

IN THE COURT OF COMMON PLEAS
CUYAHOGA COUNTY, OHIO

Page 1

CHRISTOPHER S. LONG, etc.,)
 Plaintiffs,)
 vs) Case No. 321518
 CLEVELAND CLINIC FOUNDATION)
 Defendant.)

DEPOSITION OF DENISE HROBAT, R.N.

FEBRUARY 9, 1999

The deposition of DENISE HROBAT, R.N., the 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 The Cleveland Clinic Foundation, 9500 Euclid Avenue, Cleveland, Ohio, commencing at 1:00 o'clock p.m. on the day and date above set forth.

Page 3

1 DENISE HROBAT, 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 DENISE HROBAT, R.N.
7 BY-MS. TOSTI:

8 Q. Would you state your full name and spell
9 your last name for us, please.

L0 A. Denise Marie Hrobat H-R-O-B-A-T.

Q. And what is your home address?

12 A. 6819 Mitchell Drive, North Ridgeville,
13 Ohio, 44039.

14 Q. Is that a single-family home?

15 A. Yes.

16 Q. Have you ever had your deposition taken
17 before?

18 A. No.

19 Q. This is a question and answer session under
20 oath, and it's important that you understand the
21 questions that I ask you.

22 If you don't understand a question, if you
23 would like me to repeat it or if I phrase them in
24 a way that you don't understand what I am asking,
25 just tell me and I will be happy to repeat it.

Page 2

Page 4

1 APPEARANCES:

2
3 On behalf of the Plaintiff
4 Becker & Mishkind
5 BY: JEANNE M. TOSTI, ESQ.
6 Skylight Office Tower
7 1660 West Second Street
8 Suite 660
9 Cleveland, Ohio 44113

10
11 On behalf of the Defendant
12 Roetzel & Andress
13 B Y JOHN V JACKSON, III, ESQ
14 INGRID KINKOPF-ZAJAC, ESQ
15 1375 E. 9th Street
16 Cleveland, Ohio 44114

1 Otherwise, I am going to assume that you
2 understood my question and that you are able to
3 answer it.

4 It's important that you give all of your
5 answers verbally, because our court reporter
6 cannot take down head nods or hand motions.

7 I don't know, did Mr. Jackson provide you
8 with a set of medical records?

9 A. Yes.

10 Q. If at any point you want to look at those,
11 feel free to do so.

12 He may enter an objection at some point
13 during the deposition. If he does so, you are
14 still required to answer my question unless he
15 instructs you not to. Okay?

16 A. Okay.

17 Q. Would you tell me what you have reviewed in
18 preparation for this deposition.

19 A. My charting that was related to the
20 patient.

My vital signs, flow sheets, his history
and the order sheets.

Q. Have you reviewed any textbooks or journal articles?

25 A. No.

<p style="text-align: right;">Page 5</p> <p>1 Q. And have you discussed this case with 2 anyone other than with counsel? 3 A. No. 4 Q. Do you have any personal notes or personal 5 file on this case? 6 A. No. 7 Q. Have you ever generated any personal notes 8 or a personal file on this case? 9 A. No. 10 Q. Now, you are a registered nurse in the 11 State of Ohio; is that correct? 12 A. Yes. 13 Q. And at the time that James Long had his 14 surgery in August of 1996, you were a registered 15 nurse in the State of Ohio? 16 A. Yes. 17 Q. And also, you have to let me get my 18 question out and then answer it, because the court 19 reporter can't take down two people talking at the 20 same time. 21 A. Okay. 22 Q. What type of basic nursing program did you 23 attend? 24 A. Bachelor's of science at Kent State 25 University.</p>	<p style="text-align: right;">Page 7</p> <p>1 Q. Did you have any particular orientation 2 when you started here at the Cleveland Clinic? 3 A. Yes. 4 Q. Your current employer is the Cleveland 5 Clinic; is that correct? 6 A. Correct. 7 Q. What is your current title and position? 8 A. Staff nurse, RN. 9 Q. What clinical area do you currently work 10 in? 11 A. Cardiothoracic intensive care. 12 Q. And when did you first become employed at 13 the Cleveland Clinic? 14 A. June 24th, 1991. 15 Q. So since the time that you obtained your 16 nursing license, you have been a Cleveland Clinic 17 employee? 18 A. Yes. 19 Q. And when you first became employed by 20 Cleveland Clinic, what area were you employed in? 21 What area of the hospital? 22 A. The cardiothoracic intensive care unit. 23 Q. You received an orientation from Cleveland 24 Clinic to work in that intensive care area? 25 A. Yes.</p>
<p style="text-align: right;">Page 6</p> <p>1 Q. And when did you receive your nursing 2 degree? 3 A. In 1991, May. 4 Q. And your license? 5 A. That was issued to me I think in August of 6 1991. 7 Q. And since the time of your basic nursing 8 education, have you completed any additional 9 degrees or any additional certifications in 10 nursing? 11 A. Yes. 12 Q. What are those? 13 A. Advanced cardiac life support. 14 Q. When did you complete that? 15 A. About five years ago. Intraaortic balloon 16 pump class. 17 Q. Was that here at the Cleveland Clinic? 18 A. Yes. 19 Q. When did you do that? 20 A. Maybe about five or six years ago. I can't 21 tell you the exact date. 22 Q. That's fine. 23 Anything else? 24 A. Not that I can think of off the top of my 25 head right now.</p>	<p style="text-align: right;">Page 8</p> <p>1 Q. How long was your orientation? 2 A. It was around 10 to 12 weeks. 3 Q. And in August of 1996, was your position a 4 full-time position? 5 A. Yes. 6 Q. And in August of 1996, you had worked in 7 the cardiothoracic intensive care unit about five 8 years? 9 A. Yes. 10 Q. What was the usual shift that you worked in 11 August of '96? 12 A. I would work 11 A's to 11 P's or 7 A's to 7 13 P's. 14 Q. So you were working a 12 hour shift? 15 A. Yes. 16 Q. And at that time, who was your immediate 17 supervisor? 18 A. Dolly Gantner. 19 Q. And what was her title? 20 A. Headnurse. 21 Q. She was head nurse of the cardiothoracic 22 intensive care? 23 A. Lily Hicks was the head nurse, just about 24 two years. This change might have happened right 25 in that summer. For the exact times -- I know</p>

<p style="text-align: right;">Page 9</p> <p>1 they had a nursing structural change then around 2 that time frame and it was either Dolly Gantner or 3 Lily Hicks, but I think it was Dolly Gantner, 4 actually. 5 Q. Now, in August of '96, how many patients 6 would you normally be assigned if you were working 7 in the evening? 8 A. One to two. 9 Q. And who would make that assignment of 10 patients? 11 A. Either the charge nurse or our assistant 12 head, the clinical coordinator. 13 Q. Were all of the patients that were in the 14 cardiothoracic unit at that time post-op 15 cardiothoracic patients? 16 A. Yes. Usually. It depends. If we had 17 holdover of cath patients from the PACU, then we 18 would take those patient population, or 19 preoperative aneurysms, there are some pre-op 20 patients we would get, but generally we would have 21 postoperative cardiothoracic patients. 22 Q. What was the maximum census in the unit? 23 A. Ten. 24 Q. Now, the head nurse, would she do charge 25 duties in the unit when she was on shift?</p>	<p style="text-align: right;">Page 11</p> <p>1 A. Yes. 2 Q. And in the evenings, in August of '96, how 3 many nurses would actually be doing patient care 4 in the unit? 5 A. If it was full with ten patients, probably 6 five. It just depends on the patient's acuity. 7 If we would have two balloon pumps in there, you 8 would have six RNs. It depended upon the 9 patient's acuity level and how many patients in 10 the unit, So I would have to look at the census 11 and then the patient's acuity. 12 Q. Would it be the clinical coordinator that 13 would decide on the staffing or would it be the 14 charge nurse? 15 A. Usually. 16 Q. The clinical coordinator? 17 A. The coordinator unless they weren't there. 18 Q. Prior to working in the ICU, did you 19 receive hemodynamic monitoring classes? 20 A. Just with Kent State University's 21 preparation in the critical care class that I 22 took. 23 Q. That was part of your basic nursing 24 program; correct? 25 A. Right, yes.</p>
<p style="text-align: right;">Page 10</p> <p>1 A. No. 2 Q. You had a head nurse and additionally you 3 had a charge nurse assigned? 4 A. Right, a head nurse and then a clinical 5 coordinator and then the charge nurse, who would 6 have her own patient assignment too. 7 Q. And just from your perspective, just 8 generally, the head nurse, was her job mostly 9 management? 10 A. Yes. 11 Q. She didn't do direct patient care? 12 A. No. 13 Q. And the clinical coordinator, what were her 14 duties from your perspective? 15 A. Mostly overseeing staffing needs, our staff 16 schedules, managing the patients coming in and 17 going out of the unit as far as transfers and 18 admissions, problems. 19 Q. And then you would -- did the clinical 20 coordinator take a patient assignment. 21 A. No. 22 Q. Then you had a charge nurse? 23 A. Yes. 24 Q. Did the charge nurse have any patient 25 assignment?</p>	<p style="text-align: right;">Page 12</p> <p>1 Q. In the classes that you had in preparation 2 to work in Cleveland Clinic's ICU, did they review 3 hemodynamic monitoring with you? 4 A. Yes. 5 Q. Were you taught how to recognize abnormal 6 parameters -- 7 A. Yes. 8 Q. -- in the Kent State program or in the one 9 that you received at the Cleveland Clinic? 10 A. I can't remember with Kent State, but I 11 know, yes, at the Cleveland Clinic. 12 Q. And as an ICU nurse, were you taught to 13 recognize significant trends in hemodynamic 14 monitoring? 15 A. Yes. It depends who oriented you, but, 16 yes, basically. 17 Q. Do you do that as a nurse in the intensive 18 care unit, watch for trends in the hemodynamic 19 monitoring? 20 A. Not necessarily. It depends what the 21 patient's diagnosis is, what they came back from 22 surgery with. You know, what their surgery was. 23 It just depended upon the circumstance actually. 24 Is that what you are asking me? 25 Q. I am asking whether or not you have the</p>

