

1 IN THE COURT OF COMMON PLEAS
2 OF SUMMIT COUNTY, OHIO

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4 CHARLES G. PERE, et al.,
5 Plaintiffs,

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

7 THE LEDGES OF ROCKYNOL,
8 et al.,
9 Defendants.

10 - - - - -

11 DEPOSITION OF MICHAEL CARROLL, R.N.
12 THURSDAY, NOVEMBER 14, 2003

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14 Deposition of MICHAEL CARROLL, R.N., a
15 Witness herein, called by counsel on behalf of
16 the Plaintiff for examination under the statute,
17 taken before me, Vivian L. Gordon, a Registered
18 Diplomate Reporter and Notary Public in and for
19 the State of Ohio, pursuant to agreement of
20 counsel, at the offices of Tipping Co., L.P.A.,
21 525 N. Cleveland-Massillon Road, Akron, Ohio,
22 commencing at 12:00 o'clock noon on the day and
23 date above set forth.

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25

1 APPEARANCES:

2 On behalf of the Plaintiff

3 Becker & Mishkind

4 JACQUELINE D. TRESL, ESQ.

5 The Skylight Office Building

6 Suite 660

7 1220 W. 2nd Street

8 Cleveland, Ohio 44113

9 216-241-2600

10

11 On behalf of the Defendant Rockynol

12 Tipping Co., L.P.A.

13 ALISON M. BREAU, ESQ.

14 525 N. Cleveland-Massillon Road

15 Suite 207

16 Akron, Ohio 44333

17 330-670-8400

18

19 On behalf of the Defendant Amanambu

20 Bucking, Doolittle & Burroughs

21 BRENDA COEY, ESQ.

22 4518 Fulton Drive, NW

23 P. O. Box 35548

24 Canton, Ohio 44735

25 330-492-8717

1 MICHAEL CARROLL, R.N., a witness herein,
2 called for examination, as provided by the Ohio
3 Rules of Civil Procedure, being by me first duly
4 sworn, as hereinafter certified, was deposed and
5 said as follows:

6 EXAMINATION OF MICHAEL CARROLL, M.D.

7 BY MS. TRESL:

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

11 A. You may.

12 Q. Or do you prefer Mike?

13 A. Michael, please.

14 Q. Have you ever had your deposition
15 taken before?

16 A. No, I have not.

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

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

22 A. Yes.

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

25 A. Okay.

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

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

9 A. I will.

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

12 A. Okay.

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

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

17 Q. Do you have a resume, Michael?

18 A. Yes.

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

24 A. Yes.

25 Q. What year did you graduate?

1 A. 1993.

2 Q. From what school?

3 A. Santa Rosa Junior College.

4 Q. Do you have an AD?

5 A. I do.

6 Q. Do you have any additional nursing
7 college above that?

8 A. No.

9 Q. Are you BLS certified?

10 A. Yes.

11 Q. Are you ACLS certified?

12 A. No.

13 Q. Do you have any special
14 certifications in gerontology nursing?

15 A. No.

16 Q. Do you have any other special
17 certifications?

18 A. No.

19 Q. Tell me briefly your work history for
20 the last, let's say, ten years.

21 A. I graduated in 1993. I worked in a
22 long-term care facility in Northern California
23 for approximately one year, let's say ten
24 months. I moved back to Ohio, because I am from
25 here, and I started working at Rockynol in 1994.

