IN THE COURT OF COMMON PLEAS

OF SUMMIT COUNTY, OHIO

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CHARLES G. PERE, et al.,

Plaintiffs,

vs

Case No. 03-07-3984
Judge Burnham-Unruh

THE LEDGES OF ROCKYNOL, et al.,

Defendants.

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DEPOSITION OF MICHAEL CARROLL, R.N.

THURSDAY, NOVEMBER 14, 2003

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Deposition of MICHAEL CARROLL, 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 Tipping Co., L.P.A., 525 N. Cleveland-Massillon Road, Akron, Ohio, commencing at 12:00 o'clock noon on the day and date above set forth.

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APPEARANCES:

On behalf of the Plaintiff

Becker & Mishkind

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On behalf of the Defendant Rockynol

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MICHAEL CARROLL, 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 MICHAEL CARROLL, M.D.

BY MS. TRESL:

Q. We met earlier. I represent John and Gene Pere. Please feel free to call me Jackie. May I call you Michael?

A. You may.

Q. Or do you prefer Mike?

A. Michael, please.

Q. Have you ever had your deposition taken before?

A. No, I have not.

Q. A few ground rules and then we will get into it and get you out of here sooner than I kept poor Robbin.

You understand that you are under oath to tell the truth?

A. Yes.

Q. I need you to answer yes or no, not shake your head and say uh-huh or uh-ugh.

A. Okay.

Q. I ask that you let me finish asking my question before you answer and I will hopefully give you the same courtesy to let you finish before I interrupt. I'll try to make it clear when I am done and if you do the same for me. I don't want to talk over you.

If you don't understand something, ask me, tell me you don't understand it.

A. I will.

Q. If you answer the question, I'm going to assume that you understand it.

A. Okay.

Q. For the record, would you state your name and address.

A. Michael Carroll, 907 Meadow Wood Drive, Barberton, Ohio 44203.

Q. Do you have a resume, Michael?

A. Yes.

Q. Maybe just in the interest of time if you could provide that to your attorney and I'll just ask you a few questions so we don't have to -- are you a registered nurse; is that correct?

A. Yes.

Q. What year did you graduate?

A. 1993.
Q. From what school?
A. Santa Rosa Junior College.
Q. Do you have an AD?
A. I do.
Q. Do you have any additional nursing college above that?
A. No.
Q. Are you BLS certified?
A. Yes.
Q. Are you ACLS certified?
A. No.
Q. Do you have any special certifications in gerontology nursing?
A. No.
Q. Do you have any other special certifications?
A. No.
Q. Tell me briefly your work history for the last, let's say, ten years.
A. I graduated in 1993. I worked in a long-term care facility in Northern California for approximately one year, let's say ten months. I moved back to Ohio, because I am from here, and I started working at Rockynol in 1994.

I was employed there full time until 2001. I think I need to rethink that. 2002. And now I work at Akron General Medical Center full time. I still work part time at Rockynol, on a PRN basis.

Q. About how often do you end up going back there?

A. Six times a month, approximately.

Q. When you work at Rockynol, do you always work 11:00 to 7:00 or you just happened to in this case?

A. I worked day shift at first for a couple years, and then I worked night shift primarily, probably for the last six or seven.

Q. And when did you leave Rockynol, did you say?

A. I think it was June 2001, because I started my new job at Akron General -- I'm sorry, 2002. I keep mixing those up, don't I?

Q. That's fine.

A. Summer of 2002, I switched jobs.

Q. Did you tell me what you do currently at Akron?

A. No, I did not.

Q. What floor do you work on?

A. 8100.
Q. Which is?
A. A family practice medical floor.
Q. Do you see gerontological patients or just a mix?
A. A mix.
Q. Have you ever been published?
A. No.
Q. Have you ever given any lectures?
A. No.
Q. Have you ever been disciplined for any reason?
A. No.
Q. Never called into question by the board of nursing?
A. No.
Q. Curiously, did you have to sit for the boards again in Ohio or did they reciprocate from California?
A. I had reciprocity.
Q. Great. Because I think in California, I think you have to take them again if you go from Ohio to California.
A. I think they accept New York's license but nobody else's.

Q. What did you read for today's deposition?
A. I reviewed the nurse's notes. I reviewed -- I saw, I didn't review -- I saw an acute plan of care. That's it.
Q. And when you say you saw an acute care of plan, did you see Mr. Pere's or a blank one?
A. I saw Mr. Pere's.
Q. Were you provided with Mr. Pere's complete chart if you wanted to review it or just those three sheets?
A. No, I was not. I didn't ask to review it. I was not provided with the entire chart. I reviewed my nurse's notes.
Q. Will you be able to show me as we get into the record which acute plan care sheet you reviewed?
A. Yes.
Q. Did you do any independent reading to prepare for today's deposition, any articles on gerontological nursing or anything specific to today?
A. No.
Q. Did you review any policies and

procedures?

A. No.

Q. Did you speak with anyone other than your attorney in preparation for today's deposition?

A. No.

Q. Do you remember Mr. Pere, independent of your nurse's notes?

A. One thing.

Q. Please tell me what that is.

A. He was tall.

Q. That's what Robbin said too. And why do you remember that he was tall?

A. I don't know.

Q. Did you see him standing, presumably?

MS. BREAUX: How tall was he?

MS. TRESL: I think 6 foot 1.

A. According to my nurse's notes, I saw him stand once, so presumably I saw him stand once.

Q. Before we get into your nurse's notes and the specifics of the chart, I want to ask you a few medical questions globally; a few concepts in terms of nursing care.

What is orthostatic hypotension?