Page 13	Page 15
<p>1 expertise to notice a trend in the hemodynamic 2 monitoring parameters? 3 A. I feel I do. I feel experienced to notice 4 if there is a problem occurring. 5 Q. And were you also taught to keep the 6 supervising physicians informed of any significant 7 changes that you noted? 8 A. Yes. 9 Q. Now, as a staff nurse in the cardiothoracic 10 intensive care unit in August of 1996, what were 11 your duties and responsibilities? 12 A. At that time, I was orienting new RNs. I 13 don't know if I had an orient at that time. 14 Charge nurse and staff RN. 15 Q. And in regard to patient care, what were 16 your duties and responsibilities? 17 A. Assessing the patient, recording vital 18 signs, talking to family members, monitoring the 19 patient constantly. 20 Do you want me to be very specific? Do you 21 want me just to tell you basically what I would do 22 if I was taking care of that patient? 23 Q. Yes. 24 A. Vital signs, like I said. The assessment. 25 The respiratory status. Family issues. That's</p>	<p>1 Q. Do you have any independent recollection of 2 James Long aside from what you saw in the medical 3 records? Do you remember him? 4 A. No. 5 Q. Now, on August 20 of 1996, what hours did 6 you work that day? 7 A. From my documentation if I would have left 8 at 7:00 p.m. or 7:30 p.m., I most likely worked 9 7 A to 7 P unless they cancelled me my first four 10 hours. 11 Q. And when you were working at that time, you 12 always worked in the cardiothoracic unit? 13 A. Yes, unless we were floated to the floor or 14 G-20, which is CCU. 15 Q. And based on the medical records that you 16 reviewed, when did you care for James Long? 17 A. I took care of him immediately 18 postoperatively until I gave report to the next 19 nurse at 7:00 o'clock and I probably would have 20 left by 7:30. 21 Q. And that evening, when you took care of him 22 postoperatively, did you have any other assigned 23 duties other than patient care for James Long? 24 A. I could not remember or tell you that 25 information.</p>
Page 14	Page 16
<p>1 basically all. 2 Q. And in regard to your assessment, what are 3 you assessing? 4 A. Assessing neuro status, lungs, vital signs, 5 abdominal, bowel sounds, chest tube drainage, 6 urinary output, lab values, temperatures, readings 7 on the monitor, as far as heart rates, blood 8 pressure, PA pressures, CVP pressures, oxygen 9 saturations. 10 Q. In August of '96, did the Cleveland Clinic 11 utilize any supplemental staffing; such as a PRN 12 pool or a float personnel from other areas to 13 staff the unit? 14 A. We usually do all the time. 15 Q. Can you be a little bit more clear on your 16 answer? 17 A. We have a PRN staff and we have a float 18 pool. So if the nursing staff was down, we would 19 utilize a PRN pool and the float pool, if needed. 20 Q. Are the PRN staff and the float staff 21 trained in hemodynamic monitoring? 22 A. Yes. 23 Q. Are they all ACLS certified? 24 A. They should be after two years of ICU 25 nursing.</p>	<p>1 Q. Do you know whether you had charge duty 2 responsibilities? 3 A. I couldn't tell you, honestly. 4 Q. And just to be clear, you don't know 5 whether you had an additional patient that 6 evening? 7 A. Correct, I do not know. 8 Q. If a postoperative patient developed 9 problems in the unit that required a physician's 10 attention, was there any policy or procedure you 11 followed regarding what physician would be 12 contacted? 13 A. Yes. 14 Q. Would you tell me what that is. 15 A. In the daytime, there is a resident or a 16 fellow on call from 7 A to 7 P, and they are on 17 their call sheet numbers. They are on call for 18 the unit. 19 After 7:00 p.m., it's who is on call from 7 20 P to 7 A on the call sheet for the unit, and they 21 usually, the doctors will divide, they will say I 22 will take 52 and 54, because there will be two 23 physicians on for all the G-5's, and they will -- 24 Q. I don't understand what you mean 52, 54, 25 what is that?</p>

Page 17

Page 19

1 A. At that time we had five cardiothoracic
2 intensive care units. Right now we have four
3 cardiothoracic intensive care units. So
4 generally, there would be a doctor resident on for
5 two units and another resident on for the other
6 two units.

7 Q. What clinical specialty would the person on
8 call be?

9 A. I do not know.

10 Q. Would you know whether it would be
11 anesthesia or whether it would be surgical?

12 A. Surgical, if that's the problem I was
13 having. If I was having a ventilation problem, I
14 would be calling the anesthesia on call.

15 Q. So did you have two doctors on call; one
16 for anesthesia and one for surgery?

17 A. Yes.

18 Q. Okay. Now, were you allowed to make calls
19 directly to the doctors or did you have to go
20 through, say, your clinical coordinator or head
21 nurse or charge nurse?

22 A. No, you could directly call the physician
23 if you have a problem.

24 Q. And were you instructed to call the
25 resident rather than the surgeon that actually did

1 Q. And when you find what you are looking for,
2 if you could just tell me what portion of the
3 record you are looking at, if there is a title on
4 the page.

5 A. I am looking at the flow sheet for his
6 first day that he was in the intensive care unit.
7 It starts where he came back and vital signs are
8 1730, and there is a whole flow that gives you
9 vital signs and then significant events and then
10 outputs.

11 Q. So when you received the patient from
12 surgery, what information did you receive?

13 A. They would tell you the surgery that was
14 done. He had an AVR replacement. Homograft. The
15 resident would tell you where they would like the
16 blood pressures kept.

17 Q. Now, in this instance, my question is, what
18 information did you receive on James Long? And so
19 what I am asking you to do, if you can discern
20 that from the record, is tell me as best you can
21 the information that you received on James Long at
22 the time that you admitted him to the intensive
23 care unit.

24 A. Okay. They told me, either the anesthesia
25 resident or the [REDACTED] told me the patient is

Page 18

Page 20

1 the surgery if there was a problem?

2 A. Usually the surgeon will tell you if you
3 have a problem, you could call me, or usually you
4 call the resident on call.

5 Sometimes the fellow or the person doing
6 the surgery with the staff doctor would tell you
7 to call them at home or call them, but generally
8 it was the resident on call to call if there was a
9 problem with a patient.

10 Q. Did you do the initial nursing assessment
11 on James Long when he was admitted to the
12 cardiothoracic unit?

13 A. Yes.

14 Q. Did you receive a report on the patient at
15 the time that you admitted him to the intensive
16 care unit?

17 A. Yes.

18 Q. Who gave you the report on the patient?

19 A. Anesthesia resident or an anesthesia CRNA

20 Q. And in this instant, do you know who gave
21 you the report on James Long?

22 A. No.

23 Q. What information were you given at the time
24 that you received the report?

25 A. I would have to look at the documentation.

1 obese. History of syncope. They dislodged teeth
2 during intubation. Has a normal left ventricle.
3 Gave him no blood in the OR. Told me the time
4 they gave the antibiotics in surgery. What his
5 hematocrit was in surgery. The last lab value was
6 31, last potassium was 4.4. Any allergies, which
7 none are documented. And that they gave him lasix
8 60 milligrams IV. Also, his intake of three
9 liters and his output of urine of 800 cc's. And
10 that's all I can tell what they told me or another
11 nurse.

12 Q. Okay. From what you have reviewed in the
13 record, did you find anywhere that he had a
14 bleeding problem during surgery?

15 A. No.

16 Q. If you had been told that, would it be your
17 usual manner to include that in the initial note
18 that you have just read to me?

19 A. Yes.

20 Q. So is it likely in this case that you did
21 not receive any information that he had any
22 bleeding problems in surgery?