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

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

8 A. Six times a month, approximately.

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

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

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

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

20 Q. That's fine.

21 A. Summer of 2002, I switched jobs.

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

24 A. No, I did not.

25 Q. What floor do you work on?

1 A. 8100.

2 Q. Which is?

3 A. A family practice medical floor.

4 Q. Do you see gerontological patients or
5 just a mix?

6 A. A mix.

7 Q. Have you ever been published?

8 A. No.

9 Q. Have you ever given any lectures?

10 A. No.

11 Q. Have you ever been disciplined for
12 any reason?

13 A. No.

14 Q. Never called into question by the
15 board of nursing?

16 A. No.

17 Q. Curiously, did you have to sit for
18 the boards again in Ohio or did they reciprocate
19 from California?

20 A. I had reciprocity.

21 Q. Great. Because I think in
22 California, I think you have to take them again
23 if you go from Ohio to California.

24 A. I think they accept New York's
25 license but nobody else's.

1 Q. What did you read for today's
2 deposition?

3 A. I reviewed the nurse's notes. I
4 reviewed -- I saw, I didn't review -- I saw an
5 acute plan of care. That's it.

6 Q. And when you say you saw an acute
7 care of plan, did you see Mr. Pere's or a blank
8 one?

9 A. I saw Mr. Pere's.

10 Q. Were you provided with Mr. Pere's
11 complete chart if you wanted to review it or
12 just those three sheets?

13 A. No, I was not. I didn't ask to
14 review it. I was not provided with the entire
15 chart. I reviewed my nurse's notes.

16 Q. Will you be able to show me as we get
17 into the record which acute plan care sheet you
18 reviewed?

19 A. Yes.

20 Q. Did you do any independent reading to
21 prepare for today's deposition, any articles on
22 gerontological nursing or anything specific to
23 today?

24 A. No.

25 Q. Did you review any policies and

1 procedures?

2 A. No.

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

6 A. No.

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

9 A. One thing.

10 Q. Please tell me what that is.

11 A. He was tall.

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

14 A. I don't know.

15 Q. Did you see him standing, presumably?

16 MS. BREAUX: How tall was he?

17 MS. TRESL: I think 6 foot 1.

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

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

25 What is orthostatic hypotension?

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

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

6 A. Lightheadedness upon standing.

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

9 A. Certainly.

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

13 A. Yes.

14 Q. And how would your nursing care
15 change?

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

19 Q. And presumably then what would
20 happen?

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

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

25 A. I don't know.

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

4 MS. BREAU: Objection. Go ahead and
5 answer, Michael.

6 A. Yes.

7 Q. Tell me how.

8 A. Can you repeat the question?

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

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

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

21 MS. BREAU: Objection. Go ahead and
22 answer.

23 A. Can you repeat the question?

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

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

5 A. More monitoring.

6 Q. Such as?

7 A. More frequent checks on the patient.

8 Q. And is that all?

9 A. Sometimes.

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

12 A. Sometimes.

13 Q. And what would those sometimes other
14 things be?

15 A. It depends.

16 Q. Give me the scenarios.

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

25 Q. And we were talking specifically

1 about their increased risk of injury.

2 A. Right.

3 Q. So is there an increased risk of
4 injury if they have to go to the bathroom
5 without assistance?

6 MS. BREAU: Objection. Go ahead.

7 A. It depends.

8 Q. Do you want to elaborate?

9 A. It depends on if they are stable when
10 they get up.

11 Q. What if they have orthostatic
12 hypotension when they get up and they are
13 confused, does your nursing care change in
14 ambulating them to the bathroom relative to
15 that?

16 MS. BREAU: Objection.

17 A. It depends on if they are stable when
18 they ambulate.

19 Q. How do you determine that?

20 A. By observing them.

21 Q. Until you have established whether
22 they are stable when they get up to go to the
23 bathroom, what do you do until you determine
24 that?

25 A. Continue to observe them.

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

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

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

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

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

20 A. Right.

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

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

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

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

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

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

18 MS. BREAUX: Objection. Go ahead.

19 A. Yes, that's possible.

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

24 A. Can you repeat the question?

25 Q. A call bell placed beside a patient

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

4 MS. BREAU: Objection. Go ahead.

5 A. Sometimes.

6 Q. And sometimes it is not?

7 A. That's correct.

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

13 A. May not be.

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

19 MS. BREAU: Objection. Go ahead.

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

25 Q. If a patient is frequently

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

4 MS. BREAU: Objection.

5 THE WITNESS: Am I allowed to answer
6 the question?

7 MS. BREAU: Yes. I'm sorry.

8 A. Can you repeat the question again?

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

16 A. Yes.

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

21 A. Yes.

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

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

7 MS. BREAU: Objection. Go ahead.

8 A. A bed alarm might be one.

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

11 A. A nurse.

12 Q. Any particular nurse?

13 A. Yes. Any nurse.

14 Q. Any nurse caring for the patient?

15 A. Yes.

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

17 A. No, I don't believe so.

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

20 A. Yes, I do.

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

24 A. Yes.

25 Q. Have you ever gone to get a bed alarm

1 where one is not available?

