There are about 21 RNs in the department and 14 are capable of serving as a Charge Nurse. Miller testified that the Unit Director or Clinician select the Charge Nurses for each shift at random. The unit uses an acuity tool that assigns points to patients based on the workload associated with the patient. One point is a lower workload patient while three points is the highest rating assigned to higher workload patients. RNs are assigned up to nine points worth of patients based on the acuity tool point system. Miller attempts to make sure one RN is not assigned only level three patients at once. Miller testified she uses no discretion other than attempting to evenly distribute the patients because she uses the workload tool.

Lavezoli testified the Charge Nurses are ultimately responsible for quality control and safety checks related to checking the crash cart's emergency equipment and managing narcotics supplies. Narcotic supplies are counted every Monday and reported in AcuDose. However, Charge Nurses can delegate these tasks to RNs or Anchors. Charge Nurses are not held accountable for mistakes of RNs or Patient Care Technicians ("PCTs") but it would result in a "coaching moment" if anything was done incorrectly. These coaching moments are verbal

feedback from a Charge Nurse to an RN, PCT, or Anchor but are not documented or disciplinary. Charge Nurses do not report coaching moments to Clinicians or leadership.

Charge Nurses assign patients to rooms based on physical location and available rooms. Charge Nurses can assign patients to RNs based on consultation with the RNs and may have to escalate to a Unit Director or AOD if additional support is needed.

Triage

The Employer provided a policy titled Triage Charge Nurse Responsibilities (Employer Exh. 4).[7] Regarding the assignments, the policy provides that the Triage Charge Nurse "assigns patients to Triage rooms" and "continue assignment of patients to Triage care team members." The policy also states, "Notify Patient Flow Coordinator whenever census or acuity of patients is increasing or when there is a question about patient placement and/or nurse staffing." Additionally, the policy lists other tasks performed by the Triage Charge Nurse. For example, the Triage Charge Nurse scores arriving patients on a Maternal Fetal Triage Index and assigns RNs based on the acuity tool.[8] The Triage Charge Nurse asks incoming patients initial health and physical history questions and starts triage assessment documentation. Triage Charge Nurses check the crash cart, verify the correctness of the lock number on the crash cart, check emergency equipment, and check the adult emergency equipment readiness review form each shift or the Charge Nurse can delegate these tasks to an RN or Anchor. All RNs in triage are qualified to check crash carts. Charge Nurses do a weekly count of narcotics, and can delegate this task as well. The record is silent as to whether an individual can refuse a task delegated to them by a Charge Nurse or if this has ever occurred.

The Triage Charge Nurse communicates to the RNs what patients are coming in and who will be assigned a patient in the triage unit. However, if a patient comes into the waiting room and should be assigned to a labor and delivery room or unit other than triage, the Triage Charge Nurse notifies the PFC who then assigns that patient to the correct unit. Charge Nurses can direct PCTs, Anchors, and bedside RNs to initiate nursing protocols like perform certain labs or tests; connect the patient to the fetal monitor; take urine samples; start an IV; or, perform a 12-lead EKG. RNs can also delegate patient care tasks to PCTs. There was no evidence presented about whether Anchors, RNs, or PCTs can refuse a delegated task from a Charge Nurse or an RN or if that has ever occurred.

Lavezoli testified that Triage Charge Nurses "help" review service summary sheets to ensure the nursing tasks are tracked accurately for billing but provided no additional information about what help they provide and to whom. While the policy lists transport duties, Lavezoli testified that a Charge Nurse or a bedside RN can perform transport duties. Charge Nurses oversee the completion of discharge paperwork and can delegate responsibility to the Anchor or RN to

[7] The Employer does not have a position description for any of the Charge Nurses. However, since the Employer has a policy called Triage Charge Nurse, I will use Triage Charge Nurse when discussing Charge Nurses who work in this capacity.

[8] The record is not clear on the acuity tool point system for the triage unit.

provide discharge instructions to the patient. RNs can also handle discharges like Charge Nurses. At the end of a shift, the Triage Charge Nurse provides an update to oncoming nurses about the current patient census, any known pre-arrivals, or issues with equipment. While the policy states Triage Charge Nurses act as a resource person to orientees and staff, they do not provide orientation for RNs new to triage. Lavezoli acknowledged it is daily routine for RNs to serve as a "preceptor" for students, teaching students and supervising any clinical work performed by a student. The policy states the Triage Charge Nurse is responsible for cleaning and stocking; Lavezoli testified, "anyone and everyone can clean." PCTs handle most of the cleaning and stocking of the unit, while Charge Nurses mark a bed dirty in the computer system.

Triage RNs are assigned one to three patients at a time. If there are three to four patients per RN then the unit may use the Anchors. Triage Charge Nurses are not assigned any patients but are expected to "round on all patients" in the unit meaning to check each patient's medical chart and discuss a treatment plan prior to transfer or discharge. Triage Charge Nurses do not receive a separate performance evaluation based on their duties of a Triage Charge Nurse and only receive an evaluation based on their duties as an RN.

Labor and Delivery

In the 22 labor and delivery rooms, there are three numbered teams and each team has a team lead. Based on the documentary evidence (Employer Exh. 5), the record reflects that the Employer does not use the term "Charge Nurse" for the Labor and Delivery unit but rather, uses the term "team lead." Lavezoli testified that team leads are like mini Charge Nurses who can rearrange patient assignments during shifts within the unit. The PFC determines who will be team lead on each assignment sheet. If patients assigned to a team are ready to deliver or need to be transferred, the team lead communicates that to the PFC. If a team lead believes they need more staff they notify the PFC who is authorized to add staff to a shift. If a team lead wants to down-staff, they also ask the PFCs.

Every six hours there is a safety huddle that the team leads attend with physicians or clinicians to discuss patient status. The team leads can rearrange assignments throughout the shift or they communicate to the PFC if additional staff is needed. There was no evidence presented about the factors a team lead considers when rearranging assignments. The record was silent regarding whether assignments from a team lead can or have ever been refused. PFCs, team leads, and the Anchor are paid the $1 per hour wage differential. RNs orient to the team lead role by shadowing a team lead for several shifts and must have training in intermediate fetal monitoring. There are monthly meetings for PFCs and team lead roles and there is a unit specific meeting for PFC and team leads, however attendance at these meetings is not mandatory.

