IN THE COURT OF COMMON PLEAS
OF CUYAHOGA COUNTY, OHIO
- - - - -
JESSE HATFIELD, et al.
Plaintiffs,
vs. Case No. 502766
PARMA COMMUNITY GENERAL HOSPITAL, et al.,
Defendants.
- - - - -
DEPOSITION OF SUSAN CABUYADOA
Thursday, March 11, 2004
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Deposition of SUSAN CABUYADOA, a Witness herein, called by the Plaintiffs for examination under the statute, taken before me, Karen M. Patterson, a Registered Merit Reporter and Notary Public in and for the State of Ohio, pursuant to notice of counsel, at the offices of Parma Community General Hospital, 7007 Powers Boulevard, Cleveland, Ohio, on the day and date set forth above, at 9:25 o'clock a.m.

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APPEARANCES:

On behalf of the Plaintiffs:
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On behalf of the Defendant Parma Community General Hospital:
Weston, Hurd, Fallon, Paisley & Howley, by
DANIEL A. RICHARDS, ESQ.
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SUSAN CABUYADOA, of lawful age, called for examination, as provided by the Ohio Rules of Civil Procedure, being by me first duly sworn, as hereinafter certified, deposed and said as follows:

EXAMINATION OF SUSAN CABUYADOA
BY MS. TRESL:

Q. Susan, we met just now. May I call you Susan? Is that okay?
A. That's correct.
Q. Please feel free to call me Jackie, okay.
I assume you've not had your deposition taken before; would that be correct?
A. That's correct.
Q. I assume that your good attorney went through some ground rules, but I'll just mention two things. If you don't understand something I've asked you, will you stop and tell me that you don't understand?
A. I will.
Q. If you answer, I'm going to assume that you do understand; okay?
A. That's okay.
Q. I'm going to ask that you say yes or

no, not nod or shake your head so that Karen, the court reporter, can get it down; okay?
A. Okay.
Q. And, hopefully, that won't take too long. I thank you for coming in this morning.
A. My pleasure.
Q. You'll have to speak up just a little louder. My middle-aged ears aren't as good as they used to be.
A. Okay.
Q. For the record, would you state your name and address, please.
A. My name is Susan Cabuyadao. I live at 2620 Snow Road, Parma, Ohio, 44134.
Q. I assume you continue to work at Parma Hospital?
A. That's correct.
Q. Just tell me a little bit about how long you've been here at Parma Hospital.
A. I will be on my 13th this year by July.
Q. Do you work full time?
A. Correct.
Q. Day shift or 7:00 to 11:00?
A. Night shift, 11:00 to 7:30.

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Q. So at the time that Mr. Hatfield's injury occurred, you were working night shift; is that correct?
A. That's correct.
Q. And you said you work full time; yes?
A. Yes.
Q. Tell me how you became a phlebotomist, how you got this job, in terms of training, that sort of thing.
A. I went to school downtown for medical assistant at Cleveland School of Medical/Dental Assistant.
Q. Okay.
A. And I finished that in the year 1983, I believe. And after that, I worked at Plasma Alliance, which is located at West 25th. I don't know exactly the address now. And we do plasma phoresis there, and I was phlebotomist. I was full time then.
I went to Cleveland Clinic, and I was able to get a full-time position at Cleveland Clinic night shift, 11:00 to 7:30, and I was full time for a good four years. I was getting tired of the long driving at night. I

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was looking for closer to my house, and I was able to get the chance to get to -- no. I have a part-time first. I was still full time at Cleveland Clinic, and then I was able to get a part-time job at St. Alexis at that time. Then we had a big layoff at St. Alexis. I was one of them. I was laid off and I went looking for -- a friend of mine was working at MetroHealth System in the laboratory and she monitored, you know, openings in there. With my experience, I was able to get a part-time then.
Then I was working kind of part time both at St. Alexis and Metro. Then I became full time at Metro. Then I still did want part time, and I did come put in an application here at Parma Hospital, and I was able to get into Parma Hospital part time, still full time at MetroHealth Hospital up to this time.
Q. So that was 1990, probably, that you started here part time?
A. '91, I believe, '92.
Q. Do you have any special certification?
A. Yes. I did pass the international phlebotomy, of phlebotomy science, but before