2 A. Yes.

3 Q. And what do you do then?

4 A. Report it to the supervisor that I
5 need one.

6 Q. And then what happens?

7 A. Sometimes I get one. Usually I will.

8 Q. Do you remember in this case, do you
9 remember in the time that you were caring for
10 Mr. Pere in the January 2002 time period,
11 February, if there was ever a shortage of bed
12 alarms?

13 A. I don't remember.

14 Q. Would you remember if there had been?

15 A. No, I would not remember that,
16 either.

17 Q. Can we agree that dizziness increases
18 the chance that a patient will have a tendency
19 to fall?

20 A. Yes.

21 Q. Can we agree that confusion increases
22 the chance that a patient is not as apt to
23 understand to use his call bell if he needs
24 assistance?

25 A. I think it depends on the level of

1 confusion and what kind of confusion you are
2 talking about.

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

6 A. Confusion may be disorientation to
7 place.

8 Q. Okay.

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

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

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

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

20 MS. BREAUX: Objection. Go ahead.

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

23 Q. Yes.

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

1 Q. That's my question. Is a patient who
2 is confused to place, time, person, I'm asking
3 you, the confused person, the alert person, are
4 they equally as likely to use the call bell,
5 when you say here is your call bell?

6 A. No.

7 Q. Who is more likely to use the call
8 bell?

9 A. The alert person.

10 Q. Who is less likely to use the call
11 bell?

12 A. The confused person.

13 Q. That's all I wanted. Thank you.

14 Are you familiar with the term falls
15 prevention programs that are used in nursing
16 homes?

17 A. Yes.

18 Q. Can you tell me what you know about
19 them, your familiarity with them?

20 A. It would begin with an assessment.

21 Q. Okay.

22 A. And then it would be followed with
23 interventions, hopefully to prevent a fall.

24 Q. Okay.

25 A. Followed by evaluation of whether

1 those interventions were successful and then
2 reassessment.

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

7 A. Yes.

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

10 A. Yes.

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

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

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

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

25 Q. Is dizziness on the fall risk

1 assessment or is that included in one of these?

2 A. I don't know. I would have to look
3 at the fall risk assessment to tell you if it
4 was on there or not.

5 Q. Let's look at it. I think your
6 counsel has one, but I'll get you mine.

7 MS. BREAU: I'll state an objection
8 to all questions related to this document.

9 Q. If you were the admitting nurse,
10 would you be filling out typically the fall risk
11 assessment sheet that's in front of you, but it
12 would be blank, obviously, would not have
13 Mr. Pere's name on it; correct?

14 A. Yes.

15 Q. You would be responsible for filling
16 that out?

17 A. If I were admitting him, yes.

18 Q. And I asked Robbin this, and in the
19 first box there, in terms of mentation, how do
20 you determine whether a patient should be
21 checked off on any of those in the first mental
22 status?

23 A. Probably through the interview I
24 would be able to get an inkling at least of
25 whether or not they knew where they were, why

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

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

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

21 A. No.

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

25 A. That's correct.

1 Q. You don't rely on anything that
2 happened in the past if they came to you?

3 A. If it's made available to me, but it
4 isn't always.

5 Q. Should it be made available to you?

6 MS. BREUX: Objection. You can go
7 ahead and answer, Michael.

8 A. It might help.

9 Q. I don't doubt that it might help, but
10 we talked about here the assessment, the
11 interventions to prevent falls. It sounds like
12 that's pretty much on the top of the list in a
13 patient that you are caring for.