PACU

Lavezoli testified that the term PACU Team Lead is used interchangeably with PACU Charge Nurse[9]. Stone testified that the PACU Team Leads are different than Charge Nurses. Stone testified that PACU Team Leads are focused entirely on the rooms and the patients in the rooms of the team they are leading. PACU Team Leads have no role in up-staffing or down-staffing other than to alert the PFC if the team needs more resources. In the PACU, RNs are not assigned more than two patients at a time. PACU Team Leads may occasionally rearrange staffing during a shift if an RN has to go with a patient to the Operating Room. PACU Team Leads attend two safety rounds per shift where every patient in the unit is discussed.

Operating Room

Charge Nurses[10] assign technicians to operating rooms to prepare for a particular patient including ensuring the necessary equipment is in the room. No evidence was presented regarding what considerations the Charge Nurse makes in assigning technicians. There was testimony that many of the technician's tasks in opening an operating room are the same and repetitive but no examples of those tasks were provided. A Charge Nurse can escalate a technician's mistake to management but the record is not clear about how a mistake is escalated or the consequences of such an escalation. A Charge Nurse will not be disciplined for a technician's mistakes. Charge Nurses are responsible for checking the crash charts but they can delegate this task to RNs or technicians. There is no evidence regarding whether an RN or technician can refuse a task delegated to them by a Charge Nurse or what happens if they refuse.

Medical/Surgical ("Med/Surg"), Med/Surg Step Down, Oncology. Orthopedics, Intensive Care, Transitional Care, Wound Care, and Emergency Departments

Clinical Director Lee Baron supervises Medical/Surgical ("Med/Surg"), Oncology, Med/Surg Step Down, Orthopedics, Intensive Care, Transitional Care, Wound Care, and the Emergency Department. The Unit Directors of those departments report to Barron. Barron's testimony regarding Charge Nurse duties covered all the units he supervises. There is a Charge Nurse assigned to each of the Medical/Surgical ("Med/Surg"), Oncology, Med/Surg Step Down, Orthopedics, Intensive Care, Transitional Care, Wound Care, and the Emergency Departments for 24 hours a day. The Transitional Care unit has 20 beds. The Med/Surg 5300 unit has 28 beds and can take step-down patients, whereas the Med/Surg 3200 unit has 24 beds and does not take step-down patients. Unit 4100 is an orthopedic and bariatric surgery unit with 30 beds. Unit 5800 is oncology gynecology. The ICU has 14 beds. There is a Med/Surg resource pool of 14 or 15 RNs.

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[9] According to Employer Exh. 5, that staff assignment sheets for Labor and Delivery, which includes the PACU, for the period 6/1/25 to 6/3/25 only contains a team lead ("TL") and not a Charge Nurse assignment.

[10] Although the record testimony used the term "Charge Nurse" this term is not used on the staff assignment sheet so it is not clear from the document which individual assigns work to the surgical techs who do appear on the shift assignment sheets.

The RNs' schedules are made by Unit Directors or Clinicians and posted on the online platform ShiftSelect. Each Unit Director creates a staffing grid used to determine how many RNs are needed on a particular day. RNs contact the Charge Nurse if they are calling off for a shift. Barron testified that Charge Nurses check in with either the AOD, Clinician, or Unit Director if additional RNs are needed or to find out if any RNs can be down-staffed but do not make a decision about staffing on their own.

Charge Nurses are responsible for making patient assignments each day for one of the two 12-hour shifts. Barron testified that Charge Nurses make patient assignments by reviewing the acuity tool and nurse "comfort level." The record contains multiple assertions that Charge Nurses are essentially "air traffic controllers" in their units. When assigning RNs to patients, Charge Nurses consider the following: acuity tool points: whether the nurse was assigned to the patient the day prior; or if based on the difficulty of the patient it may make sense to assign the patient to a different RN to provide the RN with a break from that patient.

Barron testified that Charge Nurses mediate between different departments or individuals, or patients and family members, but he did not provide any examples of this mediation. In the Emergency Department, Charge Nurses field calls from emergency services and assign patients accordingly. In the ICU, Charge Nurses provide emergency patient care and check crash carts.

Charge Nurses are responsible for ensuring the unit has specialized equipment or supplies. Charge Nurses monitor RNs' adherence to quality initiatives throughout their shifts during a Charge Nurses' rounds by engaging in regular patient care. If an RN fails to follow a policy, a Charge Nurse can document nonadherence to escalate the concern to the Unit Director but there was no information provided about the documentation and whether a Charge Nurse can recommend any action be taken against the RN. Charge Nurses provide verbal feedback to RNs but there was no evidence that Charge Nurses can formally discipline RNs. Charge Nurses are not disciplined or held accountable for an RNs' actions.

Units hold safety huddles several times a day to discuss any patient issues, quality issues, and things going on at the hospital, like whether a food truck will be there that day. All RNs, Clinicians, and the Unit Director participate in the huddle. Charge Nurses, Unit Directors, or Clinicians can lead the huddle. Charge Nurses are not disciplined for not attending a huddle. Charge Nurses in Barron's departments sometimes attend bed meetings where discharges and admissions are discussed.

With regard to the training that Charge Nurses may provide to other employees, Barron testified that he has seen Charge Nurses run trainings for IV sticks but that any RN can provide that training. There was also testimony that Charge Nurses may participate on some committees, but the testimony also reflected that non-charge nurse RNs can also serve on committees and participate in peer interviews for applicants to work in the unit. RNs can participate in peer interviews on a voluntary basis.

Medical, Surgery, and Telemetry Stepdown Unit

Unit Director Toni Lynn Donnelly supervises Unit 6300, a Medical, Surgery, and Telemetry Stepdown Unit with 30 to 31 RNs. There is one Charge Nurse per 12-hour shift which runs from 7 to 7. According to the Employer daily staffing sheets for this unit (Employer Exh. 3), the Clinician, a stipulated supervisor, will sometimes be assigned as the Charge Nurse. RNs receive orientation to Charge Nurse by shadowing an existing Charge Nurse for at least three day shifts and three night shifts. The Charge Nurse on the previous shift designates who will be Charge Nurse on the next shift. This is based on who on the shift is capable of serving as a Charge Nurse and may also be to preserve continuity of care if the same Charge Nurse will be working the same shift on consecutive days. There is no set schedule of who is designated as a Charge Nurse. Charge Nurses do not have their own patients when serving in that role.