23 A. Right, yes. No, he did not.

24 Q. If you had been informed that a patient had
25 bleeding problems during surgery, do you watch

<p style="text-align: right;">Page 21</p> <p>1 that patient more closely for signs of problems or 2 hemodynamic trends that would indicate bleeding? 3 A. Yes. 4 Q. What time was James Long admitted to the 5 cardiothoracic unit? 6 A. It is documented at 5:30 p.m. 7 Q. And did you do an assessment on him at that 8 point in time? 9 A. Yes. 10 Q. And what were your findings on that 11 assessment? And again, if you would tell me what 12 the page you are looking at is. 13 A. Okay. I am looking at the -- I don't have 14 it marked here clearly, but -- 15 Q. Just hold it up and I will probably be able 16 to recognize what it is. 17 A. Right here is the nursing progress record. 18 Q. Okay. 19 A. And there is this sheet and this sheet that 20 goes together. 21 Q. Which looks like a checklist for 22 assessment, the second page that you are referring 23 to. 24 A. Yes. My name is at the bottom from 1500 to 25 1900.</p>	<p style="text-align: right;">Page 23</p> <p>1 Pupils are equal and reactive to light. 2 Speech clear, coherent is starred because patient 3 is obviously intubated, even though it wasn't 4 charted on my assessment. 5 Moves all extremities, no weakness starred 6 because sometimes, you know, postoperatively we 7 are paralyzing the patient and sedating the 8 patient, so there is an alteration of normal 9 movement. Nonapplicable to study gait. 10 He is injury free from our MRA protocol. 1 Pain free is starred because I cannot tell if he 2 has pain or not because we have him sedated and 3 paralyzed. Anxiety free is starred because if we 4 -- there is a couple reasons why we would put a 5 patient back to sleep and sedate them and paralyze 6 either their shaking if they are not responding 7 appropriately. So most everybody, most every 8 single patient has anxiety with a breathing tube 9 in, so we starred that and document accordingly. 10 Q. For the rest of the assessment, if you 11 would just indicate any that there was a deviation 12 from normal. 13 A. I had none. 14 Q. Did you have any contact with James Long's 15 family when he was in the ICU?</p>
<p style="text-align: right;">Page 22</p> <p>1 Q. All right. Why don't you just go through 2 and tell me what your assessment was of this 3 patient. 4 A. He has total bathing, toileting, oral and 5 feeding care by the nurse. We need to totally 6 turn him. Total, up to bathroom. Unable to lift 7 him out of bed to the chair. He is unable to walk 8 in the halls. 9 When you star something, that means there 10 is a deviation from normal. So alert and oriented 11 to person, place and time, there is a star there 12 because I would tell you on the documentation what 13 his neuro status is. 14 Q. What was the deviation from normal for 15 James Long? 16 A. I'm not clear on what you are asking me. 17 Q. You indicated that a star means that there 18 was a deviation from normal and that you did a 19 narrative note. I am asking you what the 20 deviation from normal was that is represented by 21 the star. 22 A. By the star, okay. 23 That he was awoken. The patient awakened 24 and was put back to sleep with a Propofol drip and 25 Vecuronium.</p>	<p style="text-align: right;">Page 24</p> <p>1 A. No, because I would have documented either 2 here or on the flow sheet that the family was at 3 the bedside or he had spoken to the family 4 members. 5 Q. You would either document it on the 6 narrative note or on the flow sheet if you had? 7 A. Yes. 8 Q. Now, in regard to the nursing flow sheet 9 that has the hemodynamic parameters on it, if you 10 could turn to that page. 1 And I would like you to tell me what, if 2 any, of that documentation is in your handwriting, 3 so that I am talking about the correct portion. 4 Now, in regard to the one page that says 5 cardiothoracic intensive care record that has the 6 hemodynamic parameters is the beginning part of 7 that page in your handwriting -- 8 A. Yes. 9 Q. -- can you tell me where, at what line -- 10 and I see a number of letters running down the 11 left-hand side of the page -- what line your 12 charting starts at and then ends at? 13 A. Somebody wrote down my initial vital 14 signs. That's not my handwriting. So I am 15 usually at the head of the bed. I wrote down the</p>

Page 24

Page 27

1 drips and I documented until 1930. I just
 2 documented the temperature and the cardiac output
 3 and index and SVR and the rest of the handwriting
 4 is somebody else's.
 5 Q. Okay. Would those parameters be ones that
 6 you would be monitoring, though, on a regular
 7 basis while you were caring for the patient?
 8 A. Yes.
 9 Q. And would you be aware of what those values
 10 were even if you weren't the one that wrote them
 11 down here?
 12 A. Yes, if I was there, yes.
 13 Q. Do you know who was recording on here?
 14 A. Do you mean in the beginning?
 15 Q. Yes.
 16 A. I can't tell whose handwriting. It's
 17 whoever the nurse is around you that helps you
 18 admit the patient.
 19 Q. But after the admission, the documentation
 20 here for heart rate and blood pressure and mean
 21 blood pressure and CVP, are those in someone
 22 else's handwriting or portions of it?
 23 A. It's my handwriting all the way down from
 24 1750 until 1910.
 25 Q. Okay. So all of the parameters that are in

1 are to titrate that blood pressure to keep the
 2 systolic around 100 with whatever is ordered.
 3 So at that point it was Nipride.
 4 Q. And you have, as a nurse, you are allowed
 5 to increase or decrease the dosage?
 6 A. Yes.
 7 Q. You don't require a doctor's order to do
 8 that?
 9 A. No.
 10 Q. During the time that you were caring for
 11 James Long, did anyone inform you that he had
 12 bleeding problems while he was in surgery?
 13 A. No.
 14 Q. Did anyone tell you that he should be
 15 watched closely for bleeding problems while he was
 16 in the intensive care unit?
 17 A. No, not that I can recall.
 18 Q. Now, I believe the postoperative orders
 19 that were signed by Dr. Muellbach include an order
 20 that says initiate warming per CCT ICU policy.
 21 A. Yes.
 22 Q. What was the policy on warming patients
 23 after surgery?
 24 A. If their temperature was generally below
 25 36.5 degrees Celsius. Usually we would start at

Page 26

Page 28

1 that section is your handwriting?
 2 A. Yes.
 3 Q. I misunderstood what you were telling me.
 4 What was your understanding in regard to
 5 James Long's systolic blood pressure as to what
 6 level it was to be maintained at?
 7 A. I don't know if I understood the question.
 8 Where would the surgeons like the blood
 9 pressure to be kept at or where was the blood
 10 pressure actually at?
 11 Q. What was your understanding as to what
 12 level his blood pressure was to be kept at?
 13 A. His systolic was supposed to be kept around
 14 100.
 15 Q. Now, as a nurse in the unit, do you have
 16 any responsibilities for keeping the blood
 17 pressure at that area in regard to titrating any
 18 of the medications?
 19 A. Yes.
 20 Q. And what responsibilities do you have in
 21 regard to titrating medications?
 22 A. There are standard orders for Nipride and
 23 nitroglycerin and if a patient is hypertensive,
 24 which it appears that he must have been in the
 25 initial time frame, because he is on Nipride, we

1 below 26.0, we would put what is called a bear
 2 hugger on a patient, and warm them with a blankets
 3 and the bear hugger.
 4 Q. What is a bear hugger?
 5 A. It looks like an air mattress and it
 6 radiates the heat. You put blankets on top of it
 7 to keep the heat on and under.
 8 Q. And how long would you leave that on the
 9 patient?
 10 A. Until their temperature started rising.
 11 Usually I would shut it off around 36.5, 36.7,
 12 once they start warming up on their own.
 13 Q. Now, in James Long's case, did you do any
 14 type of warming procedure for him?
 15 A. I wouldn't have, because his temperature
 16 was documented 36, 37.0.
 17 Q. How many chest tubes did James Long have?
 18 A. I documented that he had two right chest
 19 tubes.
 20 Q. And in August of 1996, did you have a
 21 written protocol regarding how to care for chest
 22 tubes?
 23 A. I don't know what the exact documentation
 24 is for our protocol for chest tube care, but I do
 25 know what we do with our chest tubes every day. I

<p style="text-align: right;">Page 29</p> <p>1 can't tell you specifically what the protocol 2 says, but I do know what we do with the chest 3 tubes for protocol. 4 Q. Okay. In August of 1996, what were you 5 doing for the chest tubes? 6 A. We were hooking them up to negatives 20 7 degrees centimeter suction, monitoring the output 8 hourly or more. It depends if the patient was 9 bleeding or not. Making sure that they weren't 10 clotting. And draining them. 11 Q. How did you make sure that they weren't 12 clotting? 13 A. At the top where they are inserted, there 14 would be large clots in the area that would 15 accumulate there and then you would have to 16 squeeze them to get the clots out. 17 Q. That would be a term like milking the 18 tubes? 19 A. Milk the chest tubes, right. 20 Q. Did you use any type of an instrument to 21 assist in stripping tubes at all? 22 A. Not usually. A lot of times surgeons don't 23 like those being used. They just like you to 24 apply squeeze and manipulate the tube to get the 25 clot to come down.</p>	<p style="text-align: right;">Page 31</p> <p>1 usually it's anywhere from minimal to 100 would be 2 acceptable. It depended if you had turned the 3 patient, suctioned the patient. The initial 4 suction on the chest tubes from the OR, usually 5 some patients will have a larger amount come out 6 because that drainage was sitting in their chest 7 cavity from the OR, so it's not unusual to see a 8 large amount initially post-op too. 9 Q. And when you say initially, how much after 10 they arrive in the ICU would you expect to see 11 that increased drainage? For how long a period? 12 A. With the initial large amount? 13 Q. Yes. 14 A. Probably an hour time frame. 15 Q. Now, you have recorded a number of 16 hemodynamic parameters for James Long on the flow 17 sheet. 18 Were all of James Long's hemodynamic 19 parameters within the normal or expected ranges 20 for him that you recorded? 21 (Pause.) 22 A. Yes, other than this on line E the blood 23 pressure being a little bit low, 75 over 46. It 24 looks like we initiated Levophed on the next line 25 for that blood pressure.</p>
<p style="text-align: right;">Page 30</p> <p>1 Q. Did you do that on a regular basis with all 2 the patients or only if in your assessment it was 3 indicated? 4 A. It just depended upon the patient, if they 5 were clotting in that area. If it looked like 6 there was no clots in the area, I wouldn't do 7 that. 8 Q. If there was no drainage coming out of the 9 tube, would you milk the tubes at all? 10 A. If there appeared that there was clots up 11 at the site. 12 Q. So you would have to actually see a clot 13 before you would go through the motion of milking 14 the tubes or squeezing the tubes? 15 A. Correct. 16 Q. Okay. Now, in James Long's case, did you 17 have to squeeze the tube to remove any clots? 18 A. I could not tell you. I do not remember. 19 Q. If you do that, is that something that you 20 routinely chart in your notes? 21 A. No. 22 Q. What's the usual or expected amount of 23 chest tube drainage per hour for a cardiothoracic 24 chest surgery patient? 25 A. That just depends upon the patient, but</p>	<p style="text-align: right;">Page 32</p> <p>1 Q. The systemic vascular resistance recorded 2 at the time of admission of 559, is that an 3 expected normal range for this patient? 4 A. It would depend upon the patient. And with 5 the cardiac output and cardiac index being very 6 good, and us using Nipride to get the SVR down, 7 that would be an acceptable number. 8 Q. What about the central venous pressure of 9 17? 10 A. Well, I would have to ask what they were 11 running in the OR as far as central venous 12 pressure, where they were trying to keep it and 13 where it was. But 17 would be a normal number, 14 especially how big he is, if he was a very large 15 patient. 16 Q. What's the normal systemic vascular 17 resistance range? 18 A. I couldn't tell you exactly the numbers, 19 but from what we are taught, it could range 20 anywhere from 500 to 1500, or even up to 2000, we 21 get numbers from 500 to 2000. 22 Q. Now, at 1830 hour, the mean arterial 23 pressure is recorded at 59. 24 Would that be a value that you, as a nurse, 25 would report to a physician that much of a change</p>

