IN THE COURT OF COMMON PLEAS
CUYAHOGA COUNTY, OHIO

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

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DEPOSITION OF DENISE HROBAT, R.N.

FEBRUARY 9, 1999

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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.

APPEARANCES:

On behalf of the Plaintiff
Becker & Mishkind
BY: JEANNE M. TOSTI, ESQ.
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1660 West Second Street
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Cleveland, Ohio 44113

On behalf of the Defendant
Roetzel & Andress
BY JOHN V JACKSON, III, ESQ
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DENISE HROBAT, R.N., a witness herein, called for examination, as provided by the Ohio Rules of Civil Procedure, being by me first duly sworn, as hereinafter certified, was deposed and said as follows:

EXAMINATION OF DENISE HROBAT, R.N.

BY-MS. TOSTI:

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

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

Q. And what is your home address?

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

Q. Is that a single-family home?

A. Yes.

Q. Have you ever had your deposition taken before?

A. No.

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

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

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

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

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

A. Yes.

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

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

A. Okay.

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

A. My charting that was related to the patient.

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

Q. Have you reviewed any textbooks or journal articles?

A. No.

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Q. And have you discussed this case with anyone other than with counsel?
A. No.
Q. Do you have any personal notes or personal file on this case?
A. No.
Q. Have you ever generated any personal notes or a personal file on this case?
A. No.
Q. Now, you are a registered nurse in the State of Ohio; is that correct?
A. Yes.
Q. And at the time that James Long had his surgery in August of 1996, you were a registered nurse in the State of Ohio?
A. Yes.
Q. And also, you have to let me get my qucstion out and then answer it, because the court reporter can't take down two people talking at the same time.
A. Okay.
Q. What type of basic nursing program did you attend?
A. Bachelor's of science at Kent State University.

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Q. And when did you receive your nursing degree?
A. In 1991, May.
Q. And your license?
A. That was issued to me I think in August of 1991.
Q. And since the time of your basic nursing education, have you completed any additional degrees or any additional certifications in nursing?
A. Yes.
Q. What are those?
A. Advanced cardiac life support.
Q. When did you complete that?
A. About five years ago. Intraaortic balloon pump class.
Q. Was that here at the Cleveland Clinic?
A. Yes.
Q. When did you do that?
A. Maybe about five or six years ago. I can't tell you the exact date.
Q. That's fine.
Anything else?
A. Not that I can think of off the top of my head right now.

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Q. Did you have any particular orientation when you started here at the Cleveland Clinic?
A. Yes.
Q. Your current employer is the Cleveland Clinic; is that correct?
A. Correct.
Q. What is your current title and position?
A. Staff nurse, RN.
Q. What clinical area do you currently work in?
A. Cardiothoracic intensive care.
Q. And when did you first become employed at the Cleveland Clinic?
A. June 24th, 1991.
Q. So since the time that you obtained your nursing license, you have been a Cleveland Clinic employee?
A. Yes.
Q. And when you first became employed by Cleveland Clinic, what area were you employed in? What area of the hospital?
A. The cardiothoracic intensive care unit.
Q. You received an orientation from Cleveland Clinic to work in that intensive care area?
A. Yes.

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Q. How long was your orientation?
A. It was around 10 to 12 weeks.
Q. And in August of 1996, was your position a full-time position?
A. Yes.
Q. And in August of 1996, you had worked in the cardiothoracic intensive care unit about five years?
A. Yes.
Q. What was the usual shift that you worked in August of '96?
A. I would work 11 A's to 11 P's or 7 A's to 7 P's.
Q. So you were working a 12 hour shift?
A. Yes.
Q. And at that time, who was your immediate supervisor?
A. Dolly Gantner.
Q. And what was her title?
A. Headnurse.
Q. She was head nurse of the cardiothoracic intensive care?
A. Lily Hicks was the head nurse, just about two years. This change might have happened right in that summer. For the exact times -- I know

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they had a nursing structural change then around that time frame and it was either Dolly Gantner or Lily Hicks, but I think it was Dolly Gantner, actually.
Q. Now, in August of '96, how many patients would you normally be assigned if you were working in the evening?
A. One to two.
Q. And who would make that assignment of patients?
A. Either the charge nurse or our assistant head, the clinical coordinator.
Q. Were all of the patients that were in the cardiothoracic unit at that time post-op cardiothoracic patients?
A. Yes. Usually. It depends. If we had holdover of cath patients from the PACU, then we would take those patient population, or preoperative aneurysms, there are some pre-op patients we would get, but generally we would have postoperative cardiothoracic patients.
Q. What was the maximum census in the unit?
A. Ten.
Q. Now, the head nurse, would she do charge duties in the unit when she was on shift?