A. It is blood pressure which drops when a person stands up.

Q. And if a patient has orthostatic hypotension, typically, how does that manifest itself in the patient?

A. Lightheadedness upon standing.

Q. Does that lightheadedness put them at an increased risk for fall?

A. Certainly.

Q. And does your nursing care change in any way if you are caring for a patient with known orthostatic hypotension?

A. Yes.

Q. And how would your nursing care change?

A. I would probably educate the patient about how to sit on the side of the bed before standing up.

Q. And presumably then what would happen?

A. Presumably the patient would sit on the side of the bed before he stood up.

Q. And if he didn't follow what you had advised him, then what would happen?

A. I don't know.

Q. A patient with confusion, do you change the way you care for them as a nurse relative to that?

MS. BREAUX: Objection. Go ahead and answer, Michael.

A. Yes.

Q. Tell me how.

A. Can you repeat the question?

Q. Sure. If you have a patient that is confused, how does your nursing care change toward that patient than a patient that is not confused?

A. They may be at more risk for injury, for one. Second, it might be more difficult to get a patient's health history from them if they are confused.

Q. Let's take the first one first. If they are at an increased risk for injury, how does your nursing care of them change relative to that?

MS. BREAUX: Objection. Go ahead and answer.

A. Can you repeat the question?

Q. You said if you have a patient that is confused, there are two things that could

manifest. The first was they were at higher risk for injury. How would you care for that patient based on that? How does your nursing care change relative to that?

A. More monitoring.

Q. Such as?

A. More frequent checks on the patient.

Q. And is that all?

A. Sometimes.

Q. Is there more than that that you would do?

A. Sometimes.

Q. And what would those sometimes other things be?

A. It depends.

Q. Give me the scenarios.

A. It depends on their ability to ambulate. It depends on what their confusion may affect. It may affect their ability to eat, may affect their ability to dress, may affect their ability to request the use of a urinal or to go to the bathroom, so an intervention for someone that doesn't know when they have to go may be to offer to take them to the toilet, for example.

Q. And we were talking specifically

about their increased risk of injury.
A. Right.
Q. So is there an increased risk of injury if they have to go to the bathroom without assistance?
MS. BREAUX: Objection. Go ahead.
A. It depends.
Q. Do you want to elaborate?
A. It depends on if they are stable when they get up.
Q. What if they have orthostatic hypotension when they get up and they are confused, does your nursing care change in ambulating them to the bathroom relative to that?
MS. BREAUX: Objection.
A. It depends on if they are stable when they ambulate.
Q. How do you determine that?
A. By observing them.
Q. Until you have established whether they are stable when they get up to go to the bathroom, what do you do until you determine that?
A. Continue to observe them.

Q. Would you let them get up to go to the bathroom by themselves in that period of time while you were observing them?

A. Can you ask the question again with more clarity, please?

Q. Sure. I'll make it into three small questions?

A. Okay. The questions are going along and I am trying to think back to where your first question started, so I want to answer you properly.

Q. Okay, that's fine. You said that a patient who is confused has an increased risk of injury. You said that a patient with orthostatic hypotension has an increased risk of being dizzy when they stand up. Presumably you would want to be with them until you determine that they were dizzy when they stood up, I believe is what you said.

A. Right.

Q. If you have a patient who you don't know their level of dizziness or confusion, which is what you said, you would continue to observe them. What would you do in that period of time when you were continuing to observe them

to determine whether or not it was safe for them to go up and down to the bathroom by themselves?

A. The call light should be within reach if they are able to get up and use the bathroom. They can have a bedside commode. We can make sure that the rails are down so they are able to get up if they want to.

Q. Well, I think we are sort of mixing things here. If they are confused, presumably the call bell may not help them. Is that correct? Are there occasions --

A. I think that's an assumption that I can't make.

Q. Is it possible that a confused patient would be confused enough that they would not know I need to press that call button to have my nurse come in here?

MS. BREAUX: Objection. Go ahead.

A. Yes, that's possible.

Q. Is it likely that if a patient is confused, having a call button beside them provides them with a safe environment in terms of when they need to ambulate to the bathroom?

A. Can you repeat the question?

Q. A call bell placed beside a patient

who is confused, is that sufficient in your mind caring for him as a nurse to ensure his safety if he has to go to the bathroom?

MS. BREAUX: Objection. Go ahead.

A. Sometimes.

Q. And sometimes it is not?

A. That's correct.

Q. So a call bell alone with a confused patient may not -- I'm not trying to put words in your mouth -- may not be sufficient to ensure that they get back and forth to the bathroom safely?

A. May not be.

Q. How does frequent incontinence affect a patient, the care that you give that patient? If you have a patient who is frequently incontinent, what do you do in nursing care relative to that?

MS. BREAUX: Objection. Go ahead.

A. Well, there are bowel and bladder assessments that can be done. You know, more checks on the patient. Offering a urinal. Obviously more changes, more peri care would be given.

Q. If a patient is frequently

incontinent of stool or bladder or both, do they have a tendency to want to get themselves to the bathroom?

MS. BREAUX: Objection.

THE WITNESS: Am I allowed to answer the question?

MS. BREAUX: Yes. I'm sorry.

A. Can you repeat the question again?

Q. Sure. You have a patient who is incontinent of urine and/or stool. When they are incontinent of urine and stool or they believe they are going to be incontinent of urine and stool, do they have a tendency to want to go to the bathroom, to get up from the bed and walk to the bathroom?

A. Yes.

Q. If a patient is confused and dizzy, and frequently incontinent of stool, do they still have a tendency to want to walk to the bathroom?

