IN THE COURT OF COMMON PLEAS
OF CUYAHOGA COUNTY, OHIO
- - - - -
CHRISTOPHER S. LONG, etc.
Plaintiffs,
vs Case No. 321518
CLEVELAND CLINIC FOUNDATION,
Defendant.
- - - - -
DEPOSITION OF MARY ANNE BELANGER, R.N.
WEDNESDAY, APRIL 24, 2002
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Deposition of MARY ANNE BELANGER, R.N., a Witness herein, called by counsel on behalf of the Plaintiff for examination under the statute, taken before me, Vivian L. Gordon, a Registered Diplomate Reporter and Notary Public in and for the State of Ohio, pursuant to agreement of counsel, at the offices of Roetzel & Andress, One Cleveland Center, Cleveland, Ohio, commencing at 2:30 o'clock p.m. on the day and date above set forth.

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APPEARANCES:

On behalf of the Plaintiff

Becker & Mishkind

JEANNE M. TOSTI, ESQ.

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Cleveland, Ohio 44113

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On behalf of the Defendant

Roetzel & Andress

JOHN V. JACKSON, II, ESQ.

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MR. JACKSON: Ms. Belanger was asked to bring with her her entire file relative to this case, and she has done that, including correspondence between our office and her.

In the past in dealing with Ms. Tosti's office, they have taken the position on occasion that any correspondence between counsel and experts is not discoverable, although that correspondence is a part of any expert's file.

Ms. Tosti has been provided the correspondence that Ms. Belanger had in her file and Ms. Tosti has requested copies of those documents, which I will provide for her.

I just wanted to make a record that they were requested and provided, and I assume that in the future if they believe that they are entitled to discover these, that they can't take the argument on one side that they are entitled to them and on the other side that we are not. So I just wanted to put that on the record.

MS. TOSTI: 1 also would like to respond to what Mr. Jackson has said. He has exerted no attorney work product privilege in regard to these documents. These documents were contained in the witness' file, and as such, I

had asked for a copy of it. And as to what we may assert in regard to future depositions, I would reserve any right to object to the production of correspondence based on an attorney work product privilege.

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MARY ANNE BELANGER, R.N., a witness herein, called for examination, as provided by the Ohio Rules of Civil Procedure, being by me first duly sworn, as hereinafter certified, was deposed and said as follows:

EXAMINATION OF MARY ANNE BELANGER, R.N.

BY MS. TOSTI:

Q. Would you please state your full name for me.

A. Mary Anne Belanger.

Q. And your business address.

A. 115 West Liberty Street, Wooster, 44691.

Q. Have you ever had your deposition taken before?

A. Yes.

Q. How many times?

A. Perhaps six to eight times.

Q. I'm sure that defense counsel has had

an opportunity to speak with you. I'm just going to go over a few of the ground rules.

This is a question and answer session. It's under oath. It's important that you understand my questions. If you don't understand my questions, let me know and I'll be happy to rephrase the question or to repeat the question. Otherwise I'm going to assume you understood my question and that you are able to answer it,

If at any point in time you would like to refer to the medical records that have been provided to you by defense counsel, please feel free to do so. It's important that you give all of your answers verbally, because our court reporter can't take down head nods or hand motions.

At some point Mr. Jackson may choose to enter an objection for the record. You are still required to answer my questions, unless he feels he has grounds to instruct you not to.

Do you understand those directions?

A. Yes.

Q. The file that *is* on the table before you, is that your entire file on this case?

A. Yes.
Q. Has anything been removed from your file?
A. No.
Q. And is there anything that you did not bring with you today that you reviewed and considered in connection with this case?
A. No.
Q. I would like you to tell me a little bit about your experience in medical/legal matters. When is the first time that you offered your service as an expert nursing consultant in a medical negligence case?
A. I started doing nurse consulting in 1997, August.
Q. How did you happen to become a legal nurse consultant?
A. I decided that this is what I wanted to do. I looked into what I needed to do to pursue this goal and kind of took it upon myself and did it.
Q. And what did you find you needed to do to be a legal nurse consultant?
A. I found that you had to have experience in a particular field that the legal

people would want so that I could be used as an expert in medical malpractice suits. I felt because I had the experience that I did, that I would have a good background to get into the field.

Q. How many medical/legal matters have you consulted on?

A. I just counted that last night anticipating that question. In the past three years I have done 28 cases. Actually, it's since '97, so almost five years.

Q. And how many of those have been in the last year?

A. Perhaps three. And that's a guesstimate.

Q. And what proportion of the medical/legal matters on which you consulted have been for plaintiff and what proportion have been for defendant?

A. A third has been for plaintiff and two-thirds has been defense.

Q. In the cases that you have consulted on for plaintiff, what percentage of those cases have you found that there was substandard care?

A. Oh, boy. Actually a small percent.

Q. Can you give me a reasonable approximation?
A. Maybe ten percent of them.
Q. How many times have you had your deposition taken as an expert in a medical/legal matter?
MR. JACKSON: You asked that before.
A. Six to eight times.
MS. TOSTI: I think I asked how many times you had served as a -- you are correct, I did.
Q. Have you testified at trial before?
A. No.
Q. Have you ever acted an as an expert in a case involving issues of postoperative bleeding?
A. No.
Q. Cardiac tamponade?
A. No.
Q. Any involving issues dealing with complications following aortic valve surgery?
A. No.
Q. What is your charge for consultation on medical/legal matters?
A. To review the records, I charge $80

an hour. For a deposition it's $95.
Q. Is the same for your trial testimony?
A. Trial is $110.
Q. Have you ever provided your name to a professional service or medical/legal consulting firm indicating that you were available to do medical/legal consultations?
A. No.
Q. Other than this case, have you ever been consulted on a medical/legal matter by Mr. Jackson or his law firm?
A. I have worked for Roetzel & Andress in Akron, but this is my first experience with the Cleveland office.
Q. How many times have you worked with Roetzel & Andress in Akron?
A. I'm not sure I can give you --
Q. Approximately.
A. Maybe 12 or 15 times.
Q. Do you know how it is that you came to be contacted in this case?
A. My understanding is that it was through their office in Akron.
Q. Do you know when you were first contacted in regard to this case?

A. I would have to look at the first correspondence. I want to say it's almost a year ago. June of 2001. Actually, it probably was before that, because that's -- it's easily a year ago.

Q. Have you ever been named as a defendant in a medical negligence case?

A. No.

Q. Do you know when this case is set for trial?

A. My understanding is the end of June.

Q. And have you been asked to come to Cleveland to provide testimony in this matter in June?

A. I was told when the date was and I haven't had a formal invitation to come.

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(Thereupon, BELANGER Deposition Exhibit 1 was marked for purposes of identification.)

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Q. I'm going to hand you what's been identified as Plaintiff's Exhibit 1. I'm going to ask you if you just would identify what that document is for me.

A. This is my most recent CV.
Q. Is it current and up to date?
A. Yes.
Q. Any additions or corrections that you would like to make to it?
A. No.
Q. Where did you complete your basic nurses training?
A. St. Joseph's Hospital in Syracuse, New York.
Q. How long was that program?
A. Three year program.
Q. And what year did you complete your basic nursing program?
A. 1967.
Q. Were you awarded any type of an academic degree, such as an associate degree, bachelor's degree?
A. No.
Q. You have to wait until I finish my question and then answer, because she will have difficulty taking us both down.
A. Sorry.
Q. Since completing your diploma nursing program, have you completed any academic degree

programs in nursing?
A. No.
Q. Do you have any other academic degrees?
A. No.
Q. Do you hold any academic appointments with a college or a university?
A. No.
Q. Now, I see on your CV that you attended -- I don't know if I will pronounce this correctly -- LeMoyne College.
A. Yes.
Q. When did you attend there?
A. You did it at the same time that you were going through St. Joe's.
Q. So some of your sciences and that were taken at the college?
A. Yes. Our whole first year was at the college.
Q. And that was part of your diploma school program; is that correct?
A. Yes.
Q. And that the clinical component was then done at the hospital?
A. Yes.

Q. I also see that you went to University College in Syracuse, New York.
A. Yes.
Q. When did you attend there?
A. After I graduated from St. Joe's, so it probably would have been 1968 or '69.
Q. And the course work that you took, was it in relation to any particular subject matter?
A. Yes.
Q. What area?
A. English.
Q. Mercy College, I see that you attended there. When did you attend there?
A. The early 1970s.
Q. And the course work that you took there, was that in relation to any particular subject?
A. Yes.
Q. What?
A. English.
Q. Now, do you hold a professional nursing license?
A. Yes, I do.
Q. What state or states?