14 If what you are doing is assessing
15 the patient with the idea that you want to
16 intervene to prevent falls, is a patient's
17 history before they come to you in terms of
18 confusion or history of falls, is that something
19 that you would want to know?

20 A. Certainly.

21 Q. And is that information available to
22 you if you request it?

23 A. I suppose if we called the hospital
24 and asked for it.

25 Q. But the patient comes to you without

1 any history that you know of?

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

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

8 A. Yes.

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

15 A. I would hope so.

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

18 A. Yes.

19 Q. Can we agree that antihypertensives
20 can cause dizziness?

21 A. Yes.

22 Q. Can we agree that antidepressants can
23 cause dizziness?

24 A. Yes.

25 Q. So we can agree that depending on the

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

3 A. Yes.

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

9 A. Yes.

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

12 MS. BREAU: Objection.

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

15 Q. And the answer that that nurse gave
16 is?

17 A. No.

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

25 MS. BREAU: Objection. You can

1 answer.

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

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

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

17 A. Yes.

18 Q. What is that?

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

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

25 A. I believe this is for the nursing

1 assistants, I believe.

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

7 A. Yes. There is a section here.

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

11 MS. BREAU: Objection. Go ahead,
12 Michael.

13 A. Supervision.

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

16 A. Someone visually looking at him.

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

24 MS. BREAU: Objection.

25 A. Are you asking me about this sheet?

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

9 A. No.

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

16 A. Yes.

17 Q. What would that be?

18 A. An alarm.

19 Q. And that alarm would be?

20 A. A bed alarm.

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

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

5 A. A mobility order?

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

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

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

21 A. No.

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

25 A. No.

1 Q. Who would have put that?

2 A. I don't know.

3 Q. If I showed you the records, would
4 you be able to know?

5 A. Probably.

6 Q. I would like you to tell me if the
7 physician ordered it, if the nurses intervened,
8 sort of the dynamics of what was going on.

9 A. There is a mobility order that says
10 up and assist. Let me see if I can find where
11 it came from.

12 What day did he come in?

13 Q. I believe the 30th.

14 MS. BREAU: The 29th.

15 Q. The 29th.

16 A. I am trying to find the admitting
17 physician's orders. I don't see it. I see an
18 order that says up and assist on the physician's
19 order sheet. I am looking for the transfer
20 order form from either acute care facility.

21 Q. And if the minimum data sheet says
22 that the patient needs supervision to ambulate,
23 it sounds like sort of a collegial atmosphere in
24 determining level of ambulation, how much weight
25 is the minimum data sheet, that assessment given

1 in terms of ambulation?

2 A. How much weight is it given?

3 Q. I mean, if the doctor says up and
4 assist. First of all, when you read up and
5 assist, what does that mean to you?

6 A. It would mean that the patient is
7 allowed to get up.

8 MS. COEY: Objection.

9 A. It would mean that the patient is
10 allowed to be up and we would provide assistance
11 as necessary.

12 Q. And how do we know it's as necessary?

13 A. It's not specific assist.

14 Q. So up and assist means assist as
15 necessary?

16 A. Yes.

17 Q. And if he wanted him to be assisted
18 all the time, what would it say?

19 A. It might say up with assistance only.

20 Q. And if the doctor writes that and the
21 person filling out the MDS writes up with
22 supervision, is it the doctor's order then that
23 is followed or does the nurse who has assessed
24 the patient have an equal say on how you will
25 ambulate the patient? In other words, whose

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

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

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

13 A. That's how I interpret it.

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

19 A. That's how I interpret that order.

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

22 A. No.

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

25 A. No.

1 Q. Do you work very much with
2 Dr. Amanambu?

3 A. No.

4 Q. How did you learn that Mr. Pere had
5 died?

6 A. When I came to work the next time I
7 worked after his death.

8 Q. So you were already gone by the time
9 he expired?

10 A. Yes.

11 Q. Let's go through your -- do you have
12 your notes there? Do you want mine?

13 A. I can perhaps find them in here.

14 Q. Just for the record, what I'm going
15 to have you do, Michael, is to read in all of
16 the entries that you made so that it's very
17 clear. Are we starting on the one that reads
18 1-30-02 nursing observation notes?