A. Yes.

Q. If a call bell is beside the patient and they are confused, and they are so confused that they may not notice it by the side of the bed, do you have any special nursing care that

you provide in your concern of their frequent incontinence as they are confused and maybe dizzy from orthostatic hypotension, is there some intervention that you provide so that they aren't walking to the bathroom unless you are there?

MS. BREAUX: Objection. Go ahead.

A. A bed alarm might be one.

Q. And who determines if a bed alarm should be placed on the patient?

A. A nurse.

Q. Any particular nurse?

A. Yes. Any nurse.

Q. Any nurse caring for the patient?

A. Yes.

Q. Do you need an order for a bed alarm?

A. No, I don't believe so.

Q. Do you, yourself, personally feel comfortable putting bed alarms on patients?

A. Yes, I do.

Q. So that's something that if we check the patient care that you have given, you have done that on many occasions?

A. Yes.

Q. Have you ever gone to get a bed alarm

where one is not available?
A. Yes.
Q. And what do you do then?
A. Report it to the supervisor that I need one.
Q. And then what happens?
A. Sometimes I get one. Usually I will.
Q. Do you remember in this case, do you remember in the time that you were caring for Mr. Pere in the January 2002 time period, February, if there was ever a shortage of bed alarms?
A. I don't remember.
Q. Would you remember if there had been?
A. No, I would not remember that, either.
Q. Can we agree that dizziness increases the chance that a patient will have a tendency to fall?
A. Yes.
Q. Can we agree that confusion increases the chance that a patient is not as apt to understand to use his call bell if he needs assistance?
A. I think it depends on the level of

confusion and what kind of confusion you are talking about.

Q. You described to me your definition of confusion and the levels and then we will do them one by one with the call bell.

A. Confusion may be disorientation to place.

Q. Okay.

A. It may be disorientation to time, person and circumstance.

Q. Those are the only kinds of confusion that we are talking about now?

A. That's the only kind that I can think of right now.

Q. If they are confused to place and you had a call bell beside them, is it likely that they would in their confusion to place know to press that call bell that they would need you for help to get to the bathroom?

MS. BREAUX: Objection. Go ahead.

A. Is it likely to use the call bell if they were confused to place?

Q. Yes.

A. I don't know if they are going to use it or not.

Q. That's my question. Is a patient who is confused to place, time, person, I'm asking you, the confused person, the alert person, are they equally as likely to use the call bell, when you say here is your call bell?
A. No.
Q. Who is more likely to use the call bell?
A. The alert person.
Q. Who is less likely to use the call bell?
A. The confused person.
Q. That's all I wanted. Thank you.
Are you familiar with the term falls prevention programs that are used in nursing homes?
A. Yes.
Q. Can you tell me what you know about them, your familiarity with them?
A. It would begin with an assessment.
Q. Okay.
A. And then it would be followed with interventions, hopefully to prevent a fall.
Q. Okay.
A. Followed by evaluation of whether

those interventions were successful and then reassessment.

Q. And this initial assessment I assume is done when the patient comes into the nursing home, in this case, the scenario we are talking about?

A. Yes.

Q. And the assessment is done, I'm assuming, by the admitting nurse?

A. Yes.

Q. And she goes down a checklist to determine interventions to prevent falls or she is just determining the likelihood that the person will fall?

A. I believe the likelihood that the patient will fall.

Q. Can you give me some of the checklists that would make a patient more likely to fall than not fall?

A. Sure. Orientation. Mobility. Continence. Medications. History of falls. That pretty much covers it as far as I can tell you right now. Things that are usually on the fall risk assessment.

Q. Is dizziness on the fall risk

assessment or is that included in one of these?
A. I don't know. I would have to look at the fall risk assessment to tell you if it was on there or not.
Q. Let's look at it. I think your counsel has one, but I'll get you mine.
MS. BREAUX: I'll state an objection to all questions related to this document.
Q. If you were the admitting nurse, would you be filling out typically the fall risk assessment sheet that's in front of you, but it would be blank, obviously, would not have Mr. Pere's name on it; correct?
A. Yes.
Q. You would be responsible for filling that out?
A. If I were admitting him, yes.
Q. And I asked Robbin this, and in the first box there, in terms of mentation, how do you determine whether a patient should be checked off on any of those in the first mental status?
A. Probably through the interview I would be able to get an inkling at least of whether or not they knew where they were, why

they were there, they would tell me about their orientation. I don't know that I would get immediately a sense of intermittent confusion, because I am only doing an initial assessment.

I would probably be able to determine whether or not they could follow simple directions and whether or not they had possibly an impaired memory. I would ask them about where they had come from; some things about whether or not they had children. I may ask them what time of year it is or what the date is today. Those are the things that I would ask in an assessment to determine their level of mentation.

Q. When you get a patient in as an admission, does their chart come with them or does their chart from where they were coming if they came from a hospital or nursing home, do you have that with you when you are doing a fall risk assessment?

A. No.

Q. So the way you would determine if a patient had intermittent confusion is just if you observed it at the time of your interview?

A. That's correct.

Q. You don't rely on anything that happened in the past if they came to you?
A. If it's made available to me, but it isn't always.
Q. Should it be made available to you?
MS. BREAUX: Objection. You can go ahead and answer, Michael.
A. It might help.
Q. I don't doubt that it might help, but we talked about here the assessment, the interventions to prevent falls. It sounds like that's pretty much on the top of the list in a patient that you are caring for.
If what you are doing is assessing the patient with the idea that you want to intervene to prevent falls, is a patient's history before they come to you in terms of confusion or history of falls, is that something that you would want to know?
A. Certainly.
Q. And is that information available to you if you request it?
A. I suppose if we called the hospital and asked for it.
Q. But the patient comes to you without

any history that you know of?