Page 33

Page 35

1 from the previous reading?
 2 A. From 62, you mean?
 3 Q. Yes.
 4 A. No, not necessarily, because I was still in
 5 Nipride. If you go across I was still on Nipride
 6 and I would at that time shut that Nipride off and
 7 waited to see if the blood pressure came up or
 8 not.
 9 Q. Now, there is a notation under the
 10 significant events area at 1830 hour that Dr.
 11 Cosgrove is at the bedside. Is that in your
 12 handwriting, that notation?
 13 A. Yes.
 14 Q. Did you or anyone else in the unit call Dr.
 15 Cosgrove to see the patient?
 16 A. No.
 17 Q. So he was just coming in on rounds or his
 18 usual manner of coming in to see a post-op
 19 patient?
 20 A. Yes.
 21 Q. Did Dr. Cosgrove say anything to you in
 22 regard to James Long's condition at that time?
 23 A. I couldn't tell you if he did or didn't. I
 24 have no way. I do not remember.
 25 Q. Do you know whether Dr. Muellbach was with

1 postoperatively to it will be started either in OR
 2 or immediately postoperatively on almost every
 3 single cardiac patient after bypass.
 4 And it looks like my chest tubes drainage
 5 went from 50 to 100, and I must have told -- I
 6 would have to look at who gave me the order, but
 7 somebody gave me an order for 10 grams of Amicar
 8 bolus and start a drip. We have to look at the
 9 order sheet.
 10 (Pause.)
 11 A. Dr. Muellbach gave me the order around 6:30
 12 for the ten gram Amicar bolus and to start a two
 13 gram Amicar drip, an hour drip, and he gave me an
 14 order for calcium and Vecuronium.
 15 Q. Are you looking at the doctors orders? Do
 16 you have that sheet open?
 17 A. Initial postoperative?
 18 Q. The one that you just referred to with the
 19 Amicar bolus. --
 20 A. Yes.
 21 Q. -- you have that one in front of you?
 22 A. Yes.
 23 Q. The orders that are written there for 1730
 24 hour, 1800 hour and 1830 hour, are those orders
 25 that you took off as a nurse and instituted or at

Page 34

Page 36

1 Dr. Cosgrove at that time?
 2 A. I cannot remember and I don't always
 3 document if Dr. Muellbach was with Dr. Cosgrove.
 4 I generally just document if Dr. Cosgrove had come
 5 to the bedside.
 6 Q. Now, in regard to the hemodynamic
 7 parameters that you recorded on your shift, do you
 8 see any trends that would cause a heightened
 9 concern for this patient?
 10 A. Of what I documented; right?
 11 Q. Yes.
 12 A. No.
 13 Q. Do you recall having any conversations with
 14 Dr. Cosgrove at all during the time that you were
 15 in the unit that evening?
 16 A. No.
 17 Q. The flow sheet indicates that at 1830 hour,
 18 I believe, some Amicar was given by bolus to the
 19 patient. Did you give that medication?
 20 A. Yes.
 21 Q. Why was James Long receiving that
 22 medication?
 23 A. Well, we usually start an Amicar bolus when
 24 there is indication that the chest tube drainage
 25 has increased, or usually immediately

1 least arranged to have them carried out?
 2 A. Yes.
 3 Q. The order at 1800 hour, well it looks like
 4 it is at 1800 hour for Levophed. It's LEVO?
 5 A. Right.
 6 Q. Was that order at 1800 order or 1830 hour?
 7 A. It looks like 1800 hour. Oh, wait. Let me
 8 see. Well, probably 1830, because I put it under
 9 -- the verbal order, I would've wrote it at that
 10 time. If that would have been given to me at
 11 1800, I would have put it above the LR, so it was
 12 6:30.
 13 Q. It's likely that that was an 1830 order?
 14 A. Yes.
 15 Q. Now, in regard to the Amicar, from your
 16 perspective, what was the expected reaction to the
 17 dosage of Amicar that you administered?
 18 A. To slow the bleeding. If there was any
 19 bleeding starting to help the patient clot better,
 20 stop the bleeding.
 21 Q. And do you know whether this Amicar was
 22 given just as a routine order or whether because
 23 he had excessive chest tube drainage?
 24 A. I cannot recall exactly. All I could tell
 25 you is from my charting, going from 50 to 100

Page 37

1 cc's, usually if we had 100 cc's with the patient,
 2 we will start an Amicar drip, if it's not already
 3 running from the OR, already.
 4 Q. Do you do any type of laboratory follow-ups
 5 studies when you put a patient on Amicar?
 6 A. No, not usually. We will just check the
 7 hematocrit levels, unless they are really, really
 8 bleeding, but not generally, no. There is no
 9 standard orders for clotting studies with starting
 10 an Amicar drip.
 11 Q. There is an order for Propofol written by
 12 Dr. Yared at 1730 hour. Do you see that order?
 13 A. Yes.
 14 Q. And that's an order that you also received?
 15 A. Yes.
 16 Q. And did you administer Propofol to James
 17 Long?
 18 A. Yes, I did.
 19 Q. What was the purpose of that order?
 20 A. To keep the patient sedated, either because
 21 the patient was -- it wasn't documented clearly,
 22 but either the patient was waking up, not the
 23 expected result that we like to see, like the
 24 patient was either shaking, irritated, or they
 25 were having ventilation problems. There could be

Page 38

1 a lot of different reasons why we initiate
 2 Propofol drip or a fentanyl drip.
 3 Q. And in regard to what you have documented,
 4 is there any indicators in your documentation as
 5 to why he may have needed Propofol?
 6 A. No. I didn't document that he was shaking
 7 or pulling or his labs were off value, I didn't
 8 write anything.
 9 The only thing I did document was at 1900,
 10 with my assessment, that the patient was labile,
 11 and that he woke up and was put back to sleep with
 12 the Propofol drip and the Vecuronium.
 13 Q. When you say that the patient was labile,
 14 what did you mean by that?
 15 A. There is times when a patient comes back
 16 from surgery and their blood pressure will go up
 17 and it will go down and up and down. That's
 18 labile. That's what that means.
 19 Q. And that's what was happening with James
 20 Long?
 21 A. Most likely.
 22 Q. Now, the orders that you have written, are
 23 these in your handwriting, the ones that are 1730,
 24 1800 and 1830? Is that in your handwriting?
 25 A. Yes.

Page 39

1 Q. And those were verbal orders?
 2 A. Yes, except the first one, I wrote it and
 3 then Dr. Yared signed it himself.
 4 Q. Now, did you receive those orders from Dr.
 5 Muellbach in person or were they by phone?
 6 A. I couldn't tell you for sure.
 7 Q. If you received them by telephone, would it
 8 be your practice to write verbal order or
 9 telephone order next to it?
 10 A. Verbal order.
 11 Q. To your knowledge, was Dr. Muellbach in to
 12 see the patient at all during the time that you
 13 were in the intensive care unit on that evening?
 14 A. From my memory, I don't remember. From my
 15 documentation, I didn't write it, but it doesn't
 16 mean that he wasn't there, because I am not always
 17 very good about documenting every single doctor
 18 that comes by. Cardiology comes, anesthesia
 19 comes, all kind of doctors come to the bedside
 20 after surgery. I just like to document like if
 21 Dr. Cosgrove comes or if anesthesia comes or a
 22 staff doctor.
 23 Q. Now, Mr. Long had been on Nipride; is that
 24 correct?
 25 A. Yes.

Page 40

1 Q. And was he started on Levophed while you
 2 were still there?
 3 A. Yes.
 4 Q. When was the Levophed started?
 5 A. It looks around roughly 7:10. It could
 6 have been started before that, because we have the
 7 numbers -- are you at the 20 minute period gap
 8 from 1850 to 1910 -- but it's roughly around 1910.
 9 Q. So you initiated the Levophed on this
 10 patient?
 11 A. Yes.
 12 Q. Why was the Levophed initiated?
 13 A. It looks like because I shut off the
 14 Nipride and looks like the patient's index was
 15 down to 2.0 and his SVR's, he is dilated, and
 16 because the blood pressure, it looks like as I
 17 stated before, the 75 over 46 after the Nipride
 18 was shut off, so we initiated the Levophed for
 19 probably a multitude of reasons, the blood
 20 pressure, SVR.
 21 Q. Isn't that unusual to switch a patient from
 22 Nipride that maintains his blood pressure over
 23 Levophed -- I'm sorry, Nipride to bring his blood
 24 pressure down, Levophed to bring it back up?
 25 A. No.