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that, the school administered certification like after graduation and we have a one-year experience in the field of medical assisting or phlebotomy, and I was able to register -- I passed the registered test.
Then there was a certification test that was administered again all over, you know, and I did take the test and I passed the test again. So I'm a certified phlebotomist.
Q. Your duties here at Parma, do you draw blood from the beginning of your shift to the end of your shift, or do you have other duties besides drawing blood?
A. I have other duties, but just the paperwork. I do just sort those laboratory reports that they generate after the day, and I just collect them together, I mean, bundle them, and that's it. Somebody picks them up from floor-to-floor. The floor, they come and pick up their own copies, each floor.
Q. For today's deposition, other than talking to Mr. Richards, what did you review? Did you look at Mr. Hatfield's medical records?
A. No.
Q. Did you look at anything that was

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generated from the lab about Mr. Hatfield?
A. No.
Q. So for today's deposition, and I don't want to know what you discussed with Mr. Richards, but the only thing you did for today's deposition is talk to Mr. Richards; is that correct?
A. Say it again, please.
Q. For today's deposition, you did not review any materials; is that correct?
A. No.
Q. Do you remember Mr. Hatfield?
A. I do not recall. I don't remember.
Q. I want to just ask you about some general principles and then we'll get into some specifics, okay.
Tell me, first of all, what the policy is at Parma in terms of the size of needle when you do phlebotomy.
A. We are using only two sizes of needles. One for the adult that we -- that's our standard, and that's, you know, mainly what we use, the 21-gauge, one-and-one-fourth inches.
Q. Okay.
A. And for the difficult ones and the

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babies and little kids, we use the so-called butterfly, which is the 23-gauge and three-and-a-quarter.
Q. Three-and-a-quarter?
A. Right.
Q. Do you have on your tray any other size needles for adults?
A. No, we don't. I don't.
Q. Are there other size needles available if you need them?
A. No. That's all we used for venipuncture.
Q. So if you have a difficult stick --
A. Then I use the butterfly.
Q. If you can't get it with the butterfly, what do you do?
A. We have two chances to do the -- perform the venipuncture on a patient. We have only two chances. If we failed one, we attempt to do one more time, and if we don't, that's it. I will -- me, I will leave it to -- because I don't have any help, I'm just by myself, I'll leave it to the nurse, and the nurse will have to decide if they really need that blood to be drawn for that particular patient, and then the

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house doctor does. Then there's -- we'll call the doctor that's in-house to do their own procedure. I don't do -- after the second attempt and I still fail, then I don't do it anymore. I will put it aside like I didn't get it, you know. I say I wasn't able to obtain the specimen.
Q. Is there anywhere in your recordkeeping that it's reflected when you are not able to get the blood?
A. No. We just give it like what I said, if I don't -- I fail the second time, I just leave to the floor that I wasn't able to get it, and them to decide if, like, let the house doctor, if they want to have it drawn or they wait for another shift or another time, there will be somebody that won't be me.
Q. So if a phlebotomist wants to use a larger gauge needle, let's just say for whatever reason they believe they can hit a vein with a larger gauge needle, is it possible to go somewhere in the lab and get a larger gauge, a 20, an 18, and take it up to the floor?
A. No.
Q. And this was true back at the time

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of Mr. Hatfield's injury in 2002; correct?
A. Correct.
Q. Do you have a routine area of the body, the arm, presumably, that you usually use to stick?
A. It's only the arm that we are allowed, the arm and the hand, if we can't find any, and the antecubital. Then we attempt to look on the side, and if we still, we can't feel any, then we go on the hands because we also have veins in the hands, and that's when those smaller needle apply, if the veins are very small.
Q. If you see a patient, you're coming to a patient, do you have a place that you routinely stick first in the arm? I'm saying here, here, here, here, and for the record, I'm showing left of the antecubital, right of the antecubital, upper arm, forearm veins.
A. Well, we generally, me, I'm -- I put the tourniquet on and I fish around, look around.
Q. Did you say "fish" or "feel"?
A. Feel around, I should say.
Q. Did you say "fish"?

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A. I misjudge -- slip of my tongue.
Q. But you did say "fish"?
A. Yes, I did.
Q. Thank you.
A. I palpate everywhere and I decide which one I could comfortably, you know, perform the venipuncture. And then -- but tourniquet is out, and I release it, because, you know, we're not supposed to keep the tourniquet for a long time. And I release the tourniquet and I try to remember where I feel. That is before cleaning the area. So I clean the area and I put back my tourniquet, then put my gloves on, and then I kind of anchor where I feel the vein and then I perform the venipuncture.
Q. Tell me just a little bit, for my own information, your understanding of the anatomy of the way the veins and the arteries lie there in the antecubital area.
A. Okay. We are -- our main target to look at is where the antecubital is, and that's about it. That's how we can, you know -- that's how far we can only, you know, feel the veins. And if we don't feel that, and if we see some, you know, a shadow of a vein over here on this

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side, then we look in there. And if we don't, as I said, we go lower and see if we can see a better one, big ones over here on the hand or on this side of the hand over here, and that's why -- how far we can only look for the veins for venipuncture.