Charge Nurses assign RNs to patients based on the patient acuity tool and the complement of RNs on the floor and their experience level. These assignments are contained on the staffing sheet. The day shift Charge Nurse makes assignments for night shift and vice versa. Charge Nurses from day shift and night shift meet to give each other shift reports when the shifts changeover where they discuss all 28 patients in the unit. Charge Nurses use daily staffing sheets printed from ShiftSelect showing who is on shift on a given day to handwrite bed assignments on the sheet. The staffing sheet also contains a census sticker that reports the current patient census, how many admissions are planned for the unit, whether any operations are planned for that day or a transfer is coming in from another hospital, and anticipated discharges. Charge Nurses check that the RNs are present for their shift and ensure the med cell bag is locked and where it needs to be. Charge Nurses check the crash cart and sign the log that it has been checked. Charge Nurses attend a bed meeting where the AOD discusses the resources in the Hospital during that shift and the next shift coming in, unless Unit Director Donnelly can attend in their place instead of pulling them off their shift. Charge Nurses follow up with RNs to make sure they monitor high-risk drips and have not missed orders or important lab work but no evidence was presented about what happens if a Charge Nurse identifies a problem. Charge Nurses can order supplies from outside vendors. Donnelly testified that she trusts Charge Nurses to make their own decisions throughout the shift about what is best for patients and staffing but provided no examples. Charge Nurses will always check in with the AOD before down-staffing, so the AOD can confirm if an RN is needed in another department. If there is a call off, the Charge Nurse notifies the AOD who then decides if an RN is reallocated to the unit.

There is a staffing guideline sheet that specifically states how many RNs should be staffed for a certain amount of patients. Using that guideline sheet and based on the patient acuity assessment, Charge Nurses then use their judgment on whether to consult with the AOD to staff up or staff down. In this unit, there are never more than four patients assigned to an RN. Charge Nurses have to consider medication frequency when making assignments. When assigning patients, Charge Nurses try to ensure the appropriate amount of work is assigned per nurse and that the nurse can provide appropriate patient care. The unit's patient acuity tool assigns a number

to patients based on their diagnosis and frequency of needs of the patient. The Charge Nurses attempt to ensure RNs have equal numbers based on the acuity scores but Donnelly testified it is not used all the time.

If an RN makes a mistake, it will be inputted into RiskMaster but the record is unclear about what happens with a RiskMaster report after it is entered. There was no testimony that a Charge Nurse recommends any actions as a result of a mistake. A Charge Nurse is not disciplined or otherwise held accountable for a mistake of an RN. Charge Nurses do not perform evaluations of RNs. Clinicians or Unit Directors perform evaluations of their RN direct reports.

Every RN carries a phone but there is one phone designated as the charge phone which is given to the Charge Nurse of each shift. Charge Nurses do not administer breaks but can ask an RN to wait to take a break if there are not enough RNs on shift at any given moment. There was no testimony about whether there are any consequences if an RN does not comply with a request to delay a break or if that has ever occurred. Charge Nurses wear the same scrubs as all the RNs.

Neonatal Intensive Care Unit ("NICU")

Unit Director Roberta Bell oversees the NICU. There are about 180 RNs in the NICU, 20 of whom perform Charge Nurse duties[11]. Typically two or three RNs are designated as Charge Nurse per shift. RNs apply and interview to be a Charge Nurse. Bell and a Clinician decide who will be selected to be a Charge Nurse in the NICU. Bell testified that the NICU Charge Nurses are expected to have two years of delivery room experience and an overall good quality performance rating. If an RN does not have a certification when becoming a Charge Nurse, they are expected to obtain a certification within one year. Charge Nurses are paid a differential when they serve as a Charge Nurse. Charge Nurses go through an orientation process that is typically two to three weeks of shadowing a current Charge Nurse. In the unit, there is a yellow team and a red team, which are geographical designations in the NICU unit.

Each day Charge Nurses in the NICU assign RNs before a shift based on acuity scores of patients and will reassign RNs throughout the course of a shift to maintain safe RN to patient ratios, however there is not a required ratio in the NICU. Bell testified Charge Nurses are expected to unilaterally assign RNs and it is the prime part of their responsibility. Charge Nurses use an acuity tool to make assignments. The acuity tool assigns a score to patients. Bell testified that Charge Nurses can spend up to two hours assigning nurses because they have to manage call-offs, go to board meetings to see what resources are in the unit or Hospital that day, and go to bed meetings. Each morning a Charge Nurse runs a safety huddle to discuss which patients are intubated, what central lines are in place, any infections, social issues, transports that could be happening, or anticipated difficult admissions.

[11] As noted above, the Employer's spreadsheet reflects that 38 NICU RNs were paid the wage differential for Charge Nurse. However, I find the spreadsheet not to be an accurate reflection of the number of Charge Nurse hours worked and give greater weight to Unit Director Bell's testimony.

Charge Nurses are expected to reach out to the AOD if a shift needs additional resources. Charge Nurses cannot require a Clinician to come in. For example, if staff is needed from another area of the hospital a Charge Nurse will ask the AOD to coordinate that. The AODs participate in meetings where the Charge Nurses will discuss with the AOD what staffing resources are available or needed for the day. If additional RNs are needed, there is a sign-up list where RNs can volunteer to be called in. If needed, a Charge Nurse can ask another RN already working to work as a Charge Nurse that day. In this case, a Clinician would put the designation in the pay system so that RN is paid the Charge Nurse differential.

Charge Nurses in the NICU assist attending physicians and "med call" to put together a transport team if a baby is moved out or into the Hospital. Transport Nurses are paid the same differential as Charge Nurses and the pay is coded the same in Kronos. There can be an overlap between Charge Nurses and the Transport team but the unit has RNs who only perform Transport duties and RNs who only perform Charge Nurse duties. RNs do not serve as Transport Nurses and Charge Nurses at the same time.

Charge Nurses are the first person RNs will call if they have a question about policy, procedure, skill, a difficult family interaction, or need security. NICU Charge Nurses do not have patient assignments during their shift. RNs can reach out to Charge Nurses if they need a resource or would like the Charge Nurse to get a nurse practitioner to the bedside but there was no testimony that an RN is required to reach out to a Charge Nurse for these reasons. Bell testified that several times the NICU ran out of a supply such as filters, donor breast milk, and cooling units, and the Charge Nurse reached out to the supply chain department or another hospital to have the supply brought over.

Charge Nurses and RNs fill out forms in online platform RiskMaster if anything unexpected occurs during treatment of a patient. If there is a mistake, a Charge Nurse can give verbal feedback to the RN but cannot issue formal discipline. Charge Nurses are expected to escalate the situation but do not make recommendations for discipline or issue discipline. Charge Nurses are not disciplined or otherwise held accountable for an RN's actions.