Page 41	Page 43
<p>1 Q. That's something that you commonly do in 2 the intensive care on the cardiothoracic patients? 3 A. It depends on the patient. Their age, what 4 is going on with them. But a lot of times 5 patients will be unstable as far as their 6 temperatures. They either spike a temperature 7 right after surgery and it causes them to dilate 8 and their blood pressure to fall and then we have 9 to shut off the Nipride and start of Levophed. 10 Q. Did you have any concerns about this 11 patient in that his blood pressure dropped and 12 during that same hour or just around that time, he 13 had a 250 cc dump into his chest tubes? 14 A. That was documented after I left. That's 15 not my handwriting, so, no, I wasn't concerned 16 until the time I left. I documented the 41, the 17 crit of 35. That's my handwriting. So the next 18 line is not my handwriting, the 600 and 250. So I 19 probably left by that time. 20 Q. So that 250 cc's was after you left the 21 unit? 22 A. Yes. That's not my handwriting, so it must 23 have been her assessment. 24 Q. Who assumed care of James Long after you 25 left? Who did you turn the care over to?</p>	<p>1 that I had given that calcium, so she might have 2 at that time, while we were talking, might have 3 leveled the lines while we were giving report to 4 each other. I might have been giving some 5 calcium, so at that time she might have been 6 leveling the lines and I was giving the drug, so I 7 documented -- it's hard to see -- six, so around 8 7:10 I was giving calcium and she was leveling her 9 lines. That's an initial assessment to do after 10 you come on to see a patient, level and zero 11 lines. 12 Q. Was this Nurse Young, you believe? Does 13 that look like her handwriting? 14 A. I do not know her handwriting, honestly, 15 but -- 16 Q. How do you level lines and zero them in the 17 unit? 18 A. You go by their axillary, mid axillary 19 line, and you level the line to that, and you will 20 open the lines to air, and zero it on the monitor 21 to where all your numbers will go to zero, and 22 then close them off to air. 23 Q. And how often is that done? 24 A. You are supposed to do it, I think our 25 protocol is Q 24 hours, but years ago when I</p>
Page 42	Page 44
<p>1 A. Documented at Angelique Young. 2 Q. Do you recall having any conversations with 3 Dr. Muellbach during the time that you were in the 4 ICU on August 20th? 5 A. No. 6 Q. Now, there is a dose of Vecuronium given at 7 1850 hour, I believe. 8 A. Yes. 9 Q. Did you give that to the patient? 10 A. Yes. 11 Q. Do you know why he required that 12 medication? 13 A. It's not documented, but either the ABG's, 14 something is going on with the patient as far as 15 his ABG's are changing or the patient is shaking, 16 or just to stabilize. A lot of times we will 17 paralyze a patient just so they become more stable 18 as far as their blood pressures going up and down 19 and sedating and paralyzing them. 20 Q. There is a notation at 1910 about the lines 21 being leveled and zeroed. Is that in your 22 handwriting? 23 A. No. 24 Q. Was that after you left the unit? 25 A. That was Angelique. I had written down</p>	<p>1 started, it was every shift that you started to 2 rezero them, or if the numbers are off and they 3 are not seeming right, you can rezero your lines 4 and make sure it's not a zeroing problem. 5 Q. And do you know any reason why it was done 6 at 1910 hour here? 7 A. Probably because she started her shift and 8 it was a habit, 9 Q. Okay. Did you at any time on the 20th, 10 when you were in the ICU, make a request that a 11 physician look at James Long? 12 A. No, not that I'm aware of, no. 13 Q. And other than Dr. Cosgrove, that's noted, 14 do you know of any other physicians that came in 15 and assessed James Long during the time that you 16 were in the unit? 17 A. Dr. Yared must have, because he was at the 18 bedside to sign this, but other than that, I do 19 not know. Dr. Muellbach could have, but I don't 20 know if he was at the bedside or not. I did get 21 these orders from him, but I don't know if that 22 was over the telephone or at the bedside. 23 Q. Now, did you give a report to the nurse 24 that was coming on after you? 25 A. Yes.</p>

Page 45	Page 47
<p>1 Q. And in this instance, do you know what 2 information you provided in that report? 3 A. Yes. 4 Q. Could you tell me what that was. 5 A. I always go from left to right. Start with 6 the surgery, where they went. 7 MR. JACKSON: When you say left to 8 right, so she understands. 9 A. Left to right on the flow sheet with the 10 cardiothoracic intensive care record. The 11 surgery, where they want to keep the blood 12 pressures, temperatures, how they were running, 13 how the blood pressures were running, the heart 14 rates, their ventilation, their cardiac outputs, 15 the drips that they are on. 16 If I had given any medication, given any 17 fluids, which I did, 500 of LR two times, gave the 18 Amicar bolus, had sedated and paralyzed the 19 patient. 20 I would tell her how my urinary output has 21 been, which is very good. The chest tube drainage 22 went from 50 to 100. I would tell her his neuro 23 status, how he was for me. His potassium levels, 24 glucose, if they were significant, which they 25 weren't, and hemoglobin, hematocrits, and anything</p>	<p>1 like comes down, so they can see the screen and 2 see the blood pressure and PA pressure and 3 everything. It's still all monitored and 4 connected. Put all the drips on the side of the 5 bed. There is a special lever that it drops down 6 into and just disconnect your suction from the 7 bed, from the wall for your chest tubes, and 8 that's about it. 9 Q. So the pressure monitoring continues in 10 transport then? 11 A. Right, correct. 12 Q. Did you have any conversations with anyone 13 after August 20th in regard to what happened to 14 him? 15 A. No. 16 Q. Was James Long's case ever discussed in a 17 staff meeting? 18 A. No. 19 Q. Do you have any criticisms of anyone that 20 rendered care to James Long? 21 A. No. 22 MS. TOSTI: I am done. I have no 23 further questions. 24 MR. JACKSON: She will read it. 25</p>
Page 46	Page 48
<p>1 pertinent as far as orders, which I would go over 2 the orders that I had gotten. And his history, 3 which is at the top here, plus we look at the 4 history sheet, They do a preoperative assessment 5 for history sheet. We would go over that. 6 Q. Where is the ICU located in relation to the 7 operative suites? 8 A. Two floors above. 9 Q. Have you assisted or transported patients 10 between the ICU and OR? 11 A. Yes. 12 Q. How long does it take to get from one place 13 to the other? 14 A. It depends. You mean by the time I am 15 ready to pull out of the bed space with the 16 patient after I attached and detached everything? 17 Q. Yes. 18 A. Probably five minutes, if that. 19 Q. If you have to transport a patient back to 20 surgery, what do you do with all of the 21 hemodynamic lines, the pulmonary artery lines and 22 that? 23 A. What we do when they bring them up, we have 24 a little portable metal slot that the tram slips 25 into. There is a monitor that attaches on a bar,</p>	<p>1 (Deposition concluded at 2:05 o'clock p.m.; 2 signature waived.) 3 4 5 6 Denise Hrobat, R.N. 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25</p>

1 CERTIFICATE

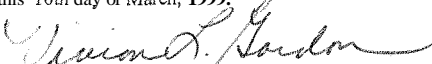
2 State of Ohio, }
3 County of Cuyahoga.) } SS:

4

5 I, Vivian L. Gordon, a Notary Public within
6 and for the State of Ohio, duly commissioned and
7 qualified, do hereby certify that the within named
8 DENISE HROBAT, R.N. was by me first duly sworn to
9 testify to the truth, the whole truth and nothing
10 but the truth in the cause aforesaid; that the
11 testimony as above set forth was by me reduced to
12 stenotypy, afterwards transcribed, and that the
13 foregoing is a true and correct transcription of
14 the testimony.

15 I do further certify that this deposition
16 was taken at the time and place specified and was
17 completed without adjournment; that I am not a
18 relative or attorney for either party or otherwise
19 interested in the event of this action.

20 IN WITNESS WHEREOF, I have hereunto set my
21 hand and affixed my seal of office at Cleveland,
22 Ohio, on this 16th day of March, 1999.

23 

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

My commission expires May 22, 1999.