A. The State of Ohio.
Q. When did you receive that?
A. 1981 or '82 when we moved here.
Q. Did you pass your nursing boards on the first attempt?
A. Yes, I did.
Q. Has your nursing license ever been suspended, revoked or called into question?
A. No.
Q. Now, you hold several professional certifications. Would you tell me what certifications you hold?
A. I'm certified in emergency nursing. I also hold an advanced cardiac life support affiliation and I have a pediatric component of that also. I'm also a sexual assault nurse examiner.
Q. When did you receive your certification as an emergency nurse?
A. I renewed it four times and it's a four year period, so -- and I just renewed it. So probably back 12, 14, 15 years ago.
Q. The recertification process, what do you have to do in order to be recertified?
A. It's an exam.

Q. Is there any clinical component required as far as the recertification?

A. Yes. You are required to have so many hours in the clinical field before you can sit for the exam.

Q. And you have to do that each certification period?

A. That's correct.

Q. Tell me what a sexual assault examiner is.

A. A sexual assault nursing examiner is a person who has been trained in forensics, who does a medical forensic exam on sexual assault victims.

Q. Did you complete any type of program or course work in order to obtain that certification?

A. Yes.

Q. How long was that?

A. I attended a 40 hour session on it in Fort Wayne, Indiana and I had to go into my own county and do 60 hours of preceptorship and an additional 200 forensic CEU's.

Q. When did you receive your certification?

A. January of '99.
Q. Do you currently utilize your certification in this area in your current clinical practice?
A. Yes. I'm the coordinator of the program at our hospital and in our county, actually.
Q. Who is your current employer?
A. The Prosecutor of Wayne County.
Q. When did you first become employed there?
A. November 1st of 2001.
Q. What are your duties and responsibilities with the prosecutor?
A. I am director of his county program, Victim Witness Assistance, which is a program that deals with victims of all crimes, and we act as a liaison, if you will, between the victim and the judicial system. I have five advocates under me.
Q. Are you doing any type of hospital practice at this time?
A. Sexual assault practice.
Q. And what do you do in regard to your sexual assault practice?

A. I'm the coordinator of the program, so I take my share of on-call time, which at the present time is about 50 percent of the time per month, because we are down to two. I also do four hours a week in the office, and then obviously any cases that I would be called in on.

Q. How many hours a week, approximately, do you spend in the clinical area?

A. It would depend on the week. Because the only time I'm in the clinical area is when there is a victim, and we average a victim about once every two weeks.

Q. And when you are there with a victim, can you approximate how much time you are usually in the hospital?

A. The exam takes anywhere from four to six hours, depending on the case.

Q. And so these exams would be normally conducted in a hospital setting?

A. I'm not sure I understand your term normally.

Q. Is that the site where you would usually conduct your examination in a hospital setting?

A. That is the site where I always conduct it.

Q. Now, I see that you were also employed at Wooster Community Hospital; is that correct?

A. That's correct.

Q. What was your term of employment with Wooster Community Hospital?

A. In years?

Q. When did you start and when did you end your employment there?

A. I was there for 18 years. I started in 1982 and I left in November from the emergency room.

Q. How large a hospital -- and by that I mean, approximately how many beds does Wooster Community Hospital have?

A. 100.

Q. The last title and position that you had with Wooster, what was it?

A. Staff nurse.

Q. And in what area were you working as a staff nurse?

A. Emergency department.

Q. How long a term were you in the

emergency department? When did you start?
A. I started in the beginning when I came to Wooster Hospital. I went between CCU, ICU and ER, and then I went full time in the ER in 1969.
Q. Did you remain full time in the emergency room from 1969 until you ended your employment at Wooster Community Hospital?
A. I was full time up until a year before I left and I went to two, 12's a week.
Q. Still in the emergency department though?
A. Yes.
Q. Were you ever a full-time staff person in the intensive care unit at Wooster?
A. At Wooster, no.
Q. When you were working at Wooster, were you working 40 hours a week up until that last year when you were doing two, 12 hour sessions?
A. We did three, 12's, so it was 36.
Q. But prior to that, were you full time 40 hours a week?
A. Full time is 36 hours.
Q. Tell me what the difference was in

your employment before you went on the three, 12 hour shifts. What did you do before that period of time?

A. I'm not sure I understand your question.

Q. You said that a year before you left Wooster, you went to three, 12 hour shifts.

A. No.

Q. Well, then I misunderstood what you said. Would you please tell me again what your work schedule was at Wooster.

A. My full time that we started out with was actually five, 8's a week, 40 hours. The hospital then went to 12 hour shifts and I worked three, 12's, up until a year ago when I worked two, 12's.

Q. Were all the nursing staff doing 12 hour shifts when they made the switch?

A. No.

Q. Just a portion of the staff?

A. Yes.

Q. Do you currently provide any professional services for anyone besides the Wayne County Prosecutor's Office? Anyone else at this time that you provide professional

services for?

A. Do you mean am I employed by anyone else?

Q. Well, let's start with that. Do you have employment with anyone besides the Wayne County Prosecutor's Office?

A. Other than my sexual assault position at the hospital, no.

Q. Is that an employed position at the hospital where you receive some type of remuneration?

A. Yes.

Q. What percentage of your income is from the hospital?

A. You want an exact percentage?

Q. I'm asking for an approximation, just so I have an idea as to how you divide your professional time.

MR. JACKSON: Why don't you tell her what percentage of your time is spent at the hospital rather than your income then.

A. I spend a minimum of four hours a week at the hospital.

Q. How much time do you spend with Wayne County Prosecutor's Office responsibilities?

A. Forty hours a week.
Q. So the last time that you worked as an emergency room nurse or as a hospital staff person was in November of 2000; is that correct?
A. 2001.
Q. 2001, okay. When you worked in the emergency room, did you work a particular shift?
A. Yes.
Q. Which shift did you work?
A. 7-A to 7-P.
Q. And during the last year that you worked in the emergency room, you were working two, 12 hour shifts a week; is that correct?
A. Yes.
Q. How many nurses normally would staff the emergency room on the shift that you worked?
A. Do you want to know how many are supposed to or how many did you have?
Q. How many did you have?
A. From 7-A until 9:30 there would be two RNs. From 9:30 until 11:00 there would be three. At 11:00 we have another one. That would be the number until we got to 7:00 p.m.
Q. How many physicians routinely staff the emergency room during the time that you were

there?

A. One physician and one PA.

Q. Now, your curriculum vitae also mentions that you worked in the coronary care department at Wooster. Were you working in a critical care coronary care area?

A. Yes.

Q. What were your duties and responsibilities in that unit?

A. I worked both as a staff nurse and a charge nurse, so depending on shift, either I was doing hands-on patient care where that was my only responsibility, or if I was in charge, I also had to handle the administrative aspect of the shift.

Q. And when did you work in the coronary care area?

A. When I first went to Wooster Hospital until I went full time in the emergency room, so it would have been from, whatever the years, up until I went full time I think I said 19 -- when did I tell you?

Q. I believe you said something like 1969.

A. '69, yes.

Q. 1969?
A. Went full time in just the emergency room.
Q. Into the emergency room. And so prior to that, how long were you working in the coronary care unit?
A. I rotated between the three units from the time I got to the Wooster Hospital, which was 1983 or wherever, until I left for the ER in 1969. Sorry. '89, I'm sorry.
Q. Let's back up here.
When did you first start at Wooster Hospital?
A. 1983 or '84.
Q. And then from 1983 or '84, until 1989, you were rotating through the emergency room, the coronary care unit --
A. And ICU.
Q. -- and ICU?
A. Yes.
Q. And then in 1989, you then went to the emergency room and were a full-time staff person in the emergency room?
A. That's correct.
Q. So does Wooster Hospital have a

separate coronary care unit from their intensive care unit?

A. They did at that time.

Q. How many beds was it?

A. The intensive care or the coronary care?

Q. The coronary care.

A. The coronary care had eight.

Q. How many in the intensive care?

A. Ten.

Q. And since that time, have they done something else rather than have two independent units?

A. They have combined the two units.

Q. How many beds is it currently?

A. Ten.

Q. And the last time you would have worked as a staff nurse in the intensive care unit or coronary care unit was 1989; correct?

A. Sometime before 1989, yes.

Q. The last time that you worked in the intensive care unit also would have been 1989?

A. Yes, because I rotated between the three units.

Q. In the time that you worked in the

intensive care unit or the coronary care unit at any point in time, were you caring for immediate post-op patients?

A. No.

Q. Did those patients go to a recovery room?

A. Wooster Hospital doesn't do cardiac surgery.

Q. Well, my question was, postoperative patients. Did the ICU get just postoperative patients from whatever surgery Wooster Hospital does?