A. I believe they come with physician orders and a transfer sheet sometimes from the hospital, like a nursing discharge summary sometimes.

Q. And is that something that you review as you are admitting the patient?

A. Yes.

Q. So if that discharge sheet talked about periods of confusion or frequent falls, that would be something that you as the admitting nurse would take note of when you were doing your fall risk assessment; is that correct?

A. I would hope so.

Q. Can we agree that certain drugs, the side effect of them are dizziness?

A. Yes.

Q. Can we agree that antihypertensives can cause dizziness?

A. Yes.

Q. Can we agree that antidepressants can cause dizziness?

A. Yes.

Q. So we can agree that depending on the

combination of medications, a patient can be at a heightened risk of dizziness?

A. Yes.

Q. Are you familiar at all with this document -- mostly because I just want to establish that Rockynol used it -- which is the side rail assessment? You have seen that before?

A. Yes.

Q. Tell me what you understand number 7 to mean.

MS. BREAUX: Objection.

A. It means is the patient aware of the inability to stand or ambulate.

Q. And the answer that that nurse gave is?

A. No.

Q. If you were caring for a patient in which your colleague ahead of you, a shift ahead of you said that Mr. Pere was unaware of his inability to stand or ambulate, is that the kind of patient that then can be educated to sit by the side of the bed? What is the implication that you as the nurse caring for the patient --

MS. BREAUX: Objection. You can

answer.

A. Can you ask the question again? I'm sorry.

Q. That's fine. I know it's distracting.

If you, in fact, did get Mr. Pere's record and it's a quiet night and you have a little extra time and you know he has orthostatic hypotension and a lot of issues that we talked about, you see that the nurse that admitted him says he is not aware of his inability to stand or ambulate, you have a patient with known orthostatic hypotension, to educate him to sit at the edge of the bed, does that have any implication to you as a nurse caring for Mr. Pere?

A. Yes.

Q. What is that?

A. It may mean that he didn't understand what I may try to teach him.

Q. And then finally, if we could go through this document. Is this something that you are familiar with, which is the caregiver plan of care dated January 30th, 2002?

A. I believe this is for the nursing

assistants, I believe.

Q. And if that's for the nursing assistants, then they go down to when they are looking at ambulation mobility transfer, they are looking to see how he should be transferred and made mobile; is that correct?

A. Yes. There is a section here.

Q. And according to that, when he is being transferred and he is mobile, what should he be? What is his level there?

MS. BREAUX: Objection. Go ahead, Michael.

A. Supervision.

Q. And what does that mean, from a nursing standpoint?

A. Someone visually looking at him.

Q. And if someone isn't visually looking at him and he needs to get up and he is confused, and we know that he can't be reoriented, possibly, to the side of the bed before he gets up, is there some mechanism in place whereby he can be supervised if somebody is not in the room with him?

MS. BREAUX: Objection.

A. Are you asking me about this sheet?

Q. No. I'm asking in terms of if this is what our nursing technicians are to be following, if we assume this is the level at which Mr. Pere is supposed to be transferred and mobile, is there some -- let me ask you this. Is it possible for someone from the nursing department to be with Mr. Pere 24 hours a day, seven days a week?

A. No.

Q. In those times when it's not possible for someone to be there, and we know that he needs supervision for transfer, mobility, is there a mechanism whereby he can be supervised when somebody's eyes and ears aren't right there?

A. Yes.

Q. What would that be?

A. An alarm.

Q. And that alarm would be?

A. A bed alarm.

Q. Thank you. Do you know in terms of the orders -- and let's be specific for ambulation, because that's obviously what this is more about. What is the doctor's role in terms of determining what Mr. Pere is or is not

allowed to do relative to ambulation? In other words, is that an independent nursing decision or does the doctor order it and the nurses follow it? What is the dynamics of that?

A. A mobility order?

Q. In terms of ambulation, you get a patient in. Do the nurses decide the level at which he can be ambulated in terms of one person, two person, always in bed, always up, or does the doctor make that order?

A. In general, it's not any one person's determination. For example, nursing may give input to the doctor, the patient may come to the facility with an order as far as bed rest. Sometimes there is an order that says ambulate with assist. Sometimes therapy determines whether or not, sometimes nursing.

Q. And do you know in this case who determined Mr. Pere's level of ability to ambulate?

A. No.

Q. And so that we just reviewed the caregiver plan of care. Do we have any idea how that supervision level was filled out?

A. No.

Q. Who would have put that?
A. I don't know.
Q. If I showed you the records, would you be able to know?
A. Probably.
Q. I would like you to tell me if the physician ordered it, if the nurses intervened, sort of the dynamics of what was going on.
A. There is a mobility order that says up and assist. Let me see if I can find where it came from.
What day did he come in?
Q. I believe the 30th.
MS. BREAUX: The 29th.
Q. The 29th.
A. I am trying to find the admitting physician's orders. I don't see it. I see an order that says up and assist on the physician's order sheet. I am looking for the transfer order form from either acute care facility.
Q. And if the minimum data sheet says that the patient needs supervision to ambulate, it sounds like sort of a collegial atmosphere in determining level of ambulation, how much weight is the minimum data sheet, that assessment given

in terms of ambulation?
A. How much weight is it given?
Q. I mean, if the doctor says up and assist. First of all, when you read up and assist, what does that mean to you?
A. It would mean that the patient is allowed to get up.
MS. COEY: Objection.
A. It would mean that the patient is allowed to be up and we would provide assistance as necessary.
Q. And how do we know it's as necessary?
A. It's not specific assist.
Q. So up and assist means assist as necessary?
A. Yes.
Q. And if he wanted him to be assisted all the time, what would it say?
A. It might say up with assistance only.
Q. And if the doctor writes that and the person filling out the MDS writes up with supervision, is it the doctor's order then that is followed or does the nurse who has assessed the patient have an equal say on how you will ambulate the patient? In other words, whose

responsibility is it to determine if orders are conflicting or assessments are conflicting? Some people say one thing, some people say another.