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A. No.
Q. You had a head nurse and additionally you had a charge nurse assigned?
A. Right, a head nurse and then a clinical coordinator and then the charge nurse, who would have her own patient assignment too.
Q. And just from your perspective, just generally, the head nurse, was her job mostly management?
A. Yes.
Q. She didn't do direct patient care?
A. No.
Q. And the clinical coordinator, what were her duties from your perspective?
A. Mostly overseeing staffing needs, our staff schedules, managing the patients coming in and going out of the unit as far as transfers and admissions, problems.
Q. And then you would -- did the clinical coordinator take a patient assignment.
A. No.
Q. Then you had a charge nurse?
A. *Yes.*
Q. Did the charge nurse have any patient assignment?

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A. Yes.
Q. And in the evenings, in August of '96, how many nurses would actually be doing patient care in the unit?
A. If it was full with ten patients, probably five. It just depends on the patient's acuity. If we would have two balloon pumps in there, you would have six RNs. It depended upon the patient's acuity level and how many patients in the unit, So I would have to look at the census and then the patient's acuity.
Q. Would it be the clinical coordinator that would decide on the staffing or would it be the charge nurse?
A. Usually.
Q. The clinical coordinator?
A. The coordinator unless they weren't there.
Q. Prior to working in the ICU, did you receive hemodynamic monitoring classes?
A. Just with Kent State University's preparation in the critical care class that I took.
Q. That was part of your basic nursing program; correct?
A. Right, yes.

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Q. In the classes that you had in preparation to work in Cleveland Clinic's ICU, did they review hemodynamic monitoring with you?
A. Yes.
Q. Were you taught how to recognize abnormal parameters --
A. Yes.
Q. -- in the Kent State program or in the one that you received at the Cleveland Clinic?
A. I can't remember with Kent State, but I know, yes, at the Cleveland Clinic.
Q. And as an ICU nurse, were you taught to recognize significant trends in hemodynamic monitoring?
A. Yes. It depends who oriented you, but, yes, basically.
Q. Do you do that as a nurse in the intensive care unit, watch for trends in the hemodynamic monitoring?
A. Not necessarily. It depends what the patient's diagnosis is, what they came back from surgery with. You know, what their surgery was. It just depended upon the circumstance actually.
Is that what you are asking me?
Q. I am asking whether or not you have the

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expertise to notice a trend in the hemodynamic monitoring parameters?
A. I feel I do. I feel experienced to notice if there is a problem occurring.
Q. And were you also taught to keep the supervising physicians informed of any significant changes that you noted?
A. *Yes.*
Q. Now, as a staff nurse in the cardiothoracic intensive care unit in August of 1996, what were your duties and responsibilities?
A. At that time, I was orienting new RNs. I don't know if I had an orient at that time. Charge nurse and staff RN.
Q. And in regard to patient care, what were your duties and responsibilities?
A. Assessing the patient, recording vital signs, talking to family members, monitoring the patient constantly.
Do you want me to be very specific? Do you want me just to tell you basically what I would do if I was taking care of that patient?
Q. Yes.
A. Vital signs, like I said. The assessment. The respiratory status. Family issues. That's

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basically all.
Q. And in regard to your assessment, what are you assessing?
A. Assessing neuro status, lungs, vital signs, abdominal, bowel sounds, chest tube drainage, urinary output, lab values, temperatures, readings on the monitor, as far as heart rates, blood pressure, PA pressures, CVP pressures, oxygen saturations.
Q. In August of '96, did the Cleveland Clinic utilize any supplemental staffing; such as a PRN pool or a float personnel from other areas to staff the unit?
A. We usually do all the time.
Q. Can you be a little bit more clear on your answer?
A. We have a PRN staff and we have a float pool. So if the nursing staff was down, we would utilize a PRN pool and the float pool, if needed.
Q. Are the PRN staff and the float staff trained in hemodynamic monitoring?
A. *Yes.*
Q. Are they all ACLS certified?
A. They should be after two years of ICU nursing.