19 A. Yes.

20 Q. Would you read for us your entries.

21 A. Do you want me to read it as written
22 or explain the abbreviations as I go?

23 Q. What the abbreviation are, read the
24 word out. Don't explain. If it's BS, say blood
25 sugar, bowel sounds. Read the date and time for

1 us.

2 A. 1-31-02, 2 a.m., alert and oriented,
3 responsive and pleasant. Denies pain. Skin
4 pink, warm and dry. Lungs clear to
5 auscultation, bowel sounds positive, one plus
6 edema bilateral feet, blood pressure 170 over
7 90, pulse 81. 91 percent room air, stands for
8 oxygen saturation, respirations 20, temperature
9 96.5 orally. M. Carroll, RN.

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

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

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

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

21 A. It's hypertensive.

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

1 A. Not that I'm aware.

2 Q. And an O2 sat of 91 percent, is there
3 any significance to that?

4 A. Yes.

5 Q. And what is the significance to that?

6 A. It's borderline low.

7 Q. And if you have low oxygen, let's say
8 to the brain, hypoxia, does that set you up for
9 anything from a nursing diagnosis for a patient
10 that would concern you?

11 A. Can you repeat the question? It was
12 full of a lot of parts.

13 Q. Sure. If a patient that has a
14 borderline O2 sat that you are caring for, does
15 that send any red flags, any signals of the way
16 that that might affect your patient;
17 specifically in terms of mentation and/or
18 ambulation?

19 A. Very low oxygen saturation will cause
20 some confusion, certainly can. Sometimes that's
21 how confusion or hypoxia is first noticed, by
22 the patient's level of mentation or fidgetiness.

23 Q. And if they have the low oxygen, it's
24 affecting their level of mentation, how does
25 that affect their ability to make good

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

3 MS. BREAUX: Objection. You can
4 answer.

5 A. It may compromise.

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

9 MS. BREAUX: Objection. You can
10 answer.

11 A. If they have hypoxia, it may.

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

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

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

20 A. That's cut off. It must be 2-1-02,
21 4 a.m., alert, some confusion noted. Skin
22 pale, warm and dry. Up to bedside commode
23 independently. Blood pressure 140 over 80.
24 Temperature 96.3 orally. 94 percent room air.
25 Pulse 74. Respiration 16. Lungs clear to

1 auscultation, bowel sounds positive.

2 M. Carroll, RN.

3 Q. Now, you say here alert and some
4 confusion noted. I assume because you have no
5 independent recollection, you can only say that
6 that's what you wrote, but you don't know how
7 you would have made that determination?

8 A. You can assume that.

9 Q. And we cannot assume the posture of
10 the patient for these vital signs; correct?

11 A. That's correct.

12 Q. And we can assume that they were
13 taken after the patient had been up to the
14 bedside commode or not?

15 A. No.

16 Q. So we can't assume?

17 A. We can't assume that I took his blood
18 pressure after using the bedside commode.

19 Q. Do you know what the cut off is?
20 Typically, as a nurse caring for a patient,
21 where do you like to see your O2 sats? Do you
22 have a level at which you would like to see
23 them?

24 A. I like to see them 90 or above,
25 especially in older people. 92 or above is

1 textbook normal.

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

4 A. Yes.

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

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

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

15 A. I don't remember that.

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

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

1 Q. Is there any significance to the two
2 plus bilateral lower extremity edema?

3 A. In terms of?

4 Q. Caring for your patient.

5 A. They are an indication of
6 circulation. So they are an indication of how
7 he is doing circulatory wise, if he is getting
8 venous return.