A. Yeah. I believe the input comes from the physician who sees the patient once every 30 days, sometimes more. But usually the input comes from the nurse and then an order is asked for by the physician if we need to change that or therapy can determine what the level of ambulation is.

Q. But if the doctor writes up and assist, and that means as needed, then --

A. That's how I interpret it.

Q. Correct. Then that means that Mr. Pere, if that was his order, could basically get up and down and go as he pleased unless nursing determined that he needed some assistance?

A. That's how I interpret that order.

Q. Did you talk to Dr. Amanambu at any time while you cared for Mr. Pere?

A. No.

Q. Did you talk to him after Mr. Pere's death relative to Mr. Pere?

A. No.

Q. Do you work very much with Dr. Amanambu?
A. No.
Q. How did you learn that Mr. Pere had died?
A. When I came to work the next time I worked after his death.
Q. So you were already gone by the time he expired?
A. Yes.
Q. Let's go through your -- do you have your notes there? Do you want mine?
A. I can perhaps find them in here.
Q. Just for the record, what I'm going to have you do, Michael, is to read in all of the entries that you made so that it's very clear. Are we starting on the one that reads 1-30-02 nursing observation notes?
A. Yes.
Q. Would you read for us your entries.
A. Do you want me to read it as written or explain the abbreviations as I go?
Q. What the abbreviation are, read the word out. Don't explain. If it's BS, say blood sugar, bowel sounds. Read the date and time for

us.

A. 1-31-02, 2 a.m., alert and oriented, responsive and pleasant. Denies pain. Skin pink, warm and dry. Lungs clear to auscultation, bowel sounds positive, one plus edema bilateral feet, blood pressure 170 over 90, pulse 81. 91 percent room air, stands for oxygen saturation, respirations 20, temperature 96.5 orally. M. Carroll, RN.

Q. Let's stop there and kind of parse through that while we are there.

First, let's discuss the significance of a blood pressure of 170 over 90. I'm assuming this patient is supine when you are making this observation since you don't say otherwise or would you not document?

A. I couldn't assume that. I don't know if he was sitting up or laying down.

Q. Is there any significance to a blood pressure of 170 over 90?

A. It's hypertensive.

Q. And is there any significance to a hypertensive blood pressure relative to orthostatic hypotension which we know that he has?

A. Not that I'm aware.
Q. And an O2 sat of 91 percent, is there any significance to that?
A. Yes.
Q. And what is the significance to that?
A. It's borderline low.
Q. And if you have low oxygen, let's say to the brain, hypoxia, does that set you up for anything from a nursing diagnosis for a patient that would concern you?
A. Can you repeat the question? It was full of a lot of parts.
Q. Sure. If a patient that has a borderline O2 sat that you are caring for, does that send any red flags, any signals of the way that that might affect your patient; specifically in terms of mentation and/or ambulation?
A. Very low oxygen saturation will cause some confusion, certainly can. Sometimes that's how confusion or hypoxia is first noticed, by the patient's level of mentation or fidgetiness.
Q. And if they have the low oxygen, it's affecting their level of mentation, how does that affect their ability to make good

decisions, such as calling the nurse or sitting by the side of the bed to get their sea legs?

MS. BREAUX: Objection. You can answer.

A. It may compromise.

Q. And does it have any effect on their ability to ambulate to the bathroom if they have hypoxia?

MS. BREAUX: Objection. You can answer.

A. If they have hypoxia, it may.

Q. When a patient has orthostatic hypotension, is their blood generally high when they are supine and drops when they sit up and stand or is it the other way around?

A. It's higher when they are laying down than when they are standing.

Q. If you could read your next entry, please.

A. That's cut off. It must be 2-1-02, 4 a.m., alert, some confusion noted. Skin pale, warm and dry. Up to bedside commode independently. Blood pressure 140 over 80. Temperature 96.3 orally. 94 percent room air. Pulse 74. Respiration 16. Lungs clear to

auscultation, bowel sounds positive.
M. Carroll, RN.
Q. Now, you say here alert and some confusion noted. I assume because you have no independent recollection, you can only say that that's what you wrote, but you don't know how you would have made that determination?
A. You can assume that.
Q. And we cannot assume the posture of the patient for these vital signs; correct?
A. That's correct.
Q. And we can assume that they were taken after the patient had been up to the bedside commode or not?
A. No.
Q. So we can't assume?
A. We can't assume that I took his blood pressure after using the bedside commode.
Q. Do you know what the cut off is? Typically, as a nurse caring for a patient, where do you like to see your O2 sats? Do you have a level at which you would like to see them?
A. I like to see them 90 or above, especially in older people. 92 or above is

textbook normal.

Q. So you would disagree with 95 percent being the textbook normal?

A. Yes.

Q. And I'm going to assume you have no independent recollection of him getting up to the bedside commode, other than what you have documented?

A. You can assume that he was up to the bedside commode independent, that I was there, but I can't tell you how he did, except that he did it by himself.