Charge Nurses put together discharge packets after the physician inserts the discharge orders, including documentation of follow up appointments, medication scripts, and information about the pediatrician. There was no evidence about whether RNs can also put together discharge packets. Bedside RNs wear black or white pants, an approved t-shirt or scrub top, while Charge Nurses, Transport Nurses, and Code Responders wear hospital issued blue scrubs in case they are called into the operating room. Charge Nurses designate the billing charge each day based on a patient's acuity and how it may have changed. This takes no more than 20 minutes per shift.

Operating Room Unit

Operating Room (OR) Administrative Director Kathleen Nauer oversees the OR Unit 32230. There are about 47 RNs in the unit. In this department, Clinicians share the Charge Nurse

role during the daylight shift. On the evening shift, RNs serve as Charge Nurses. Everyone in the unit is qualified to be a Charge Nurse but regular RNs are not trained to be a Charge Nurse on daylight shift because only Clinicians serve as Charge Nurse during the daylight shift. The daylight Charge Nurse Clinician prepares assignments for the evening and night shift, including addressing any staffing changes needed due to call offs. About 20 RNs are trained to be Charge Nurse on evening shift and they rotate. The record contains no explanation for how they are rotated as Charge Nurse. During the evening shift, the Charge Nurse can notify residents or families if a surgery scheduled for the next day is cancelled. They prepare the unit for the next day. On the night shift, there is only one RN and she is the Charge Nurse over herself and one surgical tech. The night shift Charge Nurse prepares rooms for the next day including equipment. When patients come in they are assigned to the room that corresponds with the type of surgery they will receive. Charge Nurses use RiskMaster to report any incidents and then escalate the concern, but the record is unclear about what happens with a RiskMaster report after it is entered. There was no testimony that a Charge Nurse recommends any actions as a result of a mistake. The Charge Nurse can activate someone from the on call team between 7 pm and 7 am. Nauer testified that the Charge Nurses are making routine decisions. Nauer testified that if any higher level decisions are required the Charge Nurse calls Nauer or the AOD but did not describe what constitutes a higher level decision.

For every case, there is an RN and a surgical tech assigned as part of the surgical team. Charge Nurses and RNs alike can provide guidance to surgical techs. Specifically, all RNs oversee the surgical techs to tell them what room to work in and surgical techs perform their duties under the direction of an RN. Charge Nurses collaborate with anesthesia, the surgeon, and residents regarding patient assignments. Charge Nurses then pass down instructions to the surgical team. Charge Nurses do not participate in training other RNs. Charge Nurses can provide verbal guidance if a policy is not complied with but there is no evidence that this verbal guidance is documented anywhere or is considered disciplinary.

Three individuals primarily serve as Charge Nurses on the weekend and night shifts. Heather Nemchek is the night Charge Nurse on Monday through Thursday; Erika Karns works weekend nights; and Brittany (Harr) Eynon is the weekend Charge Nurse.[12] Alice Dzimeria, Alex Nyegaard, Meagan McCormick, Cat Rico Moris, Mindy Kratz, and Maddie Ciere also take Charge Nurse shifts.

III. APPLICABLE LEGAL STANDARD

The Act expressly excludes supervisors from its protection. Section 2(11) of the Act defines a supervisor as:

[12] The record does not specify whether Eynon works the weekend daylight shift. Rather the record testimony is that Eynon works weekends.

> any 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 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 of a merely routine or clerical nature, but requires the use of independent judgment.

The three requirements to establish supervisory status are that (1) the putative supervisor possesses one or more of the above supervisory functions, (2) the putative supervisor uses independent, rather than routine or clerical, judgment in exercising that authority, and (3) the putative supervisor holds that authority in the interest of the employer. *N.L.R.B. v. Kentucky River Community Care, Inc.*, 532 U.S. 706, 712–13 (2001) (citing *N.L.R.B. v. Health Care & Retirement Corp. of America*, 511 U.S. 571, 573–74 (1994)).

Supervisory status may be shown if the alleged supervisor has the authority either to perform a supervisory function or to effectively recommend the same. Possession of any one of the enumerated powers, if accompanied by independent judgment and exercised in the interest of the employer, is sufficient to confer supervisory status. *Ky. River Cmty. Care*, 532 U.S. at 713. Supervisory status may likewise be established if the individual in question has the authority to effectively recommend one of the powers, but effective recommendation requires the absence of an independent investigation by superiors and not simply that the recommendation be followed. *Children's Farm Home*, 324 NLRB 61, 65 (1997).

The supervisor has to at least act or effectively recommend such action "without control of others and form an opinion or evaluation by discerning and comparing data." *Oakwood Healthcare*, 348 NLRB at 962-963. Judgment is not independent when the putative supervisor follows detailed instructions (e.g., policies, rules, collective-bargaining agreement requirements). *Id*. at 693. To be independent, "the judgment must involve a degree of discretion that rises above the 'routine or clerical.'" Id. at 693 (citing *J.C. Brock Corp.*, 314 NLRB 157, 158 (1994) (quoting *Bowne of Houston*, 280 NLRB 1222, 1223 (1986)) ("[T]he exercise of some 'supervisory authority' in a routine, clerical, perfunctory, or sporadic manner does not confer supervisory status."). If a choice is obvious, the judgment is not independent. *Oakwood Healthcare*, 348 NLRB at 693. The Board has an obligation not to construe the statutory language too broadly because the individual found to be a supervisor is denied the employee rights that are protected under the Act. *Avante at Wilson, Inc*., 348 NLRB 1056, 1057 (2006); *Oakwood Healthcare,* 348 NLRB at 687.

If such authority is used sporadically, the putative supervisor will not be deemed a statutory supervisor. *Coral Harbor Rehabilitation and Nursing Center*, 366 NLRB No. 75, slip op. at 17 (2018) (citing *Gaines Electric*, 309 NLRB 1077, 1078 (1992)). Where an individual is engaged a part of the time as a supervisor and the rest of the time as a unit employee, the legal standard for a supervisory determination is whether the individual spends a regular and substantial portion of his/her work time performing supervisory functions. *Oakwood Healthcare*, *Inc.,* 348 NLRB 686, 694 (2006). The Board confirmed the extant standard that "regular" means according to a pattern or schedule, as opposed to sporadic substitution. Id. Additionally, the Board found supervisory

status where the individuals have served in a supervisory role for at least 10-15 percent of their total work time. Id.