-'-			36.5 [2] 27:25 28:11	36:11 46:8 49:8	answers [1] 4:5	balloon [2] 6:15
			36.7 [1] 28:11	acceptable [2] 31:2	antibiotics [1] 20:4	11:7
			37.0 [1] 28:16	32:7	anxiety [2] 23:13	bar [1] 46:25
'96 [4] 8:11 9:5				accordingly [1] 23:19	23:18	based [1] 15:15
11:2 14:10				accumulate [1] 29:15	APPEARANCES [1]	basic [3] 5:22 6:7
-1-				ACLS [1] 14:23	2:1	11:23
10 [2] 8:2 35:7			41 [1] 41:16	action [1] 49:12	appeared [1] 30:10	basis [2] 25:7 30:1
100 [7] 26:14 27:2			44 [1] 20:6	acuity [3] 11:6	apply [1] 29:24	bathing [1] 22:4
31:1 35:5 36:25			44039 [1] 3:13	11:9 11:11	appropriately [1]	bathroom [1] 22:6
37:1 45:22			44113 [1] 2:6	additional [3] 6:8	23:17	bear [3] 28:1 28:3
11 [2] 8:12 8:12			44114 [1] 2:9	6:9 16:5	area [9] 7:9 7:20	28:4
12 [2] 8:2 8:14			46 [2] 31:23 40:17	additionally [1]	7:21 7:24 26:17	became [1] 7:19
1375 [1] 2:9				10:2	29:14 30:5 30:6	Becker [1] 2:3
1500 [2] 21:24 32:20				address [1] 3:11	33:10	become [2] 7:12
1660 [1] 2:5				adjournment [1]	areas [1] 14:12	42:17
16th [1] 49:14			50 [3] 35:5 36:25	49:11	arranged [1] 36:1	bed [5] 22:7 24:25
17 [2] 32:9 32:13			45:22	administer [1] 37:16	arrive [1] 31:10	46:15 47:5 47:7
1730 [4] 19:8 35:23			500 [3] 32:20 32:21	administered [1]	arterial [1] 32:22	bedside [7] 24:3
37:12 38:23			45:17	36:17	artery [1] 46:21	33:11 34:5 39:19
1750 [1] 25:24			52 [2] 16:22 16:24	admission [2] 25:19	articles [1] 4:24	44:18 44:20 44:22
1800 [7] 35:24 36:3			54 [2] 16:22 16:24	32:2	aside [1] 15:2	beginning [2] 24:16
36:4 36:6 36:7			559 [1] 32:2	admissions [1] 10:18	assessed [1] 44:15	25:14
36:11 38:24			59 [1] 32:23	admit [1] 25:18	assessing [3] 13:17	behalf [3] 1:15
1830 [8] 32:22 33:10			5:30 [1] 21:6	admitted [4] 18:11	14:3 14:4	2:3 2:7
34:17 35:24 36:6				18:15 19:22 21:4	assessment [14] 13:24	below [2] 27:24
36:8 36:13 38:24				Advanced [1] 6:13	14:2 18:10 21:7	28:1
1850 [2] 40:8 42:7			60 [1] 20:8	affixed [1] 49:14	21:11 21:22 22:2	best [1] 19:20
1900 [2] 21:25 38:9			600 [1] 41:18	aforesaid [1] 49:7	23:4 23:20 30:2	better [1] 36:19
1910 [5] 25:24 40:8			62 [1] 33:2	afterwards [1] 49:8	38:10 41:23 43:9	between [1] 46:10
40:8 42:20 44:6			660 [1] 2:5	again [1] 21:11	46:4	big [1] 32:14
1930 [1] 25:1			6819 [1] 3:12	age [1] 41:3	assigned [3] 9:6	bit [2] 14:15 31:23
1991 [3] 6:3 6:6			6:30 [2] 35:11 36:12	ago [3] 6:15 6:20	10:3 15:22	blankets [2] 28:2
7:14				43:25	assignment [4] 9:9	28:6
1996 [7] 5:14 8:3				agreement [1] 1:19	10:6 10:20 10:25	bleeding [11] 20:14
8:6 13:10 15:5				air [3] 28:5 43:20	assist [1] 29:21	20:22 20:25 21:2
28:20 29:4				43:22	assistant [1] 9:11	27:12 27:15 29:9
1999 [3] 1:12 49:14				alert [1] 22:10	assisted [1] 46:9	36:18 36:19 36:20
49:18				allergies [1] 20:6	assume [1] 4:1	37:8
1:00 [1] 1:22				allowed [2] 17:18	assumed [1] 41:24	blood [25] 14:7
-2-				27:4	attached [1] 46:16	19:16 20:3 25:20
2.0 [1] 40:15				almost [1] 35:2	attaches [1] 46:25	25:21 26:5 26:8
20 [3] 15:5 29:6				alteration [1] 23:8	attend [1] 5:23	26:9 26:12 26:16
40:7				always [4] 15:12	attention [1] 16:10	27:1 31:22 31:25
2000 [2] 32:20 32:21				34:2 39:16 45:5	attorney [1] 49:12	33:7 38:16 40:16
20th [3] 42:4 44:9				Amicar [13] 34:18	August [14] 5:14	40:19 40:22 40:23
47:13				34:23 35:7 35:12	6:5 8:3 8:6	41:8 41:11 42:18
22 [1] 49:18				35:13 35:19 36:15	8:11 9:5 11:2	45:11 45:13 47:2
24 [1] 43:25				36:17 36:21 37:2	13:10 14:10 15:5	bolus [6] 34:18
24th [1] 7:14				37:5 37:10 45:18	28:20 29:4 42:4	34:23 35:8 35:12
250 [3] 41:13 41:18				amount [4] 30:22	47:13	35:19 45:18
41:20				31:5 31:8 31:12	Avenue [1] 1:21	bottom [1] 21:24
26.0 [1] 28:1				Andress [1] 2:7	AVR [1] 19:14	bowel [1] 14:5
2:05 [1] 48:1				anesthesia [8] 17:11	awaken [1] 22:23	breathing [1] 23:18
-3-				17:14 17:16 18:19	awakened [1] 22:23	bring [3] 40:23
31 [1] 20:6				18:19 19:24 39:18	aware [2] 25:9	40:24 46:23
321518 [1] 1:5				39:21	44:12	BY-MS [1] 3:7
35 [1] 41:17				aneurysms [1] 9:19	axillary [2] 43:18	bypass [1] 35:3
36 [1] 28:16				Angelique [2] 42:1	43:18	
				42:25		-C-
				answer [5] 3:19		calcium [4] 35:14
				4:3 4:14 5:18		43:1 43:5 43:8
				14:16		calls [1] 17:18
					-B-	cancelled [1] 15:9
					Bachelor's [1] 5:24	

cannot[4] 4:6 23:11 34:2 36:24	24:22 36:25	concerns [1] 41:10	deviation [5] 22:10 22:14 22:18 22:20 23:21	drip [9] 22:24 35:8 35:13 35:13 37:2 37:10 38:2 38:2 38:12
cardiac [6] 6:13 25:2 32:5 32:5 35:3 45:14	check [1] 37:6	concluded [1] 48:1	diagnosis [1] 12:21	drips [3] 25:1 45:15 47:4
Cardiology [1] 39:18	checklist [1] 21:21	condition [1] 33:22	different [1] 38:1	Drive III 3:12
cardiothoracic [17] 7:11 7:22 8:7 8:21 9:14 9:15 9:21 13:9 15:12 17:1 17:3 18:12 21:5 24:15 30:23 41:2 45:10	chest [19] 14:5 28:17 28:18 28:21 28:24 28:25 29:2 29:5 29:19 30:23 30:24 31:4 31:6 34:24 35:4 36:23 41:13 45:21 47:7	connected [1] 47:4	dilate [1] 41:7	dropped [1] 41:11
care [32] 7:11 7:22 7:24 8:7 8:22 10:11 11:3 11:21 12:18 13:10 13:15 13:22 15:16 15:17 15:21 15:23 17:2 17:3 18:16 19:6 19:23 22:5 24:15 27:16 28:21 28:24 39:13 41:2 41:24 41:25 45:10 47:20	Civil [1] 3:3	contact [1] 23:24	dilated [1] 40:15	drops [1] 47:5
caring [2] 25:7	clear [4] 14:15 16:4 22:16 23:2	contacted [1] 16:12	Diplomate [1] 1:18	drug [1] 43:6
carried [1] 36:1	clearly [2] 21:14 37:21	continues [1] 47:9	direct [1] 10:11	duly [3] 3:3 49:5 49:6
case [8] 1:5 5:1 5:5 5:8 20:20 28:13 30:16 47:16	Cleveland [17] 1:6 1:20 1:21 2:6 2:9 6:17 7:2 7:4 7:13 7:16 7:20 7:23 12:2 12:9 12:11 14:10 49:14	conversations [3] 34:13 42:2 47:12	directly [2] 17:19 17:22	dump [1] 41:13
cath [1] 9:17	Clinic [12] 1:6 1:20 6:17 7:2 7:5 7:13 7:16 7:20 7:24 12:9 12:11 14:10	coordinator [8] 9:12 10:5 10:13 10:20 11:12 11:16 11:17 17:20	discern [1] 19:19	during [10] 4:13 20:2 20:14 20:25 27:10 34:14 39:12 41:12 42:3 44:15
causes [1] 41:7	Clinic's [1] 12:2	correct [10] 5:11 7:5 7:6 11:24 16:7 24:13 30:15 39:24 47:11 49:9	disconnect [1] 47:6	duties [5] 9:25 10:14 13:11 13:16 15:23
cavity [1] 31:7	clinical [9] 7:9 9:12 10:4 10:13 10:19 11:12 11:16 17:7 17:20	Cosgrove [9] 33:11 33:15 33:21 34:1 34:3 34:4 34:14 39:21 44:13	discussed [2] 5:1 47:16	duty [1] 16:1
cc [1] 41:13	close [1] 43:22	counsel [3] 1:15 1:20 5:2	dislodged [1] 20:1	
cc's [4] 20:9 37:1 37:1 41:20	closely [2] 21:1 27:15	County [2] 1:1 49:3	divide [1] 16:21	-E-
CCT [1] 27:20	clot [3] 29:25 30:12 36:19	couple [1] 23:14	doctor [4] 17:4 18:6 39:17 39:22	E [2] 2:9 31:22
CCU [1] 15:14	clots [5] 29:14 29:16 30:6 30:10 30:17	court [3] 1:1 4:5 5:18	doctor's [1] 27:7	education [1] 6:8
Celsius [1] 27:25	clotting [4] 29:10 29:12 30:5 37:9	crit [1] 41:17	doctors [5] 16:21 17:15 17:19 35:15 39:19	either [13] 9:2 9:11 19:24 23:16 24:1 24:5 35:1 37:20 37:22 37:24 41:6 42:13 49:12
census [2] 9:22 11:10	coherent [1] 23:2	critical [1] 11:21	document [7] 23:19 24:5 34:3 34:4 38:6 38:9 39:20	employed [3] 7:12 7:19 7:20
centimeter [1] 29:7	coming [5] 10:16 30:8 33:17 33:18 44:24	criticisms [1] 47:19	documentation [8] 15:7 18:25 22:12 24:12 25:19 28:23 38:4 39:15	employee [1] 7:17
central [2] 32:8 32:11	commencing [1] 1:22	CRNA [2] 18:19 19:25	documented [15] 20:7 21:6 24:1 25:1 25:2 28:16 28:18 34:10 37:21 38:3 41:14 41:16 42:1 42:13 43:7	employer [1] 7:4
ZERTIFICATE [1] 49:1	commission [1] 49:18	current [2] 7:4	documenting [1] 39:17	ends [1] 24:22
certifications [1] 6:9	commissioned [1] 49:5	Cuyahoga [2] 1:1 49:3	doesn't [1] 39:15	enter [1] 4:12
certified [2] 3:4 14:23	COMMON [1] 1:1	CVP [2] 14:8 25:21	Dolly [3] 8:18 9:2 9:3	qual [1] 23:1
certify [2] 49:6 49:10	commonly [1] 41:1		done [4] 19:14 43:23 44:5 47:22	especially [1] 32:14
chair [1] 22:7	complete [1] 6:14		dosage [2] 27:5 36:17	ESQ [3] 2:4 2:8 2:8
change [3] 8:24 9:1 32:25	completed [2] 6:8 49:11		dose [1] 42:6	etc [1] 1:3
changes [1] 13:7	concern [1] 34:9		down [18] 4:6 5:19 14:18 24:20 24:23 24:25 25:11 25:23 29:25 32:6 38:17 38:17 40:15 40:24 42:18 42:25 47:1 47:5	Euclid [1] 1:21
changing [1] 42:15	concerned [1] 41:15		Dr [20] 27:19 33:10 33:14 33:21 33:25 34:1 34:3 34:3 34:4 34:14 35:11 37:12 39:3 39:4 39:11 39:21 42:3 44:13 44:17 44:19	evening [5] 9:7 15:21 16:6 34:15 39:13
charge [10] 9:11 9:24 10:3 10:5 10:22 10:24 11:14 13:14 16:1 17:21			drainage [9] 14:5 30:8 30:23 31:6 31:11 34:24 35:4 36:23 45:21	evenings [1] 11:2
chart [1] 30:20			draining [1] 29:10	event [1] 49:12
charted [1] 23:4				events [2] 19:9 33:10
charting [3] 4:19				everybody [1] 23:17
				exact [3] 6:21 8:25 28:23
				exactly [2] 32:18 36:24
				examination [3] 1:16 3:2 3:6
				except [1] 39:2
				excessive [1] 36:23
				expect [1] 31:10
				expected [5] 30:22 31:19 32:3 36:16 37:23