Q. In terms of mobility, or you found him up there by himself?

A. I don't remember that.

Q. And if we can have your next entry, please.

A. 2-2-02, 3 a.m., responsive and pleasant. Skin pink, warm and dry. Lungs clear to auscultation. Bowel sounds positive. No complaints of pain. Two plus edema, bilateral lower extremity persists. Blood pressure 160 over 64. 96 percent on room air is the saturation. Pulse of 64, respiration 18 and unlabored. M. Carroll, RN.

Q. Is there any significance to the two plus bilateral lower extremity edema?
A. In terms of?
Q. Caring for your patient.
A. They are an indication of circulation. So they are an indication of how he is doing circulatory wise, if he is getting venous return.
Q. And does that indicate that he is or is not getting venous return?
A. It indicates that it's compromised.
Q. And if his venous return is compromised, does that have any effect long term on his mentation?
A. Gosh.
Q. As a nurse.
A. That sounds like a medical question.
Q. I don't think so. Just answer it from a nursing point of view.
A. I don't know.
Q. That blood pressure 160 over 64, is that high or low or normal?
A. For you or for this patient?
Q. For this patient.
A. It looks like it's how he runs, 170

over 90.

Q. So the fact that he runs high and we continue to see high blood pressures is not something that concerns you then?

A. No.

Q. No, it does not concern you?

A. 160 over 64 doesn't concern me in anybody.

Q. In anybody?

A. In anybody.

Q. And does 170 over 90 concern you in anybody in your earlier note of 1-31?

A. Can we talk about concern me?

Q. Sure.

A. Let's talk about 2 a.m. and 3 a.m. and do I do an intervention for a blood pressure of that kind at that hour.

Q. That's not the question. I mean, you can answer if you want.

A. That's what I mean by concern. I just want to clarify concern.

If it were my mother and her blood pressure was 170 over 90 on a daily basis, of course it would concern me. She probably has some hypotension that needs to be treated. But

in an immediate hour with the blood pressure like that, no.

Q. And if the blood pressure eight hours previous to that was 194 over 90, does that change your indicia of suspicion at all of the blood pressure of 160 over 64 at 3 a.m.?

A. Yes.

Q. And how would it change it?

A. If I took a blood pressure of 160 over 64, which I did on February 2nd, and saw that his last one was 194 other 90 when I was documenting this, if I saw that, indeed, I would come to the conclusion that that's okay for him.

Q. On the 31st, when you are doing your assessment, he has one plus edema bilateral feet; correct? At 2 a.m., you document one plus edema bilateral feet. And that would be 48 hours later he has two plus edema and it's no longer in his feet, it's in his lower extremities, according to what you document; is that correct?

A. According to what I documented.

Q. Can we agree that within 48 hours his edema has gone from one plus to two plus and has increased from his feet to his lower

extremities?

A. You can assume that by what is documented, yeah.

Q. Is that anything that would concern the reasonable nurse who is caring for Mr. Pere?

MS. BREAUX: Objection. You can answer.

A. One plus edema, two plus edema, concern the reasonable nurse?

I would note that. I don't know that I would be alarmed by edema of one plus or two plus. I don't know that I would be able to make that judgment right now without knowing how he came to us.

Q. And where would you go to find out how he came to you?

A. I could look on the initial assessment.

Q. Okay. But we know in the 48 hours that you were caring for him that he did have an increase in edema and it did go from his feet to his lower extremities, according to your documentation; correct?

A. According to my documentation.

Q. And we said earlier that peripheral

edema is a venous compromise; correct?

A. Yes.

Q. What is the significance in the edema increasing and going up the legs? Does it therefore mean the venous system is more compromised?

A. That or he has more fluid retention.

Q. If he has more fluid retention, what are the implications of that in terms of your nursing care for him?

A. I would probably most be concerned about his lung sounds with increased fluid retention. You would be concerned about congestive heart failure. There may be some -- to say it correctly, it may be some right sided compromise, the right side of his heart may be compromised and that's why he shows edema.

MS. COEY: I'm going to object. He is venturing into medical opinion now.

Q. And when you have things that are going on from the circulatory standpoint from a nursing diagnosis, can that affect the level of consciousness in mentation?

A. Circulation, yes.

Q. And what does it do in terms of

consciousness, confusion, dizziness, those sorts of things?

A. It may compromise them.

Q. Now, let's talk about sort of an ongoing -- I'm assuming and you tell me if I'm incorrect that when you take on the care of a patient, you get report from the previous nurse; correct?

A. Yes.

Q. And so your care is based on the report before you, and the report before her; it's sort of an evolution; correct?

A. Yes.

Q. You take all the knowledge that you have been given previously, apply it to what you see and sort of add your assessment to that mix; correct?

A. That's correct.

Q. And at what point in this process do you become comfortable that you know the patient's level of, let's say ability to ambulate, be confused, be dizzy, some of these things specific to Mr. Pere?

A. At what point do I become --

Q. Robbin had said it's an ongoing

process where you get familiar with the patient. It doesn't happen the first shift, it may happen later down the road. And she wasn't able to quantify it but in three encounters with Mr. Pere, you're beginning to feel that you could speak about how he would ambulate, if he was confused, if he was dizzy, those sorts of issues.

A. I think I can only document what I see. So that's what I do.

Q. So based on the documentation, you did note some confusion?

A. Yes.

Q. And if we could go back into the shifts that you bookended, okay? If we look at the shift following yours on the 31st, if I can refer you to that, Robbin and I spent a great deal of time talking about her 8 p.m., 8:30 and 10 p.m. charting.

Rather than rehash it, and we can if you would like, I think what we determined is that there was some suspicion that there was some confusion going on here; that it may not have been Mr. Pere in his most alert state sitting on the edge of the bed without his brief

on, refusing to be cleaned for stool for two hours.