A. Only on an overflow on weekends.

Q. So it wasn't routine for them to come directly to the ICU or the coronary care unit after surgery?

A. No.

Q. Now, you have indicated that Wooster Hospital doesn't do cardiothoracic surgery; correct?

A. That's correct.

Q. Do they do thoracic surgery?

A. Yes.

Q. Do they have thoracic surgeons on staff there?

A. Yes.
Q. Can you tell me the name of any of them?
A. Yes. Dr. Stern and Dr. Dick Davis.
Q. And at the time that you were working in the ICU or the coronary care, did you have an opportunity to care for immediate post-op patients that had undergone thoracic surgery?
A. Probably not, because neither of those physicians were there at that time.
Q. Since the time that you started at Wooster Hospital, which was around 1983 or '84, did you ever have an opportunity to care for any immediate post-op thoracic or cardiothoracic patients?
A. No.
Q. In any environment?
A. No.
Q. Does your absence of experience in regard to postoperative care of thoracic or cardiothoracic patients limit your opinions in this case in any way?
A. I don't feel that they do.
Q. Why do you believe you're qualified to render opinions regarding the standard of

nursing care for cardiothoracic surgery intensive care nurses in this case?

A. I feel that taking care of critical care patients is pretty much the same across the board. The standard is the same. In my experience I have taken care of patients with chest tubes. I have taken care of patients that had the same medications that this patient in the case did. I feel that the principles are the same in critical care nursing whether in a fresh post-op unit or in a trauma room in an ER.

Q. When is the last time that you have cared for an immediate postoperative patient?

A. A long time.

Q. Approximately.

A. When I went into the ER.

Q. 1989?

A. So before that, yes.

Q. Do you believe that the standard of care for nursing practice has remained the same since 1989 for patients that have undergone surgery?

A. I think the surgery that is being done to the patient has dramatically changed, but I feel the standard of care with any prudent

nurses keeping up with the changes in the field, I think that would be the same.

Q. Tell me how you have kept up with the changes in the field in regard to immediate postoperative care.

A. I have not. Because that was not my field. What I have kept up with is the field with which I work, and I work with critical care patients. So I have kept up with the changes given to a critical care patient.

Q. You said that you work with patients in an emergency room setting; correct?

A. That's correct.

Q. Critical care from a nursing perspective usually has a different connotation, wouldn't you agree?

A. Having worked in CCU, ICU and ER, I think all three of those fields are critical care nursing. If you mean to dub someone a critical care nurse because she works in a critical care unit, of course then there would be a difference geographically, but I think the same standards or the same assessment skills really don't vary between those three units.

Q. Do you routinely have patients on

ventilators in the emergency room?

A. Routinely is a word that isn't synonymous with ER, but we have patients in the ER on ventilators.

Q. Not routinely?

A. No.

Q. Do you routinely have patients in the emergency room receiving hemodynamic monitoring?

A. No.

Q. You have one publication on your curriculum vitae. Does this publication have any inference as to your opinions in this case?

A. No.

Q. Do you have any publications that are not listed on your curriculum vitae?

A. No.

Q. Have you ever lectured on or taught on the subject matter of postoperative bleeding complications?

A. No.

Q. How about on cardiac tamponade?

A. No.

Q. Hemodynamic monitoring?

A. No.

Q. Are you proficient in hemodynamic

monitoring?

A. No.

Q. Have you ever received any type of training in hemodynamic monitoring?

A. We had an in-service many years ago when they were going to start using balloon pumps at the hospital and they wanted ER nurses to go through it and we went through a minimal training in balloon pumps. That's all I can profess to.

Q. Have you ever been responsible for doing hemodynamic monitoring assessments on patients?

A. Using invasive hemodynamic monitors?

Q. Yes.

A. No.

Q. Now, your report, I believe, indicates a number of materials that you reviewed in this case, and I had an opportunity to look through the pile that you have in front of you. Is this a comprehensive list as far as you know?

A. Yes.

Q. As to all the materials that you looked at?

A. Yes.
Q. Have you since the time of rendering your report received any additional materials?
A. I just received the most recent one.
Q. Perhaps the deposition of Mary Jane Smith?
A. Is that not on that?
MR. JACKSON: It's in the correspondence, Jeanne. You can see in the correspondence.
MS. TOSTI: I'm just asking if she knows, because I didn't go through and check the two.
MR. JACKSON: There are additional things listed in the correspondence.
Q. Have all of the materials that you have been provided in regard to the depositions -- have you read all the depositions?
A. Yes.
Q. And have you had an opportunity to read the deposition of the plaintiff's expert, Mary Jane Smith?
A. Yes.
Q. And you also have a copy of her report, I believe, in your file; is that

correct?

A. Yes.

Q. Now, you were given certain portions of The Cleveland Clinic records, and from what I can see in reviewing your file, it appears that you were given the first several days of that admission. The aortic valve surgery admission to Cleveland Clinic, you were given the first several days records from that admission?

A. 8-20 through 9-13.

Q. Obviously, you don't have a complete record through September 19th. I would imagine the records that you have in front of you are about three-quarters of an inch thick. If that was a complete record from August 20th through September 19th, I would imagine that they would considerably more voluminous than that. From what I can see in the nursing records as well as the doctor's orders, it appears that you have about three days worth of records?

A. Well, I was reading what was on the front of the book.

Q. Well, I'm asking what you actually reviewed.

A. I reviewed from 8-20 through 8-23.

Q. So that's about three days worth. You have not seen any records after James Long's discharge from Cleveland Clinic; correct?

A. No.

Q. And you have not, at least from what I have reviewed, seen any of the depositions of any of the lay witnesses in this case, have you?

A. No.

Q. At any time when you were reviewing this case, did you ever request from defense counsel that they send you some additional materials?

A. No.

Q. And in formulating your opinions in this case, did you refer to any journal articles, medical literature, textbooks?

A. No.

Q. And as you sit here today, are there any publications that you believe have particular relevance to the issues in this case as you understand them?

A. No.

Q. At any time after you received this case for review, did you consult with any physicians or any nurses?

A. No.
Q. Have you ever met or had any contact with any of the health care providers that are identified in James Long's medical records?
A. No.
Q. Have you had any contact with any of the experts that have been identified in this case, either for plaintiff or for defense?
A. No.
Q. Have you ever had any professional affiliations with The Cleveland Clinic Foundation?
A. No.
Q. Have you ever visited their main campus in Cleveland?
A. I have been to The Cleveland Clinic Foundation for a seminar.
Q. And you have never worked or provided services for any of The Cleveland Clinic's affiliates?
A. No.
Q. Have you generated any personal notes in this case?
A. No.
Q. Do you have an opinion as to whether

a registered nurse should have practical experience as a nurse before becoming a staff nurse in intensive care cardiothoracic surgical intensive care?

A. I'm sorry. Repeat that.

Q. It wasn't worded very well.

I said, do you have an opinion as to whether a registered nurse should have practical experience before becoming a staff nurse in a cardiothoracic surgical intensive care unit?

MR. JACKSON: Objection.

A. Yes, I do have an opinion.

Q. What is your opinion?

A. In my experience, I have found that if a nurse has practical experience that is more general before she goes into any of the critical areas, that it is more beneficial for her.

Q. And in your experience, is it common to put inexperienced new nursing graduates in a cardiothoracic surgical intensive care unit?

MR. JACKSON: Objection. Go ahead.

A. I have really not worked in cardiothoracic surgical intensive care, so I wouldn't be able to answer that question for you.

Q. Do you currently participate in the training of any nurses who work in the intensive care unit?
A. In the intensive care unit?
Q. Yes.
A. No.
Q. Do you currently participate in training of nurses in some other area?
A. Yes.
Q. What areas is that?
A. Sexual assault.
Q. Do you provide classroom instruction or are you direct as a clinical preceptor?
A. Both.
Q. Have you ever worked as a preceptor for a registered nurse who is new to an intensive care unit setting?
A. Yes.
Q. When did you do that?
A. When I was working in Syracuse, New York, I was a head nurse in intensive care and I was part of the orientation program for new people who came through.
Q. And what year was that?
A. I was afraid you were going to ask me

that. When I graduated from school in '67 I worked in intensive care at Straum Memorial Hospital until probably '69.

I came back to the burn unit and worked there a year and then went to Straum Memorial Hospital and worked until 1970 in the intensive care unit as a head nurse. Then I moved to New York near the City of New York and worked in an intensive care unit there where I was part of the orientation program.

Q. What is the purpose of having a preceptor oversee a nurse trainee's work?

A. What would be the purpose of having a preceptor?

Q. Yes.

A. That you would be able to guide this new person in the field in which you are teaching her, making sure that she is doing the correct thing and that you can share your experience with her.

Q. And how is it determined when a nurse has the appropriate technical skills, assessment skills, expertise, to provide nursing care independently in an ICU setting?