Index Page 3

located [1]	46:6	minute [1]	40:7	22:20	23:8	23:22	49:14	45:18
Long's [7]	23:24	minutes [1]	46:18	31:19	32:3	32:13	offices [1]	1:20
26:5	28:13	Mishkind [1]	2:3	32:16			often [1]	43:23
31:18	33:22	misunderstood [1]		normally [1]	9:6		Ohio [13]	1:1
look [8]	4:10	26:3		North [1]	3:12		1:19	1:21
18:25	35:6	Mitchell [1]	3:12	Notary [3]	1:18		2:9	3:2
43:13	44:11	monitor [3]	14:7	49:5	49:17		5:11	5:15
looked [1]	30:5	43:20	46:25	notation [3]	33:9		49:5	49:14
looking [6]	19:1	monitored [1]	47:3	33:12	42:20		49:17	49:17
19:3	19:5	monitoring [10]	11:19	note [3]	20:17	22:19	once [1]	28:12
21:13	35:15	12:3	12:14	24:6			one [10]	9:8
looks [10]	21:21	13:2	13:18	noted [2]	13:7		17:15	17:16
28:5	31:24	25:6	29:7	44:13			25:10	35:18
36:3	36:7	most [4]	15:8	notes [3]	5:4		39:2	46:12
40:13	40:14	23:17	38:21	5:7	30:20		ones [2]	25:5
low [1]	31:23	mostly [2]	10:8	nothing [1]	49:7		open [2]	35:16
LR [2]	36:11	10:15		notice [2]	13:1		operative [1]	46:7
lungs [1]	14:4	motion [1]	30:13	13:3			oral [1]	22:4
-M-		motions [1]	4:6	now [25]	5:10	6:25	order [21]	4:22
M [1]	2:4	movement [1]	23:9	9:5	9:24	13:9	27:7	27:19
maintained [1]	26:6	Moves [1]	23:5	15:5	17:2	17:18	35:7	35:9
maintains [1]	40:22	MRA [1]	23:10	19:17	24:8	24:14	35:14	36:3
management [1]	10:9	MS [1]	47:22	26:15	27:18	28:13	36:6	36:9
managing [1]	10:16	Muellbach [8]	27:19	30:16	31:15	32:22	36:22	37:11
manipulate [1]	29:24	33:25	34:3	33:9	34:6	36:15	37:14	37:19
manner [2]	20:17	39:5	39:11	38:22	39:4	39:23	39:9	39:10
33:18		44:19		42:6	44:23		ordered [1]	27:2
March [1]	49:14	multitude [1]	40:19	number [4]	24:20		orders [12]	26:22
Marie [1]	3:10	must [4]	26:24	31:15	32:7	32:13	27:18	35:15
marked [1]	21:14	41:22	44:17	32:18	32:21	40:7	35:24	37:9
mattress [1]	28:5	-N-		43:21	44:2		39:1	39:4
mattress [1]	28:5	name [3]	3:8	nurse [32]	5:10		46:1	46:2
maximum [1]	9:22	3:9	21:24	5:15	7:8	8:20	orient [1]	13:13
may [4]	4:12	named [1]	49:6	8:21	8:23	9:11	orientation [3]	7:1
38:5	49:18	narrative [2]	22:19	9:24	10:2	10:3	7:23	8:1
mean [8]	16:24	24:6		10:4	10:5	10:8	oriented [2]	12:15
25:14	25:20	necessarily [2]	12:20	10:22	10:24	11:14	22:10	
33:2	38:14	33:4		12:12	12:17	13:9	orienting [1]	13:12
46:14		need [1]	22:5	13:14	15:19	17:21	otherwise [2]	4:1
means [3]	22:9	needed [2]	14:19	17:21	20:11	22:4	49:12	
22:17	38:18	38:5		25:17	26:15	27:5	output [6]	14:6
medical [3]	4:8	needs [1]	10:15	32:24	35:25	43:12	20:9	25:2
15:2	15:15	negatives [1]	29:6	44:23			32:5	45:20
medication [4]	34:19	neuro [3]	14:4	nurses [1]	11:3		outputs [2]	19:10
34:22	42:12	22:13	45:22	nursing [12]	5:22		45:14	
45:16		new [1]	13:12	6:1	6:7	6:10	overseeing [1]	10:15
medications [2]	26:18	next [4]	15:18	7:16	9:1	11:23	own [2]	10:6
26:21		39:9	41:17	14:18	14:25	18:10	oxygen [1]	14:8
		40:22	40:23	21:17	24:8		-P-	
		41:9					P [3]	15:9
		nitroglycerin [1]					16:20	16:16
		26:23					P's [2]	8:12
		nods [1]	4:6				p.m [5]	1:22
		Nonapplicable [1]					15:8	16:19
		23:9					p.m. [1]	48:1
		none [2]	20:7				PACU [1]	9:17
		20:2					page [7]	19:4
		22:10	22:14				21:22	24:10
							24:17	24:21
							pain [2]	23:11
							paralyze [2]	23:15
							42:17	
							paralyzed [2]	23:15

Plaintiff [2] 1:16	38:5 38:12	24:15 45:10	Ridgeville [1] 3:12	shut [5] 28:11 33:6
2:3	protocol [6] 23:10	recorded [5] 31:15	right [18] 6:25	40:13 40:18 41:9
Plaintiffs [1] 1:4	28:21 28:24 29:1	31:20 32:1 32:23	8:24 10:4 11:25	side [2] 24:21 47:4
PLEAS [1] 1:1	29:3 43:25	34:7	17:2 20:23 21:17	sign [1] 44:18
plus [1] 46:3	provide [1] 4:7	recording [2] 13:17	22:1 28:18 29:19	signature [1] 48:2
point [4] 4:10 4:12	provided [2] 3:2	25:13	34:10 36:5 41:7	signed [2] 27:19
21:8 27:3	45:2	records [3] 4:8	44:3 45:5 45:8	39:3
policy [3] 16:10	Public [3] 1:18	15:3 15:15	45:9 47:11	significant [5] 12:13
27:20 27:22	49:5 49:17	reduced [1] 49:8	rising [1] 28:10	13:6 19:9 33:10
pool [4] 14:12 14:18	pull [1] 46:15	referred [1] 35:18	RN [2] 7:8 13:14	45:24
14:19 14:19	pulling [1] 38:7	referring [1] 21:22	RNs [2] 11:8 13:12	signs [8] 4:21 13:18
population [1] 9:18	pulmonary III 46:21	regard [12] 13:15	Roetzel [1] 2:7	13:24 14:4 19:7
portable [1] 46:24	pump [1] 6:16	14:2 24:8 24:14	roughly [2] 40:5	19:9 21:1 24:24
portion [2] 19:2	pumps [1] 11:7	26:4 26:17 26:21	40:8	single [3] 23:18
24:13	Pupils [1] 23:1	33:22 34:6 36:15	rounds [1] 33:17	35:3 39:17
portions [1] 25:22	purpose [1] 37:19	regarding [2] 16:11	routine [1] 36:22	single-family [1] 3:14
position [3] 7:7	pursuant [1] 1:19	28:21	routinely [1] 30:20	site [1] 30:11
8:3 8:4	put [9] 22:24 23:14	registered [3] 1:17	Rules [1] 3:3	sitting [1] 31:6
post-op [3] 9:14	28:1 28:6 36:8	5:10 5:14	running [5] 24:20	six [3] 6:20 11:8
31:8 33:18	36:11 37:5 38:11	regular [2] 25:6	32:11 37:3 45:12	43:7
postoperative [4] 9:21 16:8 27:18	47:4	30:1	45:13	Skylight [1] 2:4
35:17		related [1] 4:19		sleep [3] 22:24 23:15
postoperatively [5] 15:18 15:22 23:6	-Q-	relation [1] 46:6	-S-	38:11
35:1 35:2	qualified [1] 49:6	relative [1] 49:12	S [1] 1:3	slips [1] 46:24
potassium [2] 20:6	questions [2] 3:21	remember [7] 12:10	saturation s[1] 14:9	slot [1] 46:24
45:23	47:23	15:3 15:24 30:18	saw [1] 15:2	slow [1] 36:18
practice [1] 39:8	-R-	33:24 34:2 39:14	says [3] 24:14 27:20	someone [1] 25:21
pre-op [1] 9:19	R.N [6] 1:11 1:14	remove [1] 30:17	29:2	sometimes [2] 18:5
preoperative [2] 9:19 46:4	3:1 3:6 48:6	rendered [1] 47:20	schedules [1] 10:16	23:6
preparation [3] 4:18	49:6	repeat [2] 3:23	science [1] 5:24	sorry [1] 40:23
11:21 12:1	radiates [1] 28:6	replacement [1] 19:14	screen [1] 47:1	sounds [1] 14:5
pressure [25] 14:8	range [3] 32:3	19:14	seal [1] 49:14	space [1] 46:15
25:20 25:21 26:5	32:17 32:19	report [9] 15:18	second [2] 2:5	special [1] 47:5
26:9 26:10 26:12	ranges [1] 31:19	18:14 18:18 18:21	21:22	specialty [1] 17:7
26:17 27:1 31:23	rate [1] 25:20	18:24 32:25 43:3	section [1] 26:1	specific [1] 13:20
31:25 32:8 32:12	rates [2] 14:7 45:14	44:23 45:2	sedate [1] 23:15	specifically [1] 29:1
32:23 33:7 38:16	rather [1] 17:25	reporter [3] 1:18	sedated [3] 23:12	specified [1] 49:11
40:16 40:20 40:22	reaction [1] 36:16	4:5 5:19	37:20 45:18	Speech [1] 23:2
40:24 41:8 41:11	reactive [1] 23:1	represented [1] 22:20	sedating [2] 23:7	spell [1] 3:8
47:2 47:2 47:9	read [2] 20:18 47:24	request [1] 44:10	42:19	spike [1] 41:6
pressures [6] 14:8	reading [1] 33:1	require [1] 27:7	see [16] 24:20 30:12	spoken [1] 24:3
14:8 19:16 42:18	readings [1] 14:6	required [3] 4:14	31:7 31:10 33:7	squeeze [3] 29:16
45:12 45:13	ready [1] 46:15	16:9 42:11	33:15 33:18 34:8	29:24 30:17
previous [1] 33:1	really [2] 37:7	resident [9] 16:15	36:8 37:12 37:23	squeezing [1] 30:14
PRN [4] 14:11 14:17	37:7	17:4 17:5 17:25	39:12 43:7 43:10	SS [1] 49:2
14:19 14:20	reason [1] 44:5	18:4 18:8 18:19	47:1 47:2	stabilize [1] 42:16
problem [9] 13:4	reasons [3] 23:14	19:15 19:25	seeming [1] 44:3	stable [1] 42:17
17:12 17:13 17:23	38:1 40:19	resistance [2] 32:1	session [1] 3:19	staff [12] 7:8
18:1 18:3 18:9	receive [7] 6:1	32:17	set [4] 1:23 4:8	10:15 13:9 13:14
20:14 44:4	11:19 18:14 19:12	respiratory [1] 13:25	49:8 49:13	14:13 14:17 14:18
problems [8] 10:18	19:18 20:21 39:4	responding [1] 23:16	shaking [4] 23:16	14:20 14:20 18:6
16:9 20:22 20:25	received [7] 7:23	responsibilities [5] 13:11 13:16 16:2	37:24 38:6 42:15	39:22 47:17
21:1 27:12 27:15	12:9 18:24 19:11	26:16 26:20	sheet [15] 16:17	staffing [3] 10:15
37:25	19:21 37:14 39:7	rest [2] 23:20 25:3	16:20 19:5 21:19	11:13 14:11
procedure [3] 3:3	receiving [1] 34:21	result [1] 37:23	21:19 24:2 24:6	standard [2] 26:22
program [3] 5:22	recognize [3] 12:5	review [1] 12:2	24:8 31:17 34:17	37:9
11:24 12:8	12:13 21:16	reviewed [4] 4:17	35:9 35:16 45:9	star [5] 22:9 22:11
progress [1] 21:17	recollection [1] 15:1	4:23 15:16 20:12	46:4 46:5	22:17 22:21 22:22
Propofol [6] 22:24	record [6] 19:3	rezero [2] 44:2	sheets [2] 4:21	starred [5] 23:2
37:11 37:16 38:2	19:20 20:13 21:17	44:3	4:22	23:5 23:11 23:13
			shift [6] 8:10 8:14	23:19
			9:25 34:7 44:1	
			44:7	