Q. My question, I guess -- it was an unclear question -- can you describe to me, give me the names of, the veins that are in the antecubital that you have your choice of.

A. Well, they are the so-called --

MR. RICHARDS: I'll just put an objection there, but you can go ahead and answer, Sue.

A. We don't have any, you know, particular vein -- we don't look around, like we know the veins that are shallow, and that's what we call -- that's where we perform the venipuncture.

Q. I guess my question is, though, what is the name of those veins in terms of this one is the --

A. The antecubital veins.

Q. So there's more than one antecubital vein; is that correct?

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A. Well, I don't think that if it is outside the area, or the antecubital area now, I don't know if you could still call it antecubital veins.

Q. We're getting there. You're doing great. I thank you for your patience. But what you're saying is there are more than one antecubital vein?

A. Oh, yes, yes.

Q. Do you know how many antecubital veins there are?

A. No, I don't.

MR. RICHARDS: I put a continuing objection on the record for the purpose that I'm not certain whether or not this would be information within the standard phlebotomist's training. It may well be, but I'm objecting to the extent that it's asking for information outside of her area of knowledge.

Q. That's very fair. Let me just ask you then -- we're back up to your training -- when you were in your school getting your training, were you actually shown anatomy pictures of veins in arms?

A. Yes.

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Q. During your training, were you told the names at that time? Did you learn this is called the zebra vein, this is called the elephant vein? I'm just using silly words.

A. Okay.

Q. But was there a time when you knew the names of the veins in the antecubital?

A. Well, I can't recall it anymore. That's long from out of school.

Q. I understand you can't recall it. But was that something you were taught --

A. Yes.

Q. -- the names of the veins?

A. Yes.

Q. I guess I'm tying it into what Mr. Richards said. Now, bringing it back to today, your testimony today is that there are more than one antecubital vein in this area that you have a choice of?

A. Right.

Q. And I don't want to put words in your mouth. I want to make sure. Routinely, you don't go outside the arm, inside the arm; you feel to determine which of these veins you're going to choose?

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A. Right. Correct.

Q. So you don't come up always in your mind that you're going to do the one in the middle unless there's any reason to go other places?

A. The only other places is like around in this antecubital, and, you know, there's a big vein next to it, and that's the choice. Those are our choices.

Q. Let's just say on an average night, and I understand census changes, but let's just say on an average, are most of your blood draws you do on night shift, or some of them, I assume they're on the chart for the doctor when he makes rounds in the morning?

A. Yes.

Q. So you're doing your routine sticks for the morning blood work between what periods of time?

A. Well, sometimes I constantly, you know, one or two reading an hour or three or sometimes more than that.

Q. Again, I'm not being clear, and I apologize.

My memory, when I worked in a

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hospital, is that routinely what happens is there's a whole lot of lab work ordered q.d. A phlebotomist comes up every morning to draw blood work. Is that the way it still is?
A. Yes.
Q. My question is, I guess, just really narrow here. When you're doing those routine daily sticks as the phlebotomist every six, every eight, just your routine morning sticks, what time do you generally start your sticks and end your sticks just for that routine lab work?
A. 6:00 o'clock.
Q. 6:00 o'clock you start?
A. Correct.
Q. Do you ever start a little earlier?
A. Yes. Quarter to 6:00 or 5:30 the earliest we can go for the routine.
Q. Generally, and I know it changes, again, by census, about how long does it routinely take you to finish your routine sticks in the morning?
A. Within an hour, hour-and-a-half, depending on how many you had to do.
Q. Sure. Is there more than one phlebotomist on night shift with you?