9 Q. And does that indicate that he is or
10 is not getting venous return?

11 A. It indicates that it's compromised.

12 Q. And if his venous return is
13 compromised, does that have any effect long term
14 on his mentation?

15 A. Gosh.

16 Q. As a nurse.

17 A. That sounds like a medical question.

18 Q. I don't think so. Just answer it
19 from a nursing point of view.

20 A. I don't know.

21 Q. That blood pressure 160 over 64, is
22 that high or low or normal?

23 A. For you or for this patient?

24 Q. For this patient.

25 A. It looks like it's how he runs, 170

1 over 90.

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

5 A. No.

6 Q. No, it does not concern you?

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

9 Q. In anybody?

10 A. In anybody.

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

13 A. Can we talk about concern me?

14 Q. Sure.

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

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

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

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

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

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

7 A. Yes.

8 Q. And how would it change it?

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

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

22 A. According to what I documented.

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

1 extremities?

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

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

6 MS. BREAU: Objection. You can
7 answer.

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

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

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

17 A. I could look on the initial
18 assessment.

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

24 A. According to my documentation.

25 Q. And we said earlier that peripheral

1 edema is a venous compromise; correct?

2 A. Yes.

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

7 A. That or he has more fluid retention.

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

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

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

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

24 A. Circulation, yes.

25 Q. And what does it do in terms of

1 consciousness, confusion, dizziness, those sorts
2 of things?

3 A. It may compromise them.

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

9 A. Yes.

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

13 A. Yes.

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

18 A. That's correct.

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

24 A. At what point do I become --

25 Q. Robbin had said it's an ongoing

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

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

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

13 A. Yes.

14 Q. And if we could go back into the
15 shifts that you bookended, okay? If we look at
16 the shift following yours on the 31st, if I can
17 refer you to that, Robbin and I spent a great
18 deal of time talking about her 8 p.m., 8:30 and
19 10 p.m. charting.

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

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

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

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

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

12 A. He might have been confused.

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

16 A. Correct.

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

23 MS. BREAU: Objection.

24 A. I agree that it's documented there.

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

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

5 MS. BREAU: Objection.

6 A. Can you show me where that is?

7 Q. Top right here.

8 A. Yes, that's what is documented.

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

11 A. Correct.

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

15 A. Let's see. No.

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

1 MS. BREAU: Objection.

2 A. I have to go through them all.

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

11 A. Yes.

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

16 A. Yes.

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

21 A. Yes.

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

1 interventions is nursing observation; correct?

2 A. Yes.

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

11 MS. BREAU: Objection. Go ahead.

12 A. Possibly.

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

18 MS. BREAU: Objection. Go ahead.

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

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

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

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

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

11 MS. BREAUX: Objection. Go ahead.

12 A. Sure.

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

14 MS. BREAUX: Objection. Go ahead.

15 A. No.

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

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

6 MS. BREAU: Objection. You can go
7 ahead and answer.

8 Q. Would you like me to repeat the
9 question?

10 A. Yes, to your question.

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

13 A. Yes.

14 Q. To determine his level of mentation?

15 A. Yes.

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

18 A. No.

19 Q. And is there any more documentation
20 as to his level of awareness other than your
21 2 a.m. or 3 a.m. responsive and pleasant?

22 A. No.

23 Q. Is there any reason to believe that
24 he was checked on more frequently than at
25 3 a.m.?

1 A. Yes.

2 Q. And what would you base that on?

3 A. I would base that on the fact that
4 nursing assistants make rounds three times a
5 night. I saw him at least one time that I
6 documented.

7 Q. But if we agree with Robbin that the
8 reasonable and prudent nurse is trying to
9 establish certain things to determine whether he
10 is at an increased risk of fall, one of the
11 things that's important to do is to document for
12 your colleagues sort of the progression of his
13 mentation; correct?

14 A. Yes.

15 Q. So if we can agree that that's
16 important documentation, is that something that
17 should have been in the record?

18 A. Yes.

19 Q. You have no independent recollection
20 other than this 3 a.m. -- you have no
21 recollection of this 3 a.m. other than what's
22 written in front of us; correct?

23 A. Correct.

24 Q. Tell me the particulars of how you
25 found out he died and what was said to you,

1 please.