The party asserting supervisory status has the burden of proving supervisory authority and must establish it by a preponderance of the evidence. *Ky. River Cmty. Care*, 532 U.S. at 711; *Oakwood Healthcare, Inc.*, 348 NLRB at 687. This requires the presentation of "detailed, specific evidence" that is not "in conflict or otherwise inconclusive." *Oakwood Healthcare*, supra at 694; see also *Veolia Transportation Services*, 363 NLRB 1879, 1886 fn. 19 (2016); *G4S Regulated Security Solutions*, 362 NLRB 1072, 1072–1073 (2015); *Busco Tug and Barge, Inc.*, 359 NLRB 486, 490 (2012), enfd. 696 Fed. Appx. 519 (D.C. Cir. 2017). Mere inferences or conclusory statements, without such detailed, specific evidence, are insufficient to establish supervisory authority. *UPS Ground Freight, Inc.*, 365 NLRB 1123 (2017) (citing *Lynwood Manor*, 350 NLRB 489, 490 (2007); *Golden Crest Healthcare Center*, 348 NLRB 727, 731 (2006)).

The lack of evidence is construed against the party asserting supervisory status. *Dean & DeLuca New York, Inc.*, 338 NLRB 1046, 1047–48 (2003). Similarly, supervisory status is not demonstrated when the evidence is in conflict or inconclusive. *Entergy Mississippi, Inc.,* 367 NLRB No. 109, slip op. at 2–3 (2019). When there is conflicting testimony on the issue, the Board reasonably "prioritizes the testimony of those witnesses who occupy the alleged supervisory role at the time of the hearing," who denied having that authority. *Avante at Wilson, Inc.*, supra.

Authority to Assign Work

The Board interprets the term "assign" to be "the act of designating an employee to a place (such as a location, department, or wing), appointing an employee to a time (such as a shift or overtime period), or giving significant overall duties, i.e., tasks, to an employee." *Oakwood Healthcare*, 348 NLRB at 689. Ad hoc instructions to perform discrete tasks is not the same as the ability to assign overall duties. Ibid. As with all supervisory authority, the authority to assign must be exercised using independent judgment. The act of assigning does not require independent judgment if it is routine in nature, subject to the control of others, or dictated by detailed instructions. Id. at 693 ("If there is only one obvious and self-evident choice . . . then the assignment is routine or clerical in nature and does not implicate independent judgment.")

Responsibly Direct

In *Oakwood Healthcare,* the Board explained "responsible direction," as follows: "If a person on the shop floor has 'men under him,' and if that person decides 'what job shall be undertaken next or who shall do it,' that person is a supervisor, provided that the direction is both 'responsible . . . and carried out with independent judgment." "Responsible direction," in contrast to "assignment," can involve the delegation of discrete tasks as opposed to overall duties. *Oakwood Healthcare,* above at 691. But, an individual will be found to have the authority to responsibly direct other employees only if the individual is *accountable* for the performance of the tasks by the other employee. Accountability means that the employer has delegated to the putative supervisor the authority to direct the work and to take corrective action if necessary, and the putative supervisor faces the prospect of adverse consequences if the employees under his or her command fail to perform their tasks correctly. *Oakwood Healthcare*, above at 692.

The Board will not find accountability where the evidence shows that the putative supervisors "are accountable for their *own* performance or lack thereof, not the performance of *others*." *Oakwood Healthcare*, 348 NLRB at 695; see also *Entergy Mississippi, Inc.,* 357 NLRB at 2154-2155 (responsible direction not established where the record failed to show that dispatchers were held accountable for "work deficiencies" of the field employees they purportedly supervised).

IV. THE PARTIES' CONTENTIONS

The Petitioner and Employer submitted briefs in support of their positions. The Petitioner argues that the Employer failed to meet its burden to establish any of the Charge Nurses perform supervisory functions with regularity or substantially as required by *Oakwood* and therefore it cannot be established that any individuals who perform Charge Nurse duties are statutory supervisors. The Petitioner further argues that the Employer failed to establish Charge Nurses use independent judgment in assignment of patients to RNs due to their reliance on acuity tools, patient-staffing ratios or established Hospital "staffing guidelines" that were not introduced into the record. Additionally, the Petitioner asserts that RNs serving as Charge Nurses to not responsibly direct RNs as they are not held accountable for RNs work.

The Employer argues in its brief that Charge Nurses qualify as statutory supervisors under the definition set forth in *Oakwood*. In this regard, the Employer asserts that Charge Nurses exercise independent judgment when they evaluate patient acuity and nurse skill sets to assign patients to nurses. The Employer asserts that Charge Nurses have unilateral authority to assign patients to RNs and use independent judgment in making those assignments. The Employer further argues that Charge Nurses responsibly direct RNs because they have authority to staff-up or staff-down. The Employer also argues that the spreadsheet (Employer Exh. 7) is an accurate reflection of the percentage of their time an RN worked as a Charge Nurse, citing as an example NICU RN Taylor Curtis working as a Charge Nurse 98% percent of the time. Regarding the Charge Nurse's authority to responsibly direct, the Employer describes the managers' testimonies of Charge Nurses overseeing the work of others in their units, making certain that their units have sufficient supplies and that the standard of patient care is complied with.

V. ANALYSIS

As more fully discussed below, I make the following determinations. (1) The Employer failed to meet its burden under *Oakwood* to establish that the RNs when serving as Charge Nurse, possess the supervisory indicia to assign work; (2) the Employer failed to meet its burden under *Oakwood* that the RNs when serving as Charge Nurse, possess the supervisory authority to responsibly direct the work of others as the record was clear that they are not held accountable for the actions of other employees; (3) Assuming that the Employer met its burden that the RNs, when serving as Charge Nurses, possess the statutory supervisory indicia to assign or responsibly direct, the Employer failed to meet its burden to show that RNs are rotated into the Charge Nurse role with any regularity or substantiality; and, (4) the record is not clear as to whether NICU Charge Nurse possess the supervisory authority to assign work and serve in the Charge Nurse role with any regularity or substantiality so those employees will vote subject to challenge.

1. Regularity

The Employer failed to demonstrate the RNs performed Charge Nurse duties with any regularity. The record evidence reflects that the units do not use an established pattern or predictable schedule for when and how often RNs work as a Charge Nurse. Witnesses testified that there is no consistent rotation or method for scheduling Charge Nurses and that Charge Nurses are designated for Charge Nurse duties randomly. In several units, RNs indicate their preference to be assigned as Charge Nurse to the Clinicians or Unit Directors assigned to make the schedules. In the operating room, the record indicates that on the night shift there is only one RN assigned as a Charge Nurse and on the daylight shift, the Clinician, a stipulated supervisor, serves as the Charge Nurse. Finally, the Employer's spreadsheet is not a reliable source to indicate the amount of time an RN worked as a Charge Nurse as the data used to create the spreadsheet also used hours worked in other non-supervisory roles such as an anchor or transport or, reflects hours the RN worked at another hospital of the Employer. Accordingly the Employer has not established that any RNs regularly perform Charge Nurse duties.