A. I would think that would depend on

the ICU. Anyone that I have been familiar with has set up parameters as a generality; that in this many weeks you will be ready to go. But that is definitely a generality. And what I have found in my experience is if at the end of that time period the nurse does not feel comfortable in taking that step, then the orientation is extended.

Q. Why do nurses write nurse's notes, record assessments, document observations in patient's hospital medical records?

A. So they can at a later date tell what happened at that time.

Q. Would you agree that documentation of assessments and care are a very important nursing function?

A. Yes,

Q. And isn't it true that one important reason that nurses record observations and assessments in care is so that caregivers can look back and see if there is any changes that may indicate a problem is developing?

A. Well, documentation in itself is a running tally of what is going on, so anyone who would be looking back on it would be able to see

a sequence of events, yes.

Q. So one of the objectives is to be able to look back to see if there is any type of a trend or any type of indicators of a change that's occurring in a patient; correct?

A. Well, documentation is putting down numbers, so, yes, you would be able to look at it retrospectively and see a trend.

Q. It's not just putting down numbers, there is also narrative notes that nurses write; correct?

A. That's correct.

Q. And would you agree that when routine assessments go uncharted or incomplete, that there is a risk that it may delay the recognition of a problem in a patient?

MR. JACKSON: Objection. Go ahead.

A. You know, I live in the real world and I would love to say to you that if I haven't documented it I haven't done it, but I know better than that; therefore, I guess I would have to answer your question if the patient is in need of my attention at that time, giving nursing care, probably that's where my priority is going to be and perhaps my documentation

isn't going to be done at that specific time.
Q Well, I don't think that you have addressed the question that I asked.
A Then please reask the question.
MS. TOSTI: Would you read my question back.
(Record read.)
MS. GORDON: QUESTION: And would you agree that when routine assessments go uncharted or incomplete, that there is a risk that it may delay the recognition of a problem in a patient?
MR. JACKSON: Same objection.
A So you are asking me that if in an assessment situation if I am not writing it down that there is a risk?
Q. Yes.
A That it won't be there for future reference?
Q. Yes.
A. Yes.
Q Have you utilized ICU flowsheets for charting?
A. Yes.
Q Would you tell me what a flowsheet is.

A. It's a piece of paper, in most cases it's a fold out piece of paper, sometimes it's a flipping type situation where you are able to see the whole picture of a day, usually it's a 24 hour period, and everything that would be pertinent to that patient is on that sheet of paper.

Q. And would you agree that flowsheets are specifically designed so that values such as blood pressures, temperatures, urine outputs, hemodynamic values, et cetera, can be recorded in a series and evaluated for any trends that may indicate a change in the patient's condition?

A. Yes, just by the nature of the flowsheet.

Q. And have you on occasion when you have worked at an ICU utilizing flowsheets identified trends that you have recorded that later turned out to be indicative of a problem that a patient was developing?

A. You mean as I look at something retrospectively?

Q. I'm asking in your experience, have you ever recorded a series of evaluations on the

patient on an ICU flowsheet and then have identified a trend that later turned out to be a developing problem for a patient?

A. Yes.

Q. And would you agree that an intensive care nurse caring for a patient in the immediate postoperative period has a duty to watch for trends in their assessments that may indicate early signs of complications?

A. Yes.

Q. In fact, because the nurses are with the postoperative patients constantly and the surgeons are not, the surgeons rely on the nurses to keep them informed of any trends that may indicate a significant change in the patient's condition; correct?

A. Yes.

Q. Does the position of staff nurse in a cardiothoracic surgical intensive care require any specialized training beyond that of a primary nursing program?

A. I would hope that it would.

Q. Do you know if it does or not?

A. I have not worked there, so I don't know that that would be a specific.

Q. So do you know of any specialized nursing skills that are required to work in a cardiothoracic surgical intensive care unit?

A. I would feel that they would have to know hemodynamic monitoring. I would feel they would have to know specific medications that these patients would be on. Yes, I feel there are.

Q. And do you know whether nurses trained in hemodynamic monitoring are taught to recognize abnormal parameters and to recognize significant trends in those parameters?

A. Yes, that would be part of the training, I would feel.

Q. And to recognize trends, it requires that the nurses record the hemodynamic values in a series to determine if they are going up, going down, or staying the same; correct?

A. Correct.

Q. Now, in your opinion, what are the duties and the responsibilities of a cardiothoracic ICU nurse caring for an aortic valve replacement patient in the immediate postoperative period?

A. Never having done that, I would have

to make this a generalization and I would have to say it would be assessing frequently this patient, acting upon those assessments with interventions, and then based on the interventions, whether they worked or not to continue your care.

Q. And do you know or do you have an opinion what the most important nursing assessments would be for a patient with an aortic valve replacement in the immediate postoperative period?

A. I don't know that you could single anything out as the most important. I think you are looking at this whole patient as a totality and you are looking at all of the pieces and parts of the puzzle. So I would think if I had to tell you the most important thing, I would think it would be to be able to assess this patient correctly and then act upon that assessment.

Q. Can you tell me what the nurses' responsibilities are regarding hemodynamic monitoring in a cardiothoracic surgical intensive care for a patient that has undergone aortic valve replacement?

A. What the responsibilities would be?
Q. Yes. Regarding the hemodynamic monitoring.
A. I would assume that they would have to be monitoring this in a timely manner, recording those and then acting upon their findings and correlating at all times the findings that they have with the patient that they are looking at.
Q. Would you agree that a nurse in that environment should be trained to watch postoperative patients for signs and symptoms of excessive bleeding?
A. Yes.
Q. And what would be the signs or the trends that would raise a suspicion that a postoperative aortic valve replacement patient may be having excessive bleeding?
A. Well, I think any patient having excessive bleeding, there would be some red flags, and among those flags I would consider increase in their pulse, decrease in their blood pressure, decrease in sensorium.
Q. Anything else?
A. I'm sure there are, but that's what

comes to mind right now.

Q. How about increased chest tube drainage?

A. Would that be a sign of loss of volume?

Q. Excessive bleeding.

A. If I am seeing a large amount of bloody drainage come from a chest tube, certainly.

Q. How about a drop in a hematocrit?

A. Just a single drop?

Q. A progressive drop in the hematocrit.

A. To look at a hematocrit, you are going to watch and oftentimes -- I'm sure you know this -- in a fresh post-op, a hematocrit doesn't drop right away, it's down the line. So I guess you would have to look at several hematocrits to say what was going on.

Q. And if serial hematocrits are done and there is a progressive drop in the hematocrit, would that be one red flag that there may be excessive bleeding?

A. A hematocrit is definitely going to be an indicator of bleeding. Again, it's a piece of a puzzle. You are looking at all of

it.

Q. Now, if a patient had bleeding at a suture line in surgery that required return to bypass for repair, should that cause the nurse in the cardiothoracic postoperative intensive care unit to have a higher vigilance for signs and symptoms of excessive bleeding?

A. If a patient experienced that in OR, I'm assuming that was verbalized to her, to the nurse when she received this patient. And like any other piece of information that should have been given to that nurse, that's something in the back of your mind that you are keeping there to kind of have again a whole scope. I mean, that's obviously something important to know.

Q. And why would that be important to know?

A. Because that was something that happened in surgery. Just like anything that could happen in surgery, I think it's that transference of information from surgical nurse to the intensive care nurse that has to be transmitted.

Q. Would that increase the level of vigilance for excessive bleeding in the

intensive care unit?

A. It probably would enter into their assessment, sure.

Q. What hemodynamic parameters or values does a swan line provide?

A. I have not worked with a swan line, so I would not be able to answer that for you.

Q. So you don't know whether a swan produces continuous readouts of certain values or not?

A. My understanding is that it does. But again, I have not worked with one.

Q. Do you know how to calculate a cardiac output or a cardiac index or how that is done?

A. No, I do not.

Q. Do you know what hemodynamic values an arterial line provides?

A. No, I don't.

Q. Do you have an opinion whether it's important in a cardiothoracic intensive care unit that has postoperative patients for the nurses to periodically record the hemodynamic values so that trends can be observed?

MR. JACKSON: Asked and answered.

Objection.

A. I think that's important in any line of nursing, but yes, in your unit.

Q. Do you know whether nurses have the discretion to do cardiac outputs or cardiac indexes on a more frequent schedule if they feel it's indicated?

A. I think that would be part of working in a unit like that, that you would have the autonomy to do that.

Q. Can you tell me what a cardiac tamponade is?

A. Very simply, it's blood that has gathered in a specific area that has increased in size so that the capability or the function of the heart has been impaired.

Q. And from a nursing perspective, can you tell me what assessment findings would raise a suspicion for cardiac tamponade?

A. Probably the biggest one is history. Depending on why the patient is laying there in front of you would be a big one. Cardiac tamponade, on x-ray you are going to see a mediastinal check, jugular vein distention. Off the top of my head, those are things I would be

looking for.