2 A. I don't remember specifically. I
3 remember, if you will, I remember where I was.

4 Q. Okay.

5 A. I remember sitting down, and the next
6 time that I came to work someone told me.

7 Q. The next time you came to work. Did
8 you work the following shift; do you remember?

9 A. I don't know.

10 Q. You came in. Do you remember who
11 told you?

12 A. No.

13 Q. Was it a nurse, a supervisor?

14 A. It was a nurse, but I don't know who
15 it was.

16 Q. And you don't remember anything at
17 all what she said?

18 A. That he fell; that he was on the
19 floor.

20 Q. And?

21 A. And that he died.

22 Q. And that's all you remember?

23 A. Uh-huh.

24 Q. And no one else discussed it with you
25 other than this nurse?

1 A. I don't remember if anybody else ever
2 discussed it with me or not.

3 Q. But they may have?

4 A. Yes.

5 Q. Would you think in the world of
6 nursing and nursing home environment that this
7 would be a fairly significant event?

8 A. Sure.

9 Q. Would you think that it would be
10 something that would be discussed a lot for that
11 time period?

12 A. Can you describe a lot to me?

13 Q. Most everyone commenting, saying I
14 remember here, there, this happened, this is
15 what I saw, boy I was so surprised, just sort of
16 the general chatter that goes on?

17 A. They may have, sure.

18 Q. And we would think that that was
19 probably likely what was going on?

20 A. It's possible. I don't really
21 remember. It's likely in the world of nursing
22 homes, the way people talk, but I don't
23 remember.

24 Q. But you only remember that one
25 sequence; he fell, he died?

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

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

10 MS. BREAU: Objection.

11 A. No.

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

17 MS. BREAU: Objection. Go ahead.

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

21 Q. But you don't remember?

22 A. I don't remember.

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

1 of rehash in your mind as a caring professional?

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

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

6 A. No, not specifically to him.

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

12 MS. BREAU: Objection. Go ahead.

13 A. How many is a lot?

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

17 A. It's happened before.

18 Q. I understand it happened before.

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

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

23 MS. BREAU: Objection.

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

1 Q. So presumably then there was
2 significance associated with this?

3 A. I remember that it happened.

4 Q. But you don't remember at all your
5 thought process?

6 A. I really don't. I would be guessing
7 if I tried to think what I thought. I don't
8 know what I thought or remember what I thought
9 then. I remember hearing that he had expired
10 and that he was on the floor.

11 Q. And you didn't go back and look at
12 your nurse's notes?

13 A. No.

14 Q. Or review anything to see if there
15 was anything that you could have done that would
16 have made a difference?

17 MS. BREAU: Objection.

18 A. No.

19 MS. TRESL: Give me a couple minutes
20 and I think we may be done.

21 (Recess had.)

22 Q. One last question and then I am done.
23 Based on the acute care plan that you
24 referred to -- and I don't know that we went
25 through it, but I think we did -- one of the

1 interventions was to monitor risk for falls;

2 correct? And that is an ongoing process.

3 That's not a one time intervention; is that

4 correct?

5 A. Correct.

6 Q. It should be done shift to shift;

7 correct?

8 A. Yes.

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

15 MS. BREAUX: Objection. Go ahead.

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

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

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

1 commode independently.

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

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

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

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

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

22 A. Yes.

23 MS. TRESL: No further questions.

24 EXAMINATION OF MICHAEL CARROLL, R.N.

25 BY MS. COEY:

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

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

6 A. The nurse.

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

9 A. As needed.

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

13 A. No.

14 MS. COEY: No further questions.

15 MS. BREAUX: We will read.

16 - - - - -

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

18 (Signature not waived.)

19 - - - - -

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1 AFFIDAVIT

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

5 PAGE LINE REQUESTED CHANGE

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MICHAEL CARROLL, R.N.

18

19

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

22

23 Notary Public

24

25 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, Notary Public
Within and for the State of Ohio

My commission expires June 8, 2004.

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