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A. No. They will come in -- the earliest they will come in, and it's part of -- it's still night shift, is 5:30.
Q. I know you don't remember this particular day, but is it as likely that you had a helper doing these routine sticks with you, or is it more likely that you were doing all the routine morning sticks of that day, if you remember?
A. I don't do it by myself, no.
Q. So someone comes in and assists you?
A. That's correct.
Q. So there's two of you?
A. No. We share. There's no so-called assistant. You get your share.
Q. Right.
A. Like five patients, and if you go out there at 6:00 o'clock, five is yours, and you do the best you can to do that, and that's it. If you -- if one that you didn't -- wasn't able to draw it, then you bring it down and let somebody who is available to go do it and give a try. That's how we do it.
Q. So if you go up to do it and you can't get it, you might come down and ask the

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other person that's doing blood sticks to go up and try?
A. I'll put it on the board.
Q. Right.
A. And I will write down in there that I can't get it.
Q. Right.
A. And somebody will just grab it from there, the first shift people who will be the most available to go there and give a try.
Q. So --
A. There's no particular, you know, somebody that's designated to come in, an assistant or give assistance to me.
Q. Let me make sure I understand. If you can't get it, you bring it down, put it on the board here in phlebotomy, and another phlebotomist, whoever, will try to go up and get it; is that correct?
A. That's correct.
Q. You mentioned a couple things I want to ask you about.
MR. RICHARDS: Jackie, can I interrupt for one second? When you're saying if you can't get it, earlier, she said after two

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attempts she will go to the nurse and the house officer. You're talking about can't get it. You mean can't get to it?
Q. Can't get the stick; that's what you said.
A. That is within my 11:00 o'clock to 6:00 o'clock, 5:30. Because 6:00 o'clock people will start their first shift already.
Q. But my understanding is, if you go up and you stick and you can't get it, you come down, put it on the board and someone goes up?
A. That is from 5:30 or 6:00 o'clock to the rest of the -- the end of the night shift.
Q. Right. I understood that. Thank you.
MR. RICHARDS: Thank you.
Q. Now, you mentioned two things I want to ask you about. It sounded like, on average, you have about five sticks that you're responsible for in the morning. And I understand it changes with census.
A. Yes.
Q. That's about normal. You have five patients to stick?
A. The standard is eight to -- is more

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than five. We're talking about routine.
Q. Right. So you might have ten blood draws to do from 5:30 to the end of your shift?
A. Correct.
Q. And I understand that changes.
Now, when you say you do the best you can, what does that mean? You used the phrase "best you can." You do the best you can to get the stick. If you can't get the stick, you come down and you put it on the board and have someone else come up?
A. Yes.
Q. What does that mean, "best you can"?
A. Well, that's the two chances.
Q. So you do the best you can for those two chances?
A. Correct.
Q. And then you bring it downstairs?
A. Correct.
Q. Now, tell me, sort of paint the picture for me -- because I used to do a ton of IVs in my career also -- you come up and the patients are probably sleeping?
A. Yes.
Q. Do you wake them?

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A. Yes. The moment I go into the room, I start talking, hello, knocking. I said, this is Susan from the lab. I'm here, I'm going to turn your light on. And once I turn the light on, it's either they're -- you know, only few of them are awake. So I have to wake them up, and I have to introduce myself.
From that point, I tell every step I have to do, turn the light on, I'm Susan, hello, good morning, I'm sorry to wake you up and I need to draw blood from you. And if they are just -- either they will be just closing their eyes but they're awake, I'm not going to start doing anything until I have to wake them up.
And I tell them the procedure that I'm going to do, and I tell them, I have to look around, what is the available or accessible or which arm is available for venipuncture because we are not using the arm that have IV running on it, or the arm that have fistula, or the arm that have -- we have a bracelet, we have a sign, an orange band, on them to aware us of -- that we cannot use that arm. And we are not going to use that arm for so many different reasons, like a fistula or a mastectomy or a clot that -- or a

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swollen arm or for any reason that they don't want us to draw blood from that arm.
Q. How do we know in this case that you were the one that drew Mr. Hatfield's blood at this point in time? How did Mr. Richards come to find that out? Is there a record somewhere that you were the person that did it?
A. I don't know how they keep it. I do not pay attention to those. All I can recall is -- that's why it's hard to recall somebody you did, you know. I don't even -- I just do what I'm there for, and I identify the patient and that's about it, identify -- if they tell me their name. If they can't, I look at their name band and I look at all the signs that you can -- as much as you can see on the wall, that no blood draws or check with the nurse, that kind of stuff, before I perform any --
Q. When you bring the blood down, do you initial something? Do you make a notation so that someone knows that you are the one that actually physically brought the blood down?
A. We put our number on the label of the specimen.
Q. What is your number?