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Q. Do you have any independent recollection of James Long aside from what you saw in the medical records? Do you remember him?
A. No.
Q. Now, on August 20 of 1996, what hours did you work that day?
A. From my documentation if I would have left at 7:00 p.m. or 7:30 p.m., I most likely worked 7 A to 7 P unless they cancelled me my first four hours.
Q. And when you were working at that time, you always worked in the cardiothoracic unit?
A. *Yes,* unless we were floated to the floor or G-20, which is CCU.
Q. And based on the medical records that you reviewed, when did you care for James Long?
A. I took care of him immediately postoperatively until I gave report to the next nurse at 7:00 o'clock and I probably would have left by 7:30.
Q. And that evening, when you took care of him postoperatively, did you have any other assigned duties other than patient care for James Long?
A. I could not remember or tell you that information.

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Q. Do you know whether you had charge duty responsibilities?
A. I couldn't tell you, honestly.
Q. And just to be clear, you don't know whether you had an additional patient that evening?
A. Correct, I do not know.
Q. If a postoperative patient developed problems in the unit that required a physician's attention, was there any policy or procedure you followed regarding what physician would be contacted?
A. Yes.
Q. Would you tell me what that is.
A. In the daytime, there is a resident or a fellow on call from 7 A to 7 P, and they are on their call sheet numbers. They are on call for the unit.
After 7:00 p.m., it's who is on call from 7 P to 7 A on the call sheet for the unit, and they usually, the doctors will divide, they will say I will take 52 and 54, because there will be two physicians on for all the G-5's, and they will --
Q. I don't understand what you mean 52, 54, what is that?

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A. At that time we had five cardiothoracic intensive care units. Right now we have four cardiothoracic intensive care units. So generally, there would be a doctor resident on for two units and another resident on for the other two units.
Q. What clinical specialty would the person on call be?
A. I do not know.
Q. Would you know whether it would be anesthesia or whether it would be surgical?
A. Surgical, if that's the problem I was having. If I was having a ventilation problem, I would be calling the anesthesia on call.
Q. So did you have two doctors on call; one for anesthesia and one for surgery?
A. Yes.
Q. Okay. Now, were you allowed to make calls directly to the doctors or did you have to go through, say, your clinical coordinator or head nurse or charge nurse?
A. No, you could directly call the physician if you have a problem.
Q. And were you instructed to call the resident rather than the surgeon that actually did

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the surgery if there was a problem?
A. Usually the surgeon will tell you if you have a problem, you could call me, or usually you call the resident on call.
Sometimes the fellow or the person doing the surgery with the staff doctor would tell you to call them at home or call them, but generally it was the resident on call to call if there was a problem with a patient.
Q. Did you do the initial nursing assessment on James Long when he was admitted to the cardiothoracic unit?
A. Yes.
Q. Did you receive a report on the patient at the time that you admitted him to the intensive care unit?
A. Yes.
Q. Who gave you the report on the patient?
A. Anesthesia resident or an anesthesia CRNA.
Q. And in this instant, do you know who gave you the report on James Long?
A. No.
Q. What information were you given at the time that you received the report?
A. I would have to look at the documentation.