Q. Are you aware of any hemodynamic parameter changes that would be consistent with cardiac tamponade?

A. As far as like say blood pressure or something? Is that where you are going?

Q. Hemodynamic parameters, yes. Is there any particular hemodynamic parameter changes that would be consistent with cardiac tamponade?

A. There would be hemodynamic changes probably in the pressure and the pulse.

Q. In what respect?

A. Pulse could probably go down, pressure would probably fall, but you could see those in many chest involvements.

Q. And in a surgical cardiothoracic ICU, should the nurses be alert to signs and symptoms that may be suspicious for cardiac tamponade?

A. Yes.

Q. And in regard to cardiac function, do you know what effect cardiac tamponade may have?

A. Cardiac tamponade is going to decrease your heart rate, so therefore it's going to decrease your cardiac output.

Q. Have you ever cared for a patient that developed cardiac tamponade after surgery?
A. Not after surgery.
Q. Have you cared for patients that have developed cardiac tamponade for other reasons in the emergency room?
A. Trauma.
Q. And in your experience, have you ever seen an echocardiogram ordered to assist in the diagnosis of tamponade?
A. Not in the diagnosis of tamponade.
Q. Any particular diagnostic studies done to assist with the diagnosis?
A. Of tamponade?
Q. Yes. In your experience.
A. No, not in my experience.
Q. How is it arrived at, from what your observations have been?
A. X-ray. History, again.
Q. Do you know whether in a surgical patient postoperative cardiac tamponade is an emergency situation?
A. I don't know that I could answer that question.
Q. If there is a suspicion for cardiac

tamponade, would you agree that nursing assessments should be done at frequent intervals?

A. Yes.

Q. Now, I have a copy of a letter dated August 5th of 2001 that has been marked as Plaintiff's Exhibit 2. If you would just identify this for the record.

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(Thereupon, BELANGER Deposition Exhibit 2 was marked for purposes of identification.)

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Q. Is that a copy of your report in this case?

A. Yes.

Q. And is this the only report that you have provided to your counsel?

A. Yes.

Q. Did you have any drafts of your report prior to rendering this report?

A. No.

Q. And does your report of August 5th of 2000 summarize all of your opinions that you currently hold in this case?

A. Yes.
Q. And do you still maintain the opinions that you've expressed in your August 5th, 2001 report?
A. Yes.
Q. Do you intend to do any additional work or review any additional materials in this case before the time of trial?
A. No.
Q. Have you been asked to do any additional work?
A. No.
Q. Tell me what your assignment was when you were given this case to review.
A. They asked me if I would review this case and do it from a standard of care from a nursing perspective.
Q. Were you asked to render opinions as to whether certain individuals met the standard of care?
A. No, not in particular, no.
Q. And when you reviewed this case, whose care -- and I'm speaking of which individual's care -- were you looking at, specifically?

A. Because I was rendering an opinion on the nursing care, I looked at the nurses' care.

Q. And can you identify those people for me?

A. I would have to look at the names. Hrobat, Zilka and Young.

Q. Now, at the bottom of page one of your report, you have indicated, I have concluded within a reasonable degree of professional certainty that the nursing care rendered to James Long did not fall below the standard of care.

Tell me what the standard of care required the nurses to do in Mr. Long's case.

A. The standard of care is any care that any wise and prudent nurse is going to give in the same situation with the same education. In other words, these nurses that were working in intensive care, based on their education and experience, they were going to give the care that was expected of them.

Q. Well, that's my question. What was the care that was expected of them?

A. Their care should have included assessments, interventions, reassessments and

documentation.

Q. Who is Nurse Zilka?

A. I would have to refer to her deposition. I don't know them by name, but she was one of the nurses who took care. I would have to look up to see if she was the one when the patient came in or the one who took over. Do you want me to do that?

Q. Well, we are going to be talking about her care, so I think, yes, I would like you to figure out who she is so we can discuss her care.

A. She apparently was the preceptor.

Q. And what were Nurse Zilka's responsibilities as a preceptor? Who was she precepting?

A. The nurse who was taking care of the patient that she was acting as a preceptor for.

Q. Do you know who that was?

A. Not off the top of my head. I'm not sure which one was which, I'm sorry.

Q. What were Nurse Zilka's responsibilities as a preceptor?

A. A preceptor is to watch them, carry out the care, make sure that they are doing that

correctly and kind of overseeing the whole situation.

Q. Now, do you recall that she was precepting a new nursing graduate named Nurse Young?

A. She was precepting a new nurse. I am not sure of the name.

Q. Would you agree that Nurse Zilka had a duty to monitor the care being provided by the new nursing graduate that was in her orientation providing care to Mr. Long?

A. Yes.

Q. And would you agree that one of the jobs of preceptor is to ensure that the standard of care given to the patient is not diminished because the care is being provided by someone that is inexperienced?

MR. JACKSON: Objection.

A. Yes.

Q. And would you agree that Nurse Zilka had a duty to step in and ensure that the standard of care was being met if the person she was precepting, which I'm going to tell you was Nurse Young, was unable to provide standard and appropriate care to James Long?

A. If a preceptor is under that impression, then, yes, that is part of the responsibility of precepting.

Q. Now, in your review of the records, did you find any evidence that Nurse Zilka stepped in at any point on the evening of August 20th in regard to James Long's care?

A. Not from my recollections.

Q. Now, I would like to talk to you about Nurse Young. And if you need to refer to anything to refresh your memory as to who Nurse Young is, please feel free to do so.

A. Nurse Young was the person who was taking care of the patient when he arrived in the unit; correct?

Q. That's for you to determine based on your review.

A. She was the nurse that was under Nurse Zilka's preceptorship.

Q. And how long had Nurse Young been employed at Cleveland Clinic prior to the time that she cared for James Long?

A. I think I read July, but let me just -- she first became employed July 8th of 1996 and she was taking care of Mr. Long in

August.

Q. So she was about in her 7th week; correct?

A. Yes.

Q. Did she have any prior work experience as a registered nurse prior to her employment with The Cleveland Clinic?

A. I think that was her first job.

Q. What time did she assume care for James Long on the evening of August 20th?

A. He came into the unit close to 1900. 1730, I'm sorry.

Q. And is it your impression that she assumed care for him when he immediately came into the unit?

A. Yes.

Q. Who is Nurse Hrobat?

A. H-R-O?

Q. Yes.

A. She is the nurse who took over at 7:00 p.m. when the shift ended. When these two nurses went off, she was the nurse who came on.

Q. And it's your understanding, based on your review, that Nurse Young assumed care for Mr. Long immediately from the operating room?

A. You definitely have me confused on the names of the nurses.

MR. JACKSON: Hrobat was there first and then Young took over. We don't need to play a silly little game with this.

MS. TOSTI: I would prefer that you not provide information to the witness. Let her answer. If she doesn't know, she can tell me that she doesn't know.

MR. JACKSON: It's all here, Jeanne. You are here for purposes of asking her opinions.

MS. TOSTI: Part of my purpose is to know what facts she was relying upon and what the basis of her opinions are. Part of that has to do with who had what responsibility.

MR. JACKSON: What is your next question?

Q. You would agree that Mr. Long had a right to expect the same standard of care from Miss Young as he would expect from an experienced cardiothoracic ICU nurse; correct?

MR. JACKSON: Objection. Go ahead and answer.

A. Yes.

Q. And that's why they put an experienced ICU nurse as a preceptor over a person that is in Miss Young's situation as a person learning how to care for patients in the ICU; correct?

MR. JACKSON: Objection. Go ahead.

A. Correct.

Q. And would you agree that if Nurse Young failed to provide nursing care that met the standard of care, that Nurse Zilka, her preceptor, would be equally responsible for any lapse in care?

MR. JACKSON: Objection. Go ahead and answer.

A. Yes.

Q. Now, when Nurse Young did her assessment of James Long at the beginning of her shift, did she find any changes from the previous assessment?

A. When the two shifts changed?

Q. When Nurse Young took over care for Mr. Long, I believe she testified that she did an assessment. Were there any changes in her assessment that she noted when she did her assessment?

A. She zeroed, I think it was the cardiac output, to make sure the numbers were the same. She looked at the cardiac output compared to the previous shift.

Q. Do you recall anything in her physical assessment that showed that there was a change in Mr. Long's condition?

A. I would have to look.

Q. Please feel free to refer to the medical records if that will be helpful to you.

A. When Young came on, she said that she looked at breath sounds. She talked about the secretion, she talked about his sinus rate. I'm not sure that she has said that there were any discrepancies from the previous shift.

Q. You don't believe there is anything in her deposition either, where she said that there was a change in his condition based on her assessment?