start[8] 27:25 28:12 34:23 35:8 35:12 37:2 41:9 45:5	49:6 syncope[1] 20:1 systemic[2] 32:1 32:16 systolic[3] 26:5 26:13 27:2	12:18 21:2 34:8 true[1] 49:9 truth[3] 49:7 49:7 49:7 trying[1] 32:12 tube[10] 14:5 23:18 28:24 29:24 30:9 30:17 30:23 34:24 36:23 45:21	45:20 urine[1] 20:9 used[1] 29:23 using[1] 32:6 usual[4] 8:10 20:17 30:22 33:18 usually[16] 9:16 11:15 14:14 16:21 18:2 18:3 24:25 27:25 28:11 29:22 31:1 31:4 34:23 34:25 37:1 37:6 utilize[2] 14:11 14:19	49:5 49:6 49:17 without[1] 49:11 witness[3] 1:15 3:1 49:13 woke[1] 38:11 worked[4] 8:6 8:10 15:8 15:12 would've[1] 36:9 write[3] 38:8 39:8 39:15 written[5] 28:21 35:23 37:11 38:22 42:25 wrote[5] 24:23 24:25 25:10 36:9 39:2
starting[2] 36:19 37:9	-T-	tubes[16] 28:17 28:19 28:22 28:25 29:3 29:5 29:18 29:19 29:21 30:9 30:14 30:14 31:4 35:4 41:13 47:7	-V-	
starts[2] 19:7 24:22	taking[1] 13:22 taught[4] 12:5 12:12 13:5 32:19	turn[3] 22:6 24:10 41:25	V[1] 2:8 value[3] 20:5 32:24 38:7	-Y-
state[11] 1:19 3:8 5:11 5:15 5:24 11:20 12:8 12:10 49:2 49:5 49:17	teeth[1] 20:1 telephone[3] 39:7 39:9 44:22	turned[1] 31:2 two[13] 5:19 8:24 9:8 11:7 14:24 16:22 17:5 17:6 17:15 28:18 35:12 45:17 46:8	values[2] 14:6 25:9	Yared[3] 37:12 39:3 44:17
status[4] 13:25 14:4 22:13 45:23	telling[1] 26:3 temperature[5] 25:2 27:24 28:10 28:15 41:6	type[4] 5:22 28:14 29:20 37:4	vascular[2] 32:1 32:16	years[6] 6:15 6:20 8:8 8:24 14:24 43:25
statute[1] 1:16	temperatures[3] 14:6 41:6 45:12	-U-	Vecuronium[4] 22:25 35:14 38:12 42:6	Young[2] 42:1 43:12
stenotypy[1] 49:8	ten[3] 9:23 11:5 35:12	unable[2] 22:6 22:7	venous[2] 32:8 32:11	-Z-
still[5] 4:14 33:4 33:5 40:2 47:3	term[1] 29:17 testify[1] 49:7 testimony[2] 49:8 49:9	under[5] 1:16 3:19 28:7 33:9 36:8	ventilation[3] 17:13 37:25 45:14	zero[4] 43:10 43:16 43:20 43:21
stop[1] 36:20	textbooks[1] 4:23 three[1] 20:8 through[3] 17:20 22:1 30:13	understand[4] 3:20 3:22 3:24 16:24	ventricle[1] 20:2	zeroed[1] 42:21
Street[2] 2:5	times[6] 8:25 29:22 38:15 41:4 42:16 45:17	understands[1] 45:8	verbal[4] 36:9 39:1 39:8 39:10	xroing[1] 44:4
stripping[1] 29:21	title[3] 7:7 8:19 19:3	understood[2] 4:2 26:7	verbally[1] 4:5	
structural[1] 9:1	titrate[1] 27:1 titrating[2] 26:17 26:21	unit[29] 7:22 8:7 9:14 9:22 9:25 10:17 11:4 11:10 12:18 13:10 14:13 15:12 16:9 16:18 16:20 18:12 18:16 19:6 19:23 21:5 26:15 27:16 33:14 34:15 39:13 41:21 42:24 43:17 44:16	vital[7] 4:21 13:17 13:24 14:4 19:7 19:9 24:23	
studies[2] 37:5 37:9	together[1] 21:20 toileting[1] 22:4	units[4] 17:2 17:3 17:5 17:6	Vivian[3] 1:17 49:5 49:17	
study[1] 23:9	too[2] 10:6 31:8	University[1] 5:25	vs[1] 1:5	
such[1] 14:11	took[4] 11:22 15:17 15:21 35:25	University's[1] 11:20	-W-	
suction[3] 29:7 31:4 47:6	top[4] 6:24 28:6 29:13 46:3	unless[5] 4:14 11:17 15:9 15:13 37:7	wait[1] 36:7	
suctioned[1] 31:3	TOSTI[3] 2:4 3:7 47:22	unstable[1] 41:5	waited[1] 33:7	
Suite[1] 2:5	total[2] 22:4 22:6	unusual[2] 31:7 40:21	waived[1] 48:2	
suites[1] 46:7	totally[1] 22:5	up[14] 21:15 22:6 28:12 29:6 30:10 32:20 33:7 37:22 38:11 38:16 38:17 40:24 42:18 46:23	waking[1] 37:22	
summer[1] 8:25	'rower[1] 2:4	urinary[2] 14:6	walk[1] 22:7	
supervising[1] 13:6	trained[1] 14:21		wall[1] 47:7	
supervisor[1] 8:17	tram[1] 46:24		warm[1] 28:2	
supplemental[1] 14:11	transcribed[1] 49:8		warming[4] 27:20 27:22 28:12 28:14	
support[1] 6:13	transcription[1] 49:9		watch[2] 12:18 20:25	
supposed[2] 26:13 43:24	transfers[1] 10:17		watched[1] 27:15	
surgeon[2] 17:25 18:2	transport[2] 46:19 47:10		weakness[1] 23:5	
surgeons[2] 26:8	transported[1] 46:9		weeks[1] 8:2	
29:22	trend[1] 13:1		West[1] 2:5	
surgery[22] 5:14 12:22 12:22 17:16 18:1 18:6 19:12 19:13 20:4 20:5 20:14 20:22 20:25 27:12 27:23 30:24 38:16 39:20 41:7 45:6 45:11 46:20	trends[4] 12:13		WHEREOF[1] 49:13	
surgical[2] 17:11			whole[2] 19:8 49:7	
SVR[3] 25:3 32:6 40:20			within[4] 31:19	
SVR's[1] 40:15				
witch[1] 40:21				
wom[2] 3:4				