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A. 2023.
Q. I assume you still handwrite the patient's name, you turn the blood?
A. We don't handwrite the patient's name. The label is generated, is printed already, and we have the labels with us, and we put our initial on -- whatever space we can, write our initial or our number.
Q. So you go into the room, and let's say it's not a really difficult stick, but it's not a real easy stick. Just generally, in your practice, how long do you spend there at the bedside in your morning sticks trying to get your routine blood work? And I understand an easy stick, it could be 30 seconds, and a hard stick, it could be 20 minutes. But, in general, one that's not real easy but not real difficult.
A. The time I spend to perform the phlebotomy on a particular patient?
Q. Yes. Yes.
A. Thirty seconds to -- every day -- 30 seconds, 40 seconds, because we have to clean.
Q. Right.
A. Forty seconds. We have to clean at least, scrub the patient at least, you know, no

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less than 30 seconds. Then once you are successful, you get it right, depending on how many tubes also, how many tubes you are drawing.
Q. And if you're not successful --
A. You can spend ten minutes to find -- five minutes to ten minutes.
Q. Can you?
A. Yes.
MR. RICHARDS: Jackie, again, to clarify, because I want to make sure the record is clear, are you talking about the time it takes for her to start getting the blood out? Are you talking from the time she walks into the room until the time she leaves the room?
MS. TRESL: She answered my question, Dan.
MR. RICHARDS: Can you read it back.
MS. TRESL: I think I'm asking the questions.
(Record read.)
Q. There's a lot of conversation in the literature, there's a lot of discussion in the literature that I've read. Generally, and I don't know if you can actually tell me this, but how deep do you tend to stick with your needle?

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A. Not very deep. As long as the bevel of the needle is safely in, and if I get it, I get it. If I don't, I just reposition a little bit, and if not, that's it, I withdraw it.
Q. What do you do when you encounter a vein that rolls?
A. I anchor the vein.
Q. How do you anchor the vein?
A. Okay.
Q. Say it with words so Karen can put it down.
A. I anchor the vein, once I clean the venipuncture area, the tourniquet is on, and I clean the area, then my thumb presses the skin and pull outward a little bit, then I draw the needle.
Q. And what if the vein continues to roll?
A. Then I won't get any blood. It will stop.
Q. Go ahead.
A. It stops. That's it.
Q. You know how sometimes you go to get a vein and it kind of moves away from you and you don't have it anchored? What do you do in

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that case?
A. I reposition a little bit, but I don't go no farther in.
Q. How do you reposition a little bit?
A. If I draw the needle in like that, and if I did push the skin a little bit, because it will be me or it will be him or her that will move, and I just have to position sideways that way, left or right side, and if I don't get it, I will withdraw it.
Q. So you're moving the needle left and right to sort of go back into the vein; is that correct?
A. No. I know that I am already -- the size of -- the bevel is in and the needle size and the measurement that I think is good enough to be in, and if I don't get it, I don't, you know -- the vein will disappear on me. That's why I just have to push my hand a little bit that way or a little bit that way, and I will -- if I still don't get it, that's when I call I failed it.
Q. Why do veins disappear? We all say that, as people who draw blood. All these years of experience, why do they disappear?

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A. I think if the patient move in any direction or in any kind of move, I think the whole arm move and the vein, it might also move. I don't know. Because they move, they really move, and you lose it.
Q. Yes, you do lose it. Do patients, typically, when you stick them, do they jump?
A. Some of them do. Because I tell them don't move, you beg them not to move for a second, and I do that. Some listen, some they don't. But once you draw the needle in also, they jump, they jerk. That's why I have to press and hold, you know, the arm as steady as I can.
Q. When they jump and move, does that sometimes cause the veins to roll?
A. To roll, yes.
Q. Or disappear?
A. Yes.
Q. How do you know if you're in the vein as opposed to the artery?
A. I know -- I feel that I'm in the vein -- I don't know exactly how I would explain it to you, but I feel that I'm in the vein. If I'm not in the vein, I feel that I am being

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retracted -- the needle -- I'm not going farther in, or that's it. It stops from there. If I try to push it, I am not going farther anymore, so I know I'm not in the vein.
Q. How do you know if you're in the vein?
A. They move and they complain, oops, or you're hurting me.
Q. How do you know if you're in an artery rather than a vein?
A. I don't know the answer to that because I -- I haven't done any that I recall, that I know of, into an artery.
Q. Have you ever had the experience where you put in a needle and you hit bone?
A. No.
Q. How about muscle?
A. Muscle, that's when I said it retracts. I don't go -- I can't go farther anymore, and they hurt, so I stop from there.
Q. Have you ever had the experience where, after you've drawn blood, the patient begins to swell?
A. After I draw the patient?
Q. Correct.