2. Substantiality

As the Employer has not established any regularity of RNs assigned to Charge Nurse duties it is not necessary to make an evaluation of the "substantiality" factor. *Oakwood Healthcare*, 348 NLRB at 699. The record is not clear how frequently any RN served as a Charge Nurse.[13] Thus, as the Employer did not provide any reliable evidence showing the RNs worked as Charge Nurses for a substantial amount of time I find the Employer did not meet its burden.

3. Authority to Assign

In explaining the definition of independent judgment in relation to the authority to assign, the Board has stated that the authority to effect an assignment must be independent, i.e., free of the control of others, and it must involve a judgment., i.e., forming an opinion or evaluation by discussing and comparing data, and the judgment must involve a degree of discretion that rises above the "routine or clerical." *Croft Metals, Inc*., 348 NLRB at 721. Choosing the order in which an employee will perform "discrete tasks within [the supervisory] assignments" does not demonstrate the authority to assign under Section 2(11). *Oakwood,* 348 NLRB at 689; see also *Frenchtown Acquisition Co. v. NLRB*, 683 F.3d 298 (6th Cir. 2012); *Entergy Mississippi, Inc*., 357 NLRB 2150, 2157 (2011). Assignments that are based on well-known employee skills do not involve independent judgment. *CNN America*, 361 NLRB No. 47, slip op at 22 (2014) (citing *KGW-TV*, 329 NLRB 378, 381–382 (1999)). Similarly, basing an assignment on whether the employee is capable of performing the job does not involve independent judgment. See *WSI*

[13] While the Employer's exhibit 7 purporting to demonstrate the amount of time employees worked as Charge Nurses shows two employees, Beth Boyers and Hailey Maximovich credited with 100% of their hours as a Charge Nurse, testimony confirmed that this spreadsheet is not a reliable source of information, and accordingly there are no permanent Charge Nurses.

Savannah River Site, 363 NLRB at 3 (citing *Volair Contractor*s, *Inc*., 341 NLRB 673, 675 fn. 10 (2004)); *Cook Inlet Tug & Barge, Inc.*, 362 NLRB 1153, 1154 (2015) (citing *Croft Metals,* 348 NLRB at 722). Nor is independent judgment established by the assignment of recurrent and predictable tasks. *Shaw, Inc*., 350 NLRB 354 (2007) (no independent judgment where assigned tasks were recurrent and predictable and involved rotating unskilled and routine duties among available crew to vary work and equalize burdens); *Croft Metals*, 348 NLRB at 721 fn. 14 (citing *Franklin Home Health Agency*, 337 NLRB 826, 831 (2002)). As noted above, assignment of work in a merely routine, clerical, or perfunctory manner, where there is only one self-evident choice, or solely on the basis of equalizing workloads does not require independent judgment. *Oakwood*, 348 NLRB at 693.

There is no record evidence that the Charge Nurses assign RNs to a particular place or time as contemplated by *Oakwood.* It is undisputed that the Charge Nurses are not involved in scheduling. The testimony indicated that Charge Nurses consult with a member of management if they believe that there is a need to up-staff or down-staff and I find that the Employer's arguments in this regard are without merit. Rather, in this case, the role of the Charge Nurse to assign is limited to assigning RNs to specific patients or areas. With regard to assigning significant overall duties to RNs, in *Oakwood Healthcare,* the Board observed that a nurse exercises independent judgement by weighing "the individualized condition and needs of a patient against the skills or training of available nursing personnel." 348 NLRB at 693. However, "[a]ssigning employees according to their known skills is not evidence of independent judgement." Shaw, Inc. 350 NLRB 354, 356, fn. 9 (2007). See also The Arc of South Norfolk, 368 NLRB No 32, slip op. 3 (2019); S.D.I. Operating Partners, L.P., 321 NLRB 111 (1996).

In *Oakwood Healthcare*, the Board determined that charge nurses would "choose personnel for assignments based on judgements as to the particular condition and medical needs of a given patient and the skill sets or specialized training of the available staff." 348 NLRB at 696. The record in that case contained specific testimony that a charge nurse would, for example, select a nurse particularly good at peritoneal dialysis or vasoactive drug monitoring to care for patients who required such treatment. Id. Here, with the exception of the Charge Nurses in the NICU, the record contains little more than vague and conclusory testimony that Charge Nurses match skills with specific needs of the patient, and such evidence is insufficient to establish supervisory status. See *Flow Service Partners Op-Co, LLC d/b/a Perfection Heating, Air Conditioning, and Refrigeration, LLC*, 373 NLRB No. 4 (2023) (vague and general testimony that project manager matched work to be done with the skill set of available employees insufficient to establish supervisory authority, particularly where decisions appear to be based on known skills).

4. NICU

I find that the record is not clear as to whether RNs who serve as Charge Nurses in the NICU are statutory supervisors. Unit Director Bell testified that NICU Charge Nurse's have unilateral discretion to assign patients to RNs based on the RN's nursing skills and to maintain proper RN to patient ratios. While the Charge Nurses use the acuity tool to assist them with making initial patient assignments, the record evidence describes that once the patient is assigned to an RN, the Charge Nurse will reassess the patient assignments throughout the shift. NICU Charge Nurses spend up to two hours a shift adjusting patient assignments based on patient acuity and

available nursing skills. However, the record evidence is not clear on whether the acuity tool is used by the Charge Nurse throughout the shift to make reassignments of work and the role of the Clinician, the RNs supervisor, in patient assignments.

Moreover, Charge Nurses in the NICU apply for the position and are interviewed before being selected to serve in this role. They also are required to obtain a certification for this role but the record is not clear on what this involves. This is contrary to the other units or departments where RNs may simply volunteer to serve as a Charge Nurse and then shadow a Charge Nurse before assuming that role. However, as the Employer failed to establish that any of the NICU RNs performed Charge Nurse duties based on any pattern or regular schedule, I cannot find with certainty that they are supervisors under the Act. Accordingly, I will permit the NICU Charge Nurses who perform this role on a regular and substantial basis, i.e. 10 to 15 percent of their time, to vote subject to challenge as to whether they are statutory supervisors under Section 2(11).

5. All Other Departments

As described in more detail below, the record evidence is insufficient to establish that the Charge Nurses outside of the NICU assign employees to a particular place, time, or significant overall tasks or use independent judgment in making such assignments. Further in the OR, the Clinicians, a stipulated 2(11) position, serve as the Charge Nurse during the daylight shift and make work assignments for the night shift. On the night shift there is only one RN and that person is considered the Charge Nurse and there was not evidence that this person has any supervisory authority.