Presumably if she is telling you that in report, are you thinking that perhaps that was confusion, or if she told you just what you are reading, would you say no, that is a patient who is alert and not confused?

A. I would assume that that was a patient that was not alert and oriented.

Q. Would you say that he might have been confused?

A. He might have been confused.

Q. Then you document that he has some confusion when you take over his care at 4 a.m.; correct?

A. Correct.

Q. Then if we look to the day nurse who is Ms. Lord -- I believe it's a female -- she also documents that he is confused. That would be at the bottom of that same sheet, Michael, the last line, alert and confused. Would you agree with that?

MS. BREAUX: Objection.

A. I agree that it's documented there.

Q. That's all I'm after. And then the

shift previous to yours on the 1st, we notice that J. Cuzl documents that the patient is experiencing some dizziness episodes; correct? Is that what is documented?

MS. BREAUX: Objection.

A. Can you show me where that is?

Q. Top right here.

A. Yes, that's what is documented.

Q. And in that same note, we have blood pressure of 194 over 90; correct?

A. Correct.

Q. Do we have anywhere in that note where the level of peripheral edema is addressed?

A. Let's see. No.

Q. So you would agree then based on the evolution of the reports that you have been given from the time you first cared for him on the 31st to the time you signed off with the care on the 2nd, that on your shift, the shift following yours, your shift, the shift following that one, the shift following that one, there is confusion and dizziness noted on each shift; correct? It's either/or. You either have confusion or you have dizziness noted; correct?

MS. BREAUX: Objection.

A. I have to go through them all.

Q. The one we talked about with Robbin, the 8 p.m. to 10 p.m. which we started with, which we thought it was an indicia of confusion based upon the fact that he sat on the side of the bed with his underpants on in stool. And then you document some confusion, then Ms. Lord documents some confusion, and then Ms. Cuzl documents some dizziness.

A. Yes.

Q. It's also documented what we discussed that his edema went one plus to two plus and from his feet to his lower extremities; correct?

A. Yes.

Q. Now, my question sort of standing back from this is, we know that when he comes in, one of the big concerns we have is to assess him for falls; correct?

A. Yes.

Q. And we want to have interventions to prevent falls. I'm assuming from what your testimony is and Robbin's, that one of the interventions and perhaps one of the best

interventions is nursing observation; correct?

A. Yes.

Q. At this point from what we just read over these 48 hours that we just walked through carefully, are there beginning to be red flags that say maybe something is going on where we need to be thinking about an intervention to prevent falls? In other words, is this patient beginning to look a little bit like he might be at risk for a fall?

MS. BREAUX: Objection. Go ahead.

A. Possibly.

Q. Do we see anywhere in this record or can you refer me to anywhere in the chart where someone is sort of putting these pieces together and saying, maybe we need to, let's say, apply a bed alarm?

MS. BREAUX: Objection. Go ahead.

A. Do I see anywhere in the chart where someone is putting that together in their head; is that what you are asking?

Q. Yes. I am trying to get the thought processes of very careful nurses doing very, very copious and excellent documentation. At what point does the scale tip a little bit that

maybe this man, as you said, is being set up to be at a higher likelihood of a fall, since we know that that's one of our number one concerns for Mr. Pere?

A. I don't see anything on these two pages.

Q. Would it have been reasonable at some point in these two pages to begin addressing the possibility that maybe his assessment needed to be changed?

MS. BREAUX: Objection. Go ahead.

A. Sure.

Q. And do we know why it wasn't?

MS. BREAUX: Objection. Go ahead.

A. No.

Q. Now, you took over the care of Mr. Pere at, I'm assuming 11:00. Robbin said that had she been in -- and we weren't clear of her involvement, I'll tell you up front, for the care of him from 3:00 to 11:00. We only know she did the fax with the TED hose. But she said based on what had come before her and the dizziness at 6 p.m. that she would have done things like checked him more frequently to determine his level of mentation and would have

been in and out of the room much more, keeping much closer watch on him. And I may be paraphrasing her incorrectly, but assuming that I am paraphrasing her correctly, is that reasonable and prudent to have done?

MS. BREAUX: Objection. You can go ahead and answer.

Q. Would you like me to repeat the question?

A. Yes, to your question.

Q. Yes, it would have been reasonable to have checked on him more frequently?

A. Yes.

Q. To determine his level of mentation?

A. Yes.

Q. Is there any documentation that he was checked more frequently?

A. No.

Q. And is there any more documentation as to his level of awareness other than your 2 a.m. or 3 a.m. responsive and pleasant?

A. No.

Q. Is there any reason to believe that he was checked on more frequently than at 3 a.m.?

A. Yes.
Q. And what would you base that on?
A. I would base that on the fact that nursing assistants make rounds three times a night. I saw him at least one time that I documented.
Q. But if we agree with Robbin that the reasonable and prudent nurse is trying to establish certain things to determine whether he is at an increased risk of fall, one of the things that's important to do is to document for your colleagues sort of the progression of his mentation; correct?
A. Yes.
Q. So if we can agree that that's important documentation, is that something that should have been in the record?
A. Yes.
Q. You have no independent recollection other than this 3 a.m. -- you have no recollection of this 3 a.m. other than what's written in front of us; correct?
A. Correct.
Q. Tell me the particulars of how you found out he died and what was said to you,

please.
A. I don't remember specifically. I remember, if you will, I remember where I was.
Q. Okay.
A. I remember sitting down, and the next time that I came to work someone told me.
Q. The next time you came to work. Did you work the following shift; do you remember?
A. I don't know.
Q. You came in. Do you remember who told you?
A. No.
Q. Was it a nurse, a supervisor?
A. It was a nurse, but I don't know who it was.
Q. And you don't remember anything at all what she said?
A. That he fell; that he was on the floor.
Q. And?
A. And that he died.
Q. And that's all you remember?
A. Uh-huh.
Q. And no one else discussed it with you other than this nurse?