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A. I don't see a reason why it swell, because once I get into the vein and I get all the -- I'm halfway done with the tubes, if I have three or two, I release the tourniquet, and I am still filling the rest of the tubes. Then I know that prevent me from, you know, getting swell or bruised.
Q. In your experience then, you've never had a patient swell after you've done venipuncture, that you know of?
A. Yes.
Q. That's correct?
A. That's correct.
Q. Have you ever had a patient bruise under the skin after you've stuck, that you know of?
A. Occasionally, I do. But it's -- I'm not saying a big one. I'm not letting that happen. If I see that -- because some skin are very sensitive. If I draw the needle in, and if it start -- the color of the skin turn blue-ish or dark, I pull the needle out right away, because even if I am not far enough to get the vein, I pull it out and restart another because I don't want to cause bruise or hematoma.

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Q. So you can see that then, when you're in there, begin to form?
A. Yes.
Q. To your knowledge and your training and your experience, have you ever known, a minute or two minutes or three minutes after you've left the room, a hematoma to form?
A. I haven't experienced. I haven't seen one like that. In my own venipuncture performance?
Q. Right. Correct. Have you ever had someone follow up with you and say, Susan, the blood draw you did this morning, now the man has a big hematoma, do you know what happened?
A. No. None yet.
Q. We talked to Dr. Bertin a little bit about Mr. Hatfield. He was his surgeon in this case.
A. Doctor who?
Q. Dr. Bertin. And Dr. Bertin talked a lot about trying to stay superficial and not go deep, and that sometimes we do go too deep.
What is your understanding about going too deep when you're doing a venipuncture?
A. I really don't know that -- in my

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experience, I do not go too deep because -- why do I have to go that deep if I know that if the vein is right there, I have palpated, is shallow enough, and if I didn't, you know -- I don't think it is necessary for me to go farther deep anymore.
Q. Do you ever have an occasion where you feel a vein, don't see it, and puncture it?
A. Yes.
Q. Do you ever have an occasion when you sort of see a shadow, which I believe was your word, and you go after that?
A. Mostly I -- I don't perform any venipuncture without feeling and seeing a shadow of the vein.
Q. So would you perform it if you felt it but didn't see a shadow?
A. I can feel it, but because some skin that -- you know, it's hard for them, especially when they're dark skin, that's when I can feel the vein. And if I am comfortable, I will perform the venipuncture, but if I don't feel it is a vein, I won't attempt to do any venipuncture.
Q. In your experience, are there any

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special challenges in sticking the elderly?
A. Not really.
Q. So you approach drawing blood from the elderly the same way you do all adult patients?
A. Correct.
Q. How about very thin patients? Is there any change in your technique for them?
A. The change of the size of the needle. That's when I use the butterfly, when they are very little vein, and you see that they are a vein, then that's when I apply the other size -- the butterfly needle, the smaller needle.
Q. What if their veins are a good size but their bodies are very skinny; do you approach that venipuncture technique any differently?
A. No.
Q. If you have a problem when you're drawing blood and you see some, let's say, bruising, or the patient is complaining of a lot of soreness at the site, what do you do, if anything, as a followup to that?
A. I do not -- I look at it and I do

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not perform anything. I just look somewhere and I ask the patient, how about here. Do you feel pain in here, is it sore in here? If I see a vein in there, I press it as I ask them, how about here; it is sore up to here, or around in here also. If they said no, or if they said yes, then I go far -- I go farther and look.
That's why when I can't find -- they don't let you -- because they do, they do, in any way, whether they can say it, they -- in any expression they tell you that they refuse there, and you don't go there. I don't -- I look for, you know, up, down, lower or above it, but I do not -- any redness, any bruise, any kind of hematoma, I try to avoid it.
MR. RICHARDS: I want to interrupt again, and I am sorry for interrupting, but I want to make sure the record is clear and I want to make sure the question she's answering is the question that was asked.
Are you talking about if bruising develops while she's drawing the blood or if there's bruising present when she first looks at the arm?
MS. TRESL: I'm going to come back

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to the question. Thank you.
MR. RICHARDS: Listen to the question.
MS. TRESL: She's doing a great job.
Q. My additional question is: If you get in there and there's a little bit of pain after you're done or a little bit of swelling, what do you do, if anything, about that?
MR. RICHARDS: If you get in there. What do you mean by "if you get in there"? If you get into the room or if you've stuck her in the arm?
MS. TRESL: The vein.
A. If I already am done --
Q. Correct.
A. -- with the venipuncture?
Q. Correct.
A. If the patient said that it hurts?
Q. Yes.
A. I put pressure. I stay there until it stops bleeding and make sure that there's no bleeding and there's no hematoma or there's no bruise.
Q. What does putting pressure on that do?