A. No, I don't recall.

Q. There is a nursing page that is called assessment that's a grid that has various systems on it with some boxes in which the nurses do charting.

A. This?

Q. Does it say assessment at the top?
A. Yes.
Q. Yes. You see at the top of the page, it shows that an asterisk says see note?
A. Yes.
Q. Do you know which of these assessments on this page Nurse Young did or if she did any of them?
A. Her signature is at the bottom, so I'm assuming she did them all.
Q. You assume she did all of them?
A. In her time slot.
Q. And based on this page of assessments, do you see any changes that she noted?
A. Do you mean by the fact that there is an asterisk there?
Q. Yes.
A. Yes, I see an asterisk.
Q. Where?
A. I see them at alert and oriented, speech clear, moves extremities, pain free, and we can go on through the page.
Q. Now, would you agree that under the area of cardiorespiratory, she has marked an

asterisk under breath sounds, clear bilaterally?
A. Yes.
Q. Do you recall her testifying in her deposition or making a notation in the chart anywhere that the patient now had bilateral bronchi?
A. She has that charted right here.
Q. So is that a change from the previous assessment on this patient?
A. There was no asterisk in the previous, yes.
Q. Also, down under cardiorespiratory where it says peripheral or dependent edema, she has an asterisk there; correct?
A. Yes.
Q. Do you recall her indicating in her deposition that she found that this patient had peripheral edema and that was a change in the patient's condition?
A. I can't say that I remember it from her deposition, no.
Q. Well, the previous assessment, there is a check mark in that box; correct?
A. That's correct.
Q. So that would indicate a change from

the previous assessment; correct?
A. That's right.
Q. Under gastro, which is on the right-hand column at the top of the page, under bowel sounds present, she has an asterisk there; correct?
A. That's correct.
Q. And that's a change from the previous assessment where there is a check mark; correct?
A. That's correct.
Q. Would you agree that Nurse Young and Nurse Zilka had a duty to carry out the doctor's orders as they were written?
A. Yes.
Q. How often were hemodynamic parameters being assessed on Mr. Long?
A. Being assessed?
Q. Yes.
A. It appears to be every 15 to 20 minutes from the time line on the flowsheet.
Q. Was that how often they were supposed to be observing and reporting the hemodynamic assessments?
A. The standing orders were routine vital signs every hour, hourly.

Q. Did you find anywhere in the records that you reviewed how often the nurses were supposed to be doing hemodynamic assessments?

A. It states routine vital signs, so I'm assuming that there is a policy for the unit that tells them the exact time frame on that.

Q. Were you provided in the records a page that shows treatments, nutrition, activity, hygiene, running down the left-hand side of the page with the section indicating hemodynamic assessments? Do you have that page?

MR. JACKSON: Why don't you show us the sheet, Jeanne, and she can tell you.

Q. Do you have a page that looks like this?

A. Yes.

Q. And under the section that says treatments, do you see an area that says hemodynamic assessments?

A. Yes.

Q. And it has the word swan A-line and CVP circled; correct?

A. Yes.

Q. And it indicates 15 to 20 minutes; correct?

A. Correct.
Q. Now, under the area of swan, I think you previously told me you don't know what hemodynamic values can be obtained from a swan catheter; correct?
A. That's correct.
Q. And that you weren't aware specifically of the various types of information that can be obtained from an A-line; correct?
A. Correct.
Q. But would you agree that whatever values can be obtained from those particular items, they were supposed to be obtained every 15 or 20 minutes?
A. That's correct.
Q. Now, assuming that a pulmonary artery pressure is one of the values that can be obtained from a swan, would you agree that the pulmonary artery pressures should have been assessed and recorded by the nurses every 15 or 20 minutes?
A. That's how the order reads, yes.
Q. And you would agree based on the flowsheet that you have from the ICU that there is no evidence that James Long's pulmonary

artery pressures were being continually assessed, or assessed at all during the last two hours and 40 minutes that he was in the ICU; correct?

A. There is no documentation there. I can't assume that they weren't being assessed.

Q. Do you have any evidence that they were assessed during that period of time?

A. I don't have any hard evidence, no.

Q. Well, what evidence do you have?

A. I guess what I would have to say is I would have to base it on their care of this gentleman up until now. I mean, obviously they are taking good care of him and assessing him, so I can't imagine at that time frame they just chose to stop looking at his pulmonary artery pressures.

Q. You are making an assumption that they did it?

A. Based on their previous care.

Q. The fact that they previously did them, you are assuming they did them after the point in time when there is no documentation?

A. Yes.

Q. So what is your understanding as to

why the pulmonary artery pressures were recorded every 20 minutes until 2050 hour and then they stopped at the point when his systolic blood pressure is still down in the 80s?

A. You are asking me why they stopped doing that?

Q. Yes.

A. I don't know that I could tell you that. I mean, unless I was there, how would I know?

Q. I'm just asking if you have an understanding as to why it stopped at that point?

A. Well, again, it would be an assumption, and it would be an assumption that they were taking care of him; that the priority was on something else. I don't know. I wasn't there.

Q. Now, the last pulmonary artery pressure was recorded at 2050 hour, which I believe is at letter K on that flowsheet. And at that point in time, his blood pressure was 81 over 52.

A. Uh-huh, yes.

Q. Would you agree that it was a

deviation from the standard of care for Nurse Zilka and Nurse Young to fail to assess and record the pulmonary artery pressures for the last two hours and 40 minutes that James Long was in the ICU?

MR. JACKSON: Objection.

A. During that same time period they are looking at all the other parameters. Why it wasn't documented, I am not sure, but I don't feel that they fell below standard of care.

Q. In your opinion --

A. That's just a piece of the picture.

Q. In your opinion, was it prudent to stop assessing Mr. Long's pulmonary artery pressures at 2050 hours?

MR. JACKSON: Objection. Go ahead.

A. We don't know they stopped it. All it is is not documented.

Q. You don't have any evidence that it was done after that point in time; correct?

A. Well, that's correct.

Q. Would you agree that Nurse Zilka, as Nurse Young's preceptor, should have stepped in and ensured that the pulmonary artery pressures were documented every 15 to 20 minutes so that

trends could be observed for this particular patient, particularly because of the hypotension that he had and the unresponsiveness to the vasopressors he was on?

MR. **JACKSON:** Objection. ***Go*** ahead.

A. The preceptor needs to step in when she sees that there is something that is falling below the standard. At this point, you know, again I'm going to reiterate that this is one piece of the puzzle. They were doing everything else they were supposed to be doing.

By eliminating that one reading, is that in any way jeopardizing this man's care? I mean, they should be looking at it, yes. Was it documented? We don't know if they are not looking at it.

I guess to answer your question, a preceptor should be teaching her how to document, yes, and it should be being documented.

Q. When Mr. Long returned from his reoperation and went back into the intensive care unit, how often were his pulmonary artery pressures assessed?

A. He came back like at 3:00 o'clock in

the morning, I think, on 8-21. Is this the date we are talking about? Is that what you want to know?

Q. When he came back from his surgery, he came into the unit. How often were they doing his pulmonary artery pressures?

A. It appears again every 20 minutes.

Q. Any gaps in the times there?

A. I don't see any there, no.

Q. So consistently every 20 minutes; correct?

A. That's correct.

a. We are back in the unit prior to his reoperation, and you may want to look at that flowsheet because we are going to be talking about it.

After James Long had that long period of hypotension followed by the 250 cc chest tube drainage recorded at 2210 hour, which I think is at letter O, would you agree that it would have been prudent for the nurses to do cardiac outputs and cardiac indexes more frequently than every two hours as a nursing measure?

MR. JACKSON: Objection. Go ahead.

A. Tell me the every two hours again.

I'm not sure where you are coming from there.

Q. Do you know how often they routinely did cardiac outputs and cardiac indexes in the ICU?

A. They were ordered every 20 minutes.

Q. Your understanding is that the cardiac outputs and the cardiac indexes were ordered every 20 minutes?

A. I would have to go back and look at the order, but I'm not sure I understand your question. Could you rephrase it?

Q. Mr. Long had a long period of hypotension that lasted for, I believe, about an hour and 40 minutes, and that was followed by a 250 cc drainage over the course of an hour into his chest tubes. Do you recall that?

A. Yes, I do.

Q. Would you agree that it would be prudent for the nurses following that period of hypotension and the chest tube drainage to be doing frequent cardiac outputs and cardiac indexes on him?

A. Yes.

MR. JACKSON: Objection.

Q. And would you agree that it should be

more frequent than every two hours?

MR. JACKSON: Objection. *Go* ahead.

A. Yes, I would agree it should be more than every two hours.

Q. Every 15 or 20 minutes, would that be appropriate?

A. I think I would have to be there with a patient and see what was going on.

Q. And the reason why you would want to do more frequent cardiac outputs and cardiac indexes is in order to see if there was a trend downward indicating that this patient was having a problem with his cardiac function; correct?