The Employer's proffered testimony establishes that Charge Nurses make patient assignments based on the RNs' availability and equalizing workload. The Charge Nurses do not schedule RNs but assign RNs to patients. RN Stone testified that RNs are just slotted into blank spaces on the shift assignment sheet. OR Administrative Director Nauer testified that Charge Nurses in the OR make routine decisions. Testimony from several departments confirmed that Charge Nurses make assignments based on acuity which is determined by acuity or workload tool. These tools assign point values to patients based on the patient's acuity and Charge Nurses attempt to equalize the point value across the RNs during a shift. In some departments there is a maximum point value that an RN can be assigned at a time and in others there are patient to RN ratios that must be maintained. *Shaw, Inc.*, 350 NLRB 354, fn. 9 (2007)(assignments based on known skills are routine in nature and do not involve the type of independent judgement required to establish supervisory authority.) As the Charge Nurses use these acuity tools to make RN assignments, I find they do not exercise independent judgement when assigning RNs to patients. The Employer presented conclusory testimony from Barron, and Lavezoli that Charge Nurses take into account specific nursing skills. This lack of specific examples undercuts any finding that Charge Nurses use independent judgement is the assignment of work.

Much testimony was elicited regarding a Charge Nurse's role in the decision to down-staff or up-staff. This testimony established that the Charge Nurses cannot unilaterally make a decision to up-staff or down-staff and those decisions are made by the AOD.

6. Responsible Direction

In *Oakwood Healthcare, Inc*., 348 NLRB 686, 691 (2006), the Board stated that if an individual has employees "under him" and if the individual decides "what job shall be undertaken next or who shall do it," that individual is a supervisor, provided that the direction is both "responsible" and carried out with independent judgment. Under the Board's definition, "for direction to be 'responsible,' the person directing and performing the oversight of the employee must be accountable for the performance of the task by the other, such that some adverse consequence may befall the one providing the oversight if the tasks performed by the employee are not performed properly." Id. at 691–692. The Board held that to establish accountability, "it must be shown that the employer delegated to the putative supervisor the authority to direct the work and the authority to take corrective action, if necessary. It also must be shown that there is a prospect of adverse consequences for the putative supervisor if he/she does not take these steps." Id. at 692. This prospect of adverse consequences "must be a more-than-merely-paper showing that such a prospect exists." *Golden Crest*, 348 NLRB at 731. The Board will not find accountability where the evidence shows that the putative supervisors "are accountable for their *own* performance or lack thereof, not the performance of others." *Oakwood Healthcare*, 348 NLRB at 695; see also *Entergy Mississippi, Inc.,* 357 NLRB at 2154-2155 (responsible direction not established where the record failed to show that dispatchers were held accountable for "work deficiencies" of the field employees they purportedly supervised).

The record evidence clearly establishes that Charge Nurses are not held accountable for the performance of RNs or techs to whom they assign patients. Rather, the record is clear that Charge Nurses are only held accountable for their own mistakes. Charge Nurses are never disciplined or face an adverse consequence based on an RN's or tech's work performance. See *Buchanan Marine, L.P.*, 363 NLRB 523 (2015). I find without merit, the Employer's arguments that the Charge Nurses responsibly direct because they have the authority to staff up or staff down as this involves the assignment of work and is not supported by the record testimony. Accordingly, the Employer has not sustained its burden to demonstrate that Charge Nurses responsibly direct other employees. *See Entergy Mississippi, Inc.*, 357 NLRB 2150, 2154–55 (2011), *enfd. in relevant part* 810 F.3d 287 (5th Cir. 2015).

7. Secondary Indica

Indicia other than those enumerated in Section 2(11) of the Act are secondary indicia. Although secondary indicia may be considered in determining supervisory issues, they are not dispositive. In the absence of one of the enumerated primary indicia, secondary indicia, standing alone, are insufficient to establish supervisory status. *St. Francis Medical Center-West*, 323 NLRB 1046 (1997). Here, the Charge Nurses are paid $1.00 to $1.50 more per hour than RNs when performing Charge Nurse duties, but this secondary indicia alone is insufficient to establish supervisory status.

If Charge Nurses were found to be supervisors, the ratio of supervisors to employees would be unusually top-heavy. Across the Hospital, one in four RNs would be a supervisor and in some units 100% of the RNs would be considered supervisors. See *Airkaman, Inc*., 230 NLRB 924, 926 (1977) (one to three ratio is unrealistic and excessively high); *Beverly California Corporation v.*

NLRB, 970 F.2d 1548, 1555-1556 (6th Cir. 1992) (classifying 25% of nursing home staff as supervisors makes ranks of supervisors "pretty populous"); *NLRB v. Res-Care, Inc.*, 705 F.2d 1461, 1468 (7th Cir. 1983) (33% found to be high).

Finally, there is no position description for a Charge Nurse at the Employer. While the Employer provided position descriptions of other positions, these apply to all RNs who are Professional Staff Nurse Experts on the career ladder. Barron and Bell's testimony that the duties on the job descriptions are also performed by Charge Nurses undermines any argument attempting to distinguish Charge Nurses from RNs.

VI. CONCLUSION

Based upon the record, it is concluded that, with the exception of the NICU Charge Nurses, the evidence is insufficient to establish that the Charge Nurses are supervisors within the meaning of Section 2(11) of the Act and thus they are eligible to vote in the election.

Based on the foregoing, I conclude that the following employees of the Employer constitute a unit appropriate for the purpose of collective bargaining within the meaning of Section 9(b) of the Act:

Included: All full time and regular part time[14] Registered Nurses (RNs) including Staff Nurse, Professional Staff Nurse I, Professional Staff Nurse II, and Professional Staff Nurse Expert employed by UPMC Magee Womens Hospital who work at 300 Halket St., Pittsburgh, PA 15213.

Others Permitted To Vote: At this time, no decision has been made regarding whether the NICU Charge Nurse who works in that role with regularity or substantiality, Lead Lactation Consultant, Lactation Consultant, Expert Lactation Consultant classifications are included in, or excluded from, the bargaining unit, and individuals in those classifications may vote in the election but their ballots shall be challenged since their eligibility has not been resolved. The eligibility or inclusion of these individuals will be resolved, if necessary, following the election.