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A. I put the gauze and keep it in there, I hold my hand, press it, until it's a good time to take a look at it, and if there's no bruise or it stopped bleeding, there's no bruise, there's no other marks but the needle mark, then I put the Band-Aid on.
Q. What does your putting pressure on that actually do? How does that work?
A. It helps -- I don't know, but it helps stop bleeding and it prevent from swelling and it prevent from developing any hematoma.
Q. Do you have to do that every once in a while, or commonly?
A. Mostly, but almost everybody.
Q. Mostly everybody you have to do that, or you don't have to do that?
A. I have to do it. I stay there until like it's a good time to leave the patient with no bruise, stop bleeding, and ready to put a Band-Aid or tape over the gauze that I, you know, put it in there.
Q. So you routinely, after you draw the blood, stand over the patient and apply pressure?
A. That's right.

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Q. How long do you apply pressure for?
A. That depends. It varies because there are veins that are bigger and smaller and -- bigger are a little bit more time to stop bleeding, and I, you know, I constantly checking it while I'm there, or a minute or two, make sure that it stopped bleeding.
Q. Let me just look over my notes a little bit and then we may be done, okay?
A. Okay.
(Pause.)
Q. The bevel of the needle, what direction are you trying to put the bevel into the vein when you're going into the --
A. Up.
Q. The bevel up?
A. Yes.
Q. When you get blood in your tube, when you hit the vein, do you advance the needle any further, or how does that work?
A. No.
Q. Tell me your exact technique and then we'll be done. You put the tourniquet on, you find your vein, you take the tourniquet off and cleanse. Then tell me what you do, just the

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finest detail from that point until you take the needle out.
A. Say that again.
Q. You have your tourniquet on, you find your vein. Then I believe you said you take the tourniquet off while you cleanse; correct?
A. That's correct.
Q. Then tell me what you do after you're done cleansing, just step-by-step-by-step describe the needle, how you put it in, the whole way.
A. Well, I have my gloves on. Then that's my needle to my Vacutainer. Then I look a little bit more to know -- to make sure I know still where the vein is. Then I press my -- anchor the skin where the needle, just below the vein, then I draw the needle in, and I push my Vacutainer, my tubes on, and keep filling it. Then getting closer to finishing it, I release my tourniquet and keep filling.
When I'm done, I withdraw all my tubes that are filled; then put the clean gauze over the needle and then I -- as I pull the needle, then put down, press down, the gauze and

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hold it there until I'm ready to tape, meaning I have to keep looking, if it's done, look what I did. If there's no bruise and stop bleeding, that's the most important thing that my concern is, then I tape it, and then I'm done.
Q. When you pull the needle out to get ready to put it on your Vacutainer, do you hold the needle up to look at the bevel?
A. No. Because our needle, we have the retract -- not the retractable. We have those needles now that once you withdraw the needle, you press the cover of that needle to prevent us from resticking them in another area or resticking ourself.
Q. I'm talking about before that, and maybe we need to clarify. In 2002, is that the kind of needle you were using?
A. Yes.
Q. Do you know the name of that kind of needle? Is there a brand name? And I can find that out from your attorney. I'm just wondering if you know, since you say it's a special retractable needle, if there's a certain company, Upjohn or --
A. Well, I can't --

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Q. That's fine. Before you stick the needle in is the question -- this is what I'm focused on here -- you open up the package, you pull the needle out; correct?
A. Say it again.
Q. You've cleansed and you are getting ready to stick. You pull your needle out of your box?
A. Right.
Q. I assume you have a little carrying case?
A. Right.
Q. You open the needle?
A. Yes. I don't open the needle.
Q. From the package.
A. The package. And connect it, connect it to my Vacutainer, and the needle is still capped, the cap is still on, until I am ready to stick.
Q. And when you take the cap off, my question is, how do you know where the bevel is before you put it into the --
A. I look. I look, make sure the bevel is up before I draw.
Q. So the bevel goes into the patient,