MR. JACKSON: Objection. *Go* ahead.

A. It's a piece of what would be telling you that the patient could be in trouble, sure.

Q. From a nursing perspective, does a falling urine output have any significance the first few hours after surgery?

A. Depending on the surgery. Just as a general statement?

Q. Yes.

A. I have seen patients that had a decrease in urinary output as a result of the anesthesia.

Q. Can hemorrhaging have any effect on urinary output?
A. Yes.
Q. When a patient slips into a shock condition, is there generally a decrease in urinary output?
A. Yes.
Q. Is that one of the indicators that nurses watch the urinary output to determine whether or not this patient may be slipping into a shock type condition?
A. Yes, but urine output is usually one of the latter symptoms that you see.
Q. Sure, but it's one of things that the nurses should be assessing, particularly in a postoperative patient; correct?
A. You are going to assess urine output for many reasons in a post-op, yes.
Q. That's one of the reasons?
A. That could be one of the reasons, yes.
Q. And how often were the nurses supposed to be recording James Long's urine output?
A. Again, I would have to look. Hourly.

Q. And did you find that his hourly urine outputs were assessed by Nurse Zilka and Nurse Young after 2210 hour?

A. After 2210, there is no urinary output after 2210.

Q. And given the fact that he had 250 cc's of chest tube drainage at 2210, and the hypotension that we discussed a minute ago, would you agree that his urine output should have been monitored closely by Nurse Zilka and Nurse Young?

MR. JACKSON: Objection. Go ahead.

A. At 2250, this is the same time when this patient is being prepared to go back to surgery; correct? So there are many things going on at this time.

You were going to say something?

Q. No, I'm listening to your answer.

A. At this time, you know, they are getting this patient ready to go back to surgery. I'm not going to sit here and say they weren't looking at urinary output. It just isn't written down.

Q. Why is it your impression that at 2250 they were getting the patient ready to go

back to surgery?

A. It was close to the time that they were going back to surgery. This was the time, my understanding is, this is when the physicians were there and decisions were being made to take him back.

Q. He went back to surgery at 2330 hour; correct?

A. Yes.

Q. And what indicated to you at 2250 hour that there was reason to believe that he was going back to surgery?

A. I was looking at the time frame thinking that that really is a short period of time, and the decisions to take patients back to surgery, you know, there is a time element there. And I guess my assumption was all these people were gathered around making this decision during that time.

Q. So you don't have a problem with the fact that the nurses from 2210 until 2330 didn't record any urine output?

A. They should have been recording it, yes.

Q. They should have been?

A. Yes.
Q. So that was substandard care that they did not record the hourly urine output as ordered?
MR. JACKSON: Objection.
A. I'm not sure the standard reads that every hour you should record urinary output. The standard reads that you are doing timely assessments.
Q. Didn't you just read me an order written by the doctor that said that he was to have intake and output done every hour?
A. Yes, I did.
Q. And did he have an intake and output done --
A. It's not recorded.
Q. Let me finish my question. Did he have an intake and output done the last hour that he was in the intensive care unit?
A. I do not know that because it's not recorded.
Q. Now, on line 2210, there is a systemic vascular resistance that's recorded at a level of 411. Do you see that?
A. Yes, I do.

Q. Now, you would agree that that's the lowest systemic vascular resistance that was recorded while he was in the intensive care unit; correct?

A. That's correct.

Q. Would you agree that although this was the lowest systemic vascular resistance recorded, that there is no indication that the nurses were continuing to assess the systemic vascular resistance for the remainder of the time that he was in the intensive care unit before returning to surgery?

A. There are no others documented.

Q. Would you agree that given this low systemic vascular resistance, the nurses should have repeated the systemic vascular reading in 15 or 20 minutes to see if it was continuing to drop, improving, or staying the same?

A. Yes.

Q. Now, I see that James Long received a unit of packed red blood cells that finished infusing at 2310 hour, which is at the letter R. There is a physician's order that says that there should be a hematocrit done after each unit of packed red blood cells. Did you find

that that order was carried out by the nurses; that a hematocrit was done after the infusion of that unit of packed red blood cells?

A. No, I did not.

Q. Now, given the fact that the hematocrit had fallen from 36 to 35 to 27 while he was in the unit, shouldn't Nurse Young or Nurse Zilka have made sure that that hematocrit was obtained after the packed red blood cells were infused?

A. There is a period of, what, 20 minutes before the patient leaves, from the time the packed cells were infused until the time the patient goes back to the OR?

Q. Yes.

A. I'm not sure there is physically time to draw and get a result from the hematocrit then. I think they were getting the patient to the OR just that simple.

Q. So you don't have a problem with the fact that that wasn't done?

A. I'm not sure at that point in time it was going to make a whole lot of difference. The man was back on his way to the OR.

Q. Now, your report indicates that

reassessments took place after each intervention and documentation was done. I would like you to tell me what the interventions are that you are referring to, and then point out the documentations to which you are referring to in your report.

MR. JACKSON: Would you read that back.

(Record read.)

A. I saw the nurses evaluating this gentleman -- even let's take an example of blood pressure. Apparently they were working under standard orders where they could, if they did not keep the blood pressure between the parameters that it was ordered, they were able to start various medications, which they did. They were able to give him boluses of fluid, which they did. They assessed the fact that he was becoming restless on the ventilator and he was given medications to relieve some of that anxiety. Those are just some of the things I saw as far as interventions after assessments.

Q. So you've referred to the medications. Any other interventions other than the institution of various medications or the

change of doses in medications?

A. As far as interventions?

Q. Yes. I'm trying to discern what you are referring to as far as interventions.

A. Right. Medications.

Q. You mentioned the medications.

A. Right.

Q. What else?

A. That would be the interventions, because they were monitoring parameters of his vital signs, and based on those vital signs, they were trying to effect the result with the medication.

Q. Now, your report also indicates that there was frequent and timely communication with the medical staff; correct?

A. Yes.

Q. I would like you to point out to me what time those communications occurred and then we will talk a little bit about them.

A. Well, we can start with the orders that were given. All of these orders were written from the time the gentleman, Mr. Long, came back. 1730, 1800, 1830, for every one of those orders there was a physician there.

Q. So you have mentioned 1730 order, a 1830 order. What other communications are you referring to?

A. Then in the nurse's notes, they are making note of when doctors were at the bedside under significant events. There are physician's names there.

Q. Tell me what time those communications occurred.

A. It's easier said than done in these charts. Looks like Dr. Cosgrove at 1830. Well, you can start with the fact that someone was with the physician when he came at 1730, all right? So either PACU or anesthesia or someone.

Cosgrove was there at 1830. These orders appear, you can intersperse when they were there to write the orders. The time line would be much easier to do this.

I think we established 1730, 1800, 1830 and the next two are not timed. You then have a documentation that doctor -- line L, 2110. 2215. And then they seem to be at bedside almost consistently after that.

Q. What is a reasonable range for chest tube drainage per hour for a person who has

undergone an aortic valve replacement surgery?

A. As I have told you, I have not taken care of a patient with an aortic valve replacement, but my dealings with chest tube placements is anywhere between 50 cc's and 100 cc's an hour, but I have seen that volume increase depending on what is going on.

Q. The 50 to 100 an hour would be reasonable for a postoperative patient that has had chest surgery?

A. The ones that I have taken care of, that was, yes.

Q. Is there any amount of hourly drainage that would raise a concern in your mind that the patient was having excessive bleeding?

A. I would have to couple it with other things going on, I have turned a patient and dumped 250 cc's of chest tube drainage but nothing else has gone on at that same point. No drop in his hemodynamic status, nothing like that. I have seen a patient drop a lot when he coughs while on a respirator. I guess that I would be more concerned about consistent large volumes of chest tube drainage.

Q. Would you agree that chest tube

drainage in a new postoperative patient that increases from 100 to 250 cc's in the first two hours should raise a concern from a nursing perspective that the patient may be having excessive postoperative bleeding?

A. I think it's something the nurse should be watching. I don't think you can draw any definite conclusions just from one piece of information.