Excluded: All office clerical employees, managerial employees, confidential employees, directors, Advanced Clinical Education Specialists, Clinicians, Clinical Education Specialists, Clinical Research Coordinators, Women's Health Coordinators, Improvement Specialists, Senior Improvement Specialists, Nurse Educators, OP Nurse Coordinator I and II with direct employee reports, Senior Infection Preventionists, Quality Nurse Coordinator Intermediates, Discharge Plan Managers, Discharge Plan Associates, Discharge Planning Coordinators, Expert Discharge Plan Managers, Senior Discharge Plan Managers, CRNPs, and guards, and supervisors as defined in the Act.

[14] The parties stipulated that casual or irregular part-time employees, which is defined for purposes of this proceeding as an employee working an average of six hours per week or less for the 13-week period immediately before the eligibility date are not eligible to vote in the election regardless of job classification.

VII. DIRECTION OF ELECTION

The National Labor Relations Board will conduct a secret ballot election among the employees in the unit found appropriate above. Employees will vote whether or not they wish to be represented for purposes of collective bargaining by SEIU Healthcare Pennsylvania.

A. Election Details

The election will be held on **Tuesday, August 19, 2025 and Saturday, August 23, 2025** from 6:00 a.m. to 8:30 a.m.; 11:30 a.m. to 12:30 p.m.; 2:00 p.m. to 4:30 p.m.; and 6:00 p.m. to 8:30 p.m. at the Hayashi Auditorium in the Employer's facility at 300 Halket Street, Pittsburgh, PA 15213.

B. Voting Eligibility

Eligible to vote are those in the unit who were employed during the payroll period ending **Saturday, July 26, 2025**, including employees who did not work during that period because they were ill, on vacation, or temporarily laid off. In a mail ballot election, employees are eligible to vote if they are in the unit on both the payroll period ending date and on the date they mail in their ballots to the Board's designated office.

Employees engaged in an economic strike, who have retained their status as strikers and who have not been permanently replaced, are also eligible to vote. In addition, in an economic strike that commenced less than 12 months before the election date, employees engaged in such strike who have retained their status as strikers but who have been permanently replaced, as well as their replacements, are eligible to vote. Unit employees in the military services of the United States may vote if they appear in person at the polls.

Ineligible to vote are (1) employees who have quit or been discharged for cause since the designated payroll period, and, in a mail ballot election, before they mail in their ballots to the Board's designated office; (2) striking employees who have been discharged for cause since the strike began and who have not been rehired or reinstated before the election date; and (3) employees who are engaged in an economic strike that began more than 12 months before the election date and who have been permanently replaced.

C. Voter List

As required by Section 102.67(l) of the Board's Rules and Regulations, the Employer must provide the Regional Director and parties named in this decision a list of the full names (that employees use at work), work locations, shifts, job classifications, and contact information (including home addresses, available personal email addresses, and available home and personal cell telephone numbers) of all eligible voters.

To be timely filed and served, the list must be *received* by the regional director and the parties by **August 5, 2025.** The list must be accompanied by a certificate of service showing service on all parties. **The region will no longer serve the voter list.**

Unless the Employer certifies that it does not possess the capacity to produce the list in the required form, the list must be provided in a table in a Microsoft Word file (.doc or docx) or a file that is compatible with Microsoft Word (.doc or docx). The first column of the list must begin with each employee's last name and the list must be alphabetized (overall or by department) by last name. Because the list will be used during the election, the font size of the list must be the equivalent of Times New Roman 10 or larger. That font does not need to be used but the font must be that size or larger. A sample, optional form for the list is provided on the NLRB website at www.nlrb.gov/what-we-do/conduct-elections/representation-case-rules-effective-april-14-2015.

When feasible, the list shall be filed electronically with the Region and served electronically on the other parties named in this decision. The list may be electronically filed with the Region by using the E-filing system on the Agency's website at www.nlrb.gov. Once the website is accessed, click on **E-File Documents**, enter the NLRB Case Number, and follow the detailed instructions.

Failure to comply with the above requirements will be grounds for setting aside the election whenever proper and timely objections are filed. However, the Employer may not object to the failure to file or serve the list within the specified time or in the proper format if it is responsible for the failure.

No party shall use the voter list for purposes other than the representation proceeding, Board proceedings arising from it, and related matters.

D. Posting of Notices of Election

Pursuant to Section 102.67(k) of the Board's Rules, the Employer must post copies of the Notice of Election, which will issue on a date after the issuance of this Decision, in conspicuous places, including all places where notices to employees in the unit found appropriate are customarily posted. The Notice must be posted so all pages of the Notice are simultaneously visible. In addition, if the Employer customarily communicates electronically with some or all of the employees in the unit found appropriate, the Employer must also distribute the Notice of Election electronically to those employees. The Employer must post copies of the Notice at least 3 full working days prior to 12:01 a.m. of the day of the election and copies must remain posted until the end of the election. For purposes of posting, working day means an entire 24-hour period excluding Saturdays, Sundays, and holidays. However, a party shall be estopped from objecting to the nonposting of notices if it is responsible for the nonposting, and likewise shall be estopped from objecting to the nondistribution of notices if it is responsible for the nondistribution. Failure to follow the posting requirements set forth above will be grounds for setting aside the election if proper and timely objections are filed.

VIII. RIGHT TO REQUEST REVIEW

Pursuant to Section 102.67 of the Board's Rules and Regulations, a request for review may be filed with the Board at any time following the issuance of this Decision until 10 business days after a final disposition of the proceeding by the Regional Director. Accordingly, a party is not precluded from filing a request for review of this decision after the election on the grounds that it did not file a request for review of this Decision prior to the election. The request for review must conform to the requirements of Section 102.67 of the Board's Rules and Regulations.

A request for review must be E-Filed through the Agency's website and may not be filed by facsimile. To E-File the request for review, go to www.nlrb.gov, select E-File Documents, enter the NLRB Case Number, and follow the detailed instructions. If not E-Filed, the request for review should be addressed to the Executive Secretary, National Labor Relations Board, 1015 Half Street SE, Washington, DC 20570-0001, and must be accompanied by a statement explaining the circumstances concerning not having access to the Agency's E-Filing system or why filing electronically would impose an undue burden. A party filing a request for review must serve a copy of the request on the other parties and file a copy with the Regional Director. A certificate of service must be filed with the Board together with the request for review. Neither the filing of a request for review nor the Board's granting a request for review will stay the election in this matter unless specifically ordered by the Board.

Dated: August 1, 2025

/s/ Nancy Wilson

NANCY WILSON
REGIONAL DIRECTOR
NATIONAL LABOR RELATIONS BOARD
REGION 06
1000 Liberty Ave Rm 904
Pittsburgh, PA 15222-4111