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and then let's say you advance the needle and you get a little bit of blood; am I correct?
A. I do not advance it. What do you mean by advance it?
Q. Well, you put it through the skin.
A. Yes.
Q. So you advance it through the skin; correct?
A. Yes.
Q. Or you tell me, how do you put it through the skin?
A. Well, I draw directly where I see the vein, where the vein is, you know.
Q. Right.
A. Where the vein is. And I draw it in and hold my hand over here. As I hold it steady, then I start filling up my tubes. And when I'm like -- like I said, when I'm almost done, release my tourniquet and finish filling up the last, or the last couple, tubes and I will pull the entire tube out and set it aside. Then I hold my hand over here where I want to have it steady so the needle won't move and I pick up my clean gauze and put it over here, and ready to pull the needle out, and I press and

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put the pressure in there. And then, as I pull the needle out, I press the cup, the safety cup, of the needle, and then set it aside, put it far away, you know, where it won't be in my way, and I stay there for a few seconds to make sure that it's ready, until it's ready to tape it or Band-Aid.
MS. TRESL: I think we are done, and I thank you for your patience.
MR. RICHARDS: We'll read.
(Discussion off the record.)
MS. TRESL: My understanding is that Susan is the one that drew at 5:20 after we have the nurse's notation that at 5:20 we have edema at the right antecubital area. You're telling me today that she's the one that did the blood work before that?
MR. RICHARDS: What I've been told is that she is the one whose identification numbers, and I think she testified what her number was --
MS. TRESL: Right.
MR. RICHARDS: -- shows up for that blood draw that occurred between 5:00 and 6:00 a.m. on August 6th. The only thing that I would

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add as a caveat to that is that it's my understanding that sometimes, such as for dialysis patients, that it's not impossible for a patient, while they're on dialysis, to have a draw while they're there and that the draw is delivered to the phlebotomist whose numbers will show up. But I don't think that there's any indication that he was in dialysis at this time period. It would probably be pretty unusual at that hour.
But there's situations that arise where a phlebotomist's ID numbers are on the sticker and show up where they're not the person who actually did the draw. I don't have any knowledge that that happened in that case, but I just want to say that, because that's how I understand how it works.
MS. TRESL: The only reason I'm a little concerned on this, and we can always redo more phlebotomy, but she said that her blood draw sticks start about 5:30, and this note is 5:20, and it would seem to me on a busy night she would start at 5:00. I just want to be sure, because she just testified she starts at 5:30, your belief is she could have done it at

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5:10.
MR. RICHARDS: Yes. Well, it's my belief, and that it's her -- of the numbers that identify the phlebotomy department, her numbers are the ones that are attributed to this particular time period.
MS. TRESL: And Jim, who was going to come next, he did blood work after this?
MR. RICHARDS: Subsequently. His numbers are attached to the ones that occurred later in the morning on the 6th.
MS. TRESL: And, further, Ms. Duska does not remember Mr. Hatfield?
MR. RICHARDS: None of them have any specific recollection.
MS. TRESL: You've talked to her. I think I don't need to depose Jim.
MR. RICHARDS: Okay.
MS. TRESL: We can go off record on that.
(Discussion off the record.)
MS. TRESL: Why don't we put on record we've agreed that we reserve the right to depose Ms. Duska and Jim if you decide to --
MR. RICHARDS: If we decide they

would be viable trial witnesses.
MS. TRESL: Otherwise we'll --
MR. RICHARDS: We'll call it quits for the day.
Based upon conversations with counsel, at this time we're going to, according to Ms. Tresl's agreement, hold off on the further depositions of the additional phlebotomists. However, I've agreed with Ms. Tresl that if we were to want to call them as witnesses at the time of trial, we would certainly produce them at a convenient time for everybody, regardless of any court record, discovery cutoffs or anything like that.
MS. TRESL: Off the record.
(Deposition concluded at 10:25 o'clock a.m.)
(Signature not waived.)

AFFIDAVIT

I have read the foregoing transcript from page 1 through 45 and note the following corrections:

PAGE	LINE	REQUESTED CHANGE

_____
SUSAN CABUYADOA

Subscribed and sworn to before me this _____ day of _____, 2004.

_____
Notary Public
My commission expires _____.

CERTIFICATE

State of Ohio,)
) SS:
County of Cuyahoga.)

I, Karen M. Patterson, a Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within named SUSAN CABUYADOA 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 17th day of March 2004.

Karen M. Patterson

Karen M. Patterson, Notary Public
Within and for the State of Ohio
My commission expires October 7, 2004.