Q. Should it raise a concern for excessive postoperative bleeding?

A. It's going to raise a concern, yes. I'm going to watch it.

Q. Now, at 2010, James Long's pulse was 104. That's tachycardic; correct?

A. Where are you?

Q. 2010.

A. You are telling me 104 is tachycardic?

Q. Yes.

A. Yeah, barely.

Q. It's tachycardic; correct?

A. Yes. By four points.

Q. And his blood pressure was 72 over 42; correct?

A. Yes.
Q. And his mean arterial pressure, I believe, was 55 at that time?
A. Correct.
Q. From a nursing perspective, should that have raised a concern for excessive postoperative bleeding?
A. The nurses saw that as a change and that's when they hung the Levophed and Epi, so they did see that was a change from how it had been and acted upon that.
Q. That's not what I asked you. I asked you in a patient who has -- in James Long's case, with a pulse of 104, a blood pressure of 72 over 42, a mean arterial pressure of 55, and having just had a 250 cc drainage from his chest tube, should that have raised a concern from a nursing perspective that he may be having excessive postoperative bleeding?
A. It's going to raise a concern. I'm not sure that postoperative bleeding was going to be my answer to that. I mean --
Q. What is your understanding as to why James Long was placed on Amicar?
A. Amicar is a medication that's going

to increase clotting, so obviously it looked to be a standing order. So if I'm remembering from the depositions, they did contact a physician and they were told to start the Amicar.

Q. And they started that at the time when his blood pressure was 75 down to, I guess it's 75 over 46. Just after he had that 75 blood pressure, they started the Amicar?

A. That's correct.

Q. And it was also in conjunction with the bleeding that he had of 250 cc's; correct?

A. That's correct.

Q. So you believe that it was just a standing order; that it had nothing to do with the assessments that the nurses were providing to the doctor?

A. No. It was done because of the results that they saw, but it appears to be an order that they have as a routine order to do in those cases.

Q. What's your understanding as to why he was placed on Levophed?

A. To raise his blood pressure.

Q. What's your understanding as to why he required Epinephrine?

A. Again, it has to do with his blood pressure and the results that they were getting when they are monitoring his hemodynamic status.

Q. You would agree that between the hours of 1950 and 2130 that Nurse Young was unable to maintain James Long's blood pressure at a level of at least 90 systolic as the physicians had ordered; correct?

MR. JACKSON: Objection. Go ahead.

A. She at that time was trying to titrate the medication to maintain a blood pressure.

Q. And she was unable to get the blood pressure up to the level that the doctor wanted with the two drugs running; correct?

A. Yes.

Q. During that period of time she was also increasing the drips; correct?

A. Yes.

Q. Both the Epinephrine and the Levophed; correct?

A. That's correct.

Q. Did you find any evidence that Nurse Young or Nurse Zilka informed the surgical service that James Long was not responding to

the vasopressors between 1950 hour and 2130 hour?

A. 1950, which would be H?

Q. Correct. And 2130, which would be M. Did you find that they notified the surgical service at all that they were having difficulty in getting his blood pressure to come up to the 90 systolic that the physicians had ordered?

A. It says that there was a doctor at the bedside at 2110. I would have to look and see. Again, those orders are not timed.

Q. Do you know who Dr. Yared is?

A. I would have to look.

Q. Do you know whether he is part of the surgical service or not?

A. I would have to look at the list.

Q. You don't know?

A. I don't know names and occupations, no.

Q. Well, the doctor that saw the patient at line L, 2110, you don't know what his responsibilities were in regard to the management of Mr. Long, do you?

A. No.

Q. Did you read Dr. Yared's deposition?

A. Yes, I did.
Q. During that period of time that I just mentioned, between 1950 and 2130, would you agree that it would have been prudent for Nurse Young or Nurse Zilka to request that a physician from a surgical service come to the bedside and evaluate the patient?
MR. JACKSON: Objection. Go ahead.
A. There were no other physicians around. I mean, that's a difficult question. Yes, someone should have been informed of what was going on with the patient. I don't know that they weren't, though, I guess is what I'm saying to you.
Q. Well --
A. There is no documentation that they were told that, that's correct.
Q. And you don't have any basis to assume or presume that anybody was contacted during that period of time and informed that they were having problems maintaining the blood pressure above 90 systolic, do you?
A. No, I don't know that they did that, no.
Q. Have you ever requested a physician

to come down and see a patient because of changes that you found on an assessment?

A. Yes.

Q. Do you know whether it's common for a postoperative aortic valve patient to require two vasopressor medications to support the blood pressure?

A. I have not taken care of a patient post-op there.

Q. Would you agree that it's important for the nurses to keep the chest tubes of a postoperative cardiothoracic patient free from clots by routinely milking the tubes at intervals?

A. My experience with chest tubes and how they are to be milked is according to the physician who has the patient.

Q. Okay.

A. So if the physician tells me to do that, then, yes, I'm going to do that.

Q. And nurses working in a cardiothoracic intensive care with surgeons would be aware of what a surgeon wants; correct?

A. I would feel so, yes.

Q. So if Dr. Cosgrove, who did the

surgery, expected the nurse to do it on a routine basis, you would expect that Nurse Zilka and Nurse Young would be doing that on a routine basis; correct?

A. If the order was written that they were to do it at a specific time interval, yes.

Q. Even if there is not an order, aren't there usually understandings between the surgeons and the nurses in the unit as to whether they are supposed to be doing that or not?

A. I will say that there is usually an understanding between the surgeon and the nurses, yes. As to what that is, I couldn't tell you. It depends.

Q. Do you have an opinion as to whether Nurse Zilka and Nurse Young had a duty to routinely milk the chest tubes to keep them clear from clots in Mr. Long's case?

A. If they didn't see clots in there, then, no. And depending on what the surgeon had told them, you know.

Q. Can you have clots in chest tubes that are in the portion of chest tubes that you can't see?

A. Yes.
Q. And what happens if you get clots in the chest tubes and they block off the drainage of the chest tube?
MR. JACKSON: You just answered your own question, didn't you?
A. You are going to have a blockage.
Q. Does anything happen to the cardiac hemodynamics when you have a blockage in the chest tubes?
A. You are going to increase thoracic pressure.
Q. Can that cause cardiac tamponade in some instances?
A. In some instances, it could, yes.
Q. Now, if Nurse Zilka and Nurse Young failed to routinely milk the chest tubes as expected by Dr. Cosgrove in James Long's case, would you agree that that would be a deviation from the standard of care?
MR. JACKSON: Objection. Go ahead.
A. Is the expectation written? I mean, are you telling me that there is an expectation that was actually documented on chest tubes? The order on the chest tubes, let's check that.

Q. Well, let me ask this question.
A. Okay.
Q. Are nurses only required to routinely milk chest tubes if there is an order written to that effect?
A. My dealings with chest tubes has been on a personal basis with the surgeon, and he pretty much told me when he wanted the chest tubes touched or not touched.
Q. I'm asking in this case. Are you saying that Miss Zilka and Miss Young required an order to routinely milk chest tubes?
A. Again, what they did with the chest tubes has to do with how the surgeon wanted them treated.
Q. But does the surgeon have to write an order to that effect in order to have the expectation that the nurses will do it?
A. I don't know that I can answer that. I mean, sometimes there is a communication between a doctor and a nurse that isn't written down, so depending on what he told them.
Q. Would you expect an experienced ICU nurse to know what the physician's routine was if they had worked with that particular surgeon

on a regular continuing basis?

A. Oftentimes that's true, yes.

Q. Are you critical of any of the nursing care provided by any of the nursing staff while James Long was in the cardiothoracic surgical intensive care unit?

A. No.

Q. Have I covered all the opinions that you presently intend to offer at trial in this case?

A. Yes.

Q. Are there any opinions that we haven't discussed that you intend to offer at trial?

A. No.

Q. If you arrive at any new opinions between now and the time of trial, I would ask that you tell defense counsel, and then I would continue your deposition relative to any new opinions that you should have.

MS. TOSTI: With that, I think we are finished.

MR. JACKSON: You have to tell Vivian that you want to read it.

THE WITNESS: I would like to read.

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(Deposition concluded at 4:30 p.m.)

(Signature not waived.)

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AFFIDAVIT

I have read the foregoing transcript from page 1 through 96 and note the following corrections:

PAGE	LINE	REQUESTED CHANGE

MARY ANNE BELANGER, R.N.

Subscribed and sworn to before me this day of , 2002.

Notary Public

My commission expires

CERTIFICATE

State of Ohio,

SS:

County of Cuyahoga.

I, Vivian L. Gordon, a Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within named MARY ANNE BELANGER, R.N. was by me first duly sworn to testify to the truth, the whole truth and nothing but the truth in the cause aforesaid; that the testimony as above set forth was by me reduced to stenotypy, afterwards transcribed, and that the foregoing is a true and correct transcription of the testimony.

I do further certify that this deposition was taken at the time and place specified and was completed without adjournment; that I am not a relative or attorney for either party or otherwise interested in the event of this action. I am not, nor is the court reporting firm with which I am affiliated, under a contract as defined in Civil Rule 28 **(D)**.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Cleveland, Ohio, on this 30th day of April, 2002.

Vivian L. Gordon, Notary Public
Within and for the State of Ohio

My commission expires June 8, 2004.

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EXAMINATION OF MARY ANNE BELANGER, R.N.