A. I don't remember if anybody else ever discussed it with me or not.
Q. But they may have?
A. Yes.
Q. Would you think in the world of nursing and nursing home environment that this would be a fairly significant event?
A. Sure.
Q. Would you think that it would be something that would be discussed a lot for that time period?
A. Can you describe a lot to me?
Q. Most everyone commenting, saying I remember here, there, this happened, this is what I saw, boy I was so surprised, just sort of the general chatter that goes on?
A. They may have, sure.
Q. And we would think that that was probably likely what was going on?
A. It's possible. I don't really remember. It's likely in the world of nursing homes, the way people talk, but I don't remember.
Q. But you only remember that one sequence; he fell, he died?

A. I remember that somebody told me that he had fallen and that he died, and I remember where I was when they told me, but I can't remember specifically what they said or if somebody else said anything to me about it.

Q. Did you wonder at the time if there was something you may have done since you were the shift preceding that may have made a difference in terms of him dying?

MS. BREAUX: Objection.

A. No.

Q. You didn't go back and review in your mind, was there anything that Mr. Pere was exhibiting that maybe I missed or could have passed along to someone that might have helped him be alive today?

MS. BREAUX: Objection. Go ahead.

A. As a nurse, I thought about him, because I was told. I assume I thought about him.

Q. But you don't remember?

A. I don't remember.

Q. Would you typically in caring for a patient who died right after you left, would that be typically something that you would sort

of rehash in your mind as a caring professional?

A. Sure. What happened or how were they when I saw them.

Q. And you have no recollection of that rehashing that you did?

A. No, not specifically to him.

Q. Have you had a lot of events where patients who are presumably up and ambulating and, you know, talking, have you lost a lot of patients like that right after you leave your shift?

MS. BREAUX: Objection. Go ahead.

A. How many is a lot?

Q. I am trying to determine if there is a great significance or if this just happens to you all the time?

A. It's happened before.

Q. I understand it happened before.

A. It doesn't happen every day or once a week, certainly not.

Q. Does it happen so frequently that the significance of it is lost on you or not?

MS. BREAUX: Objection.

A. No, it doesn't happen that frequently.

Q. So presumably then there was significance associated with this?
A. I remember that it happened.
Q. But you don't remember at all your thought process?
A. I really don't. I would be guessing if I tried to think what I thought. I don't know what I thought or remember what I thought then. I remember hearing that he had expired and that he was on the floor.
Q. And you didn't go back and look at your nurse's notes?
A. No.
Q. Or review anything to see if there was anything that you could have done that would have made a difference?
MS. BREAUX: Objection.
A. No.
MS. TRESL: Give me a couple minutes and I think we may be done.
(Recess had.)
Q. One last question and then I am done.
Based on the acute care plan that you referred to -- and I don't know that we went through it, but I think we did -- one of the

interventions was to monitor risk for falls; correct? And that is an ongoing process. That's not a one time intervention; is that correct?

A. Correct.

Q. It should be done shift to shift; correct?

A. Yes.

Q. Can we agree that there is no documentation in the record at any time that you cared for him on your shift, the intervening shift, the final shift where he died where there is any indication where he was being monitored for an increased risk for fall?

MS. BREAUX: Objection. Go ahead.

A. I think that I talked about that I was monitoring his ability to ambulate, which is part of monitoring somebody at increased risk for fall when I talked about his bedside commode, so I think that there is --

Q. Would you point me to where your comment is looking like you are monitoring his ability to ambulate and not fall?

A. 1-1-02. Alert. Some confusion noted. Skin pale, warm and dry. Up to bedside

commode independently.

Q. But the fact that there is some confusion noted, does that not sort of maybe have some impact on the fact that you have recognized that he got up to the bedside commode independently?

A. I don't know. I charted that he got up to the bedside commode independently.

Q. But my question is, is there documentation that is showing that there is an increased monitoring for risk for fall? And you said, well, I documented it relative to him getting up to the bedside commode.

That's true that you did document that he was up to the bedside commode, but you also said he had some confusion noted.

My question to you is, the fact that you document the fact that he got up to the commode, noting that he has some confusion, your documentation is that you are monitoring him for risk of falls?

A. Yes.

MS. TRESL: No further questions.

EXAMINATION OF MICHAEL CARROLL, R.N.

BY MS. COEY:

Q. My name is Brenda Coey and I represent Dr. Amanambu.

If a physician gives an order and it isn't clear, whose responsibility is it to get that order clarified?

A. The nurse.

Q. Whenever the letters PRN follow a physician's order, what does PRN stand for?

A. As needed.

Q. When you read that order earlier for up and assist, did the letters PRN follow that order?

A. No.

MS. COEY: No further questions.

MS. BREAUX: We will read.

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(Deposition concluded at 1:05 p.m.)

(Signature not waived.)

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AFFIDAVIT

I have read the foregoing transcript from page 1 through 62 and note the following corrections:

PAGE	LINE	REQUESTED CHANGE

MICHAEL CARROLL, R.N.

Subscribed and sworn to before me this day of , 2003.

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 MICHAEL CARROLL, 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 19th day of November, 2003.

Vivian L. Gordon

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

My commission expires June 8, 2004.

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EXAMINATION OF MICHAEL CARROLL, R.N.