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Q. And when you find what you are looking for, if you could just tell me what portion of the record you are looking at, if there is a title on the page.
A. I am looking at the flow sheet for his first day that he was in the intensive care unit. It starts where he came back and vital signs are 1730, and there is a whole flow that gives you vital signs and then significant events and then outputs.
Q. So when you received the patient from surgery, what information did you receive?
A. They would tell you the surgery that was done. He had an AVR replacement. Homograft. The resident would tell you where they would like the blood pressures kept.
Q. Now, in this instance, my question is, what information did you receive on James Long? And so what I am asking you to do, if you can discern that from the record, is tell me as best you can the information that you received on James Long at the time that you admitted him to the intensive care unit.
A. Okay. They told me, either the anesthesia resident or the [redacted] told me the patient is

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obese. History of syncope. They dislodged teeth during intubation. Has a normal left ventricle. Gave him no blood in the OR. Told me the time they gave the antibiotics in surgery. What his hematocrit was in surgery. The last lab value was 31, last potassium was 44. Any allergies, which none are documented. And that they gave him lasix 60 milligrams IV. Also, his intake of three liters and his output of urine of 800 cc's. And that's all I can tell what they told me or another nurse.
Q. Okay. From what you have reviewed in the record, did you find anywhere that he had a bleeding problem during surgery?
A. No.
Q. If you had been told that, would it be your usual manner to include that in the initial note that you have just read to me?
A. Yes.
Q. So is it likely in this case that you did not receive any information that he had any bleeding problems in surgery?
A. Right, yes. No, he did not.
Q. If you had been informed that a patient had bleeding problems during surgery, do you watch

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that patient more closely for signs of problems or hemodynamic trends that would indicate bleeding?
A. Yes.
Q. What time was James Long admitted to the cardiothoracic unit?
A. It is documented at 5:30 p.m.
Q. And did you do an assessment on him at that point in time?
A. Yes.
Q. And what were your findings on that assessment? And again, if you would tell me what the page you are looking at is.
A. Okay. I am looking at the -- I don't have it marked here clearly, but --
Q. Just hold it up and I will probably be able to recognize what it is.
A. Right here is the nursing progress record.
Q. Okay.
A. And there is this sheet and this sheet that goes together.
Q. Which looks like a checklist for assessment, the second page that you are referring to.
A. Yes. My name is at the bottom from 1500 to 1900.

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Q. All right. Why don't you just go through and tell me what your assessment was of this patient.
A. He has total bathing, toileting, oral and feeding care by the nurse. We need to totally turn him. Total, up to bathroom. Unable to lift him out of bed to the chair. He is unable to walk in the halls.
When you star something, that means there is a deviation from normal. So alert and oriented to person, place and time, there is a star there because I would tell you on the documentation what his neuro status is.
Q. What was the deviation from normal for James Long?
A. I'm not clear on what you are asking me.
Q. You indicated that a star means that there was a deviation from normal and that you did a narrative note. I am asking you what the deviation from normal was that is represented by the star.
A. By the star, okay.
That he was awaken. The patient awakened and was put back to sleep with a Propofol drip and Vecuronium.

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Pupils are equal and reactive to light. Speech clear, coherent is starred because patient is obviously intubated, even though it wasn't charted on my assessment.
Moves all extremities, no weakness starred because sometimes, you know, postoperatively we are paralyzing the patient and sedating the patient, so there is an alteration of normal movement. Nonapplicable to study gait.
He is injury free from our MRA protocol. Pain free is starred because I cannot tell if he has pain or not because we have him sedated and paralyzed. Anxiety free is starred because if we -- there is a couple reasons why we would put a patient back to sleep and sedate them and paralyze either their shaking if they are not responding appropriately. So most everybody, most every single patient has anxiety with a breathing tube in, so we starred that and document accordingly.
Q. For the rest of the assessment, if you would just indicate any that there was a deviation from normal.
A. I had none.
Q. Did you have any contact with James Long's family when he was in the ICU?

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A. No, because I would have documented either here or on the flow sheet that the family was at the bedside or he had spoken to the family members.
Q. You would either document it on the narrative note or on the flow sheet if you had?
A. Yes.
Q. Now, in regard to the nursing flow sheet that has the hemodynamic parameters on it, if you could turn to that page.
And I would like you to tell me what, if any, of that documentation is in your handwriting, so that I am talking about the correct portion.
Now, in regard to the one page that says cardiothoracic intensive care record that has the hemodynamic parameters is the beginning part of that page in your handwriting --
A. Yes.
Q. -- can you tell me where, at what line -- and I see a number of letters running down the left-hand side of the page -- what line your charting starts at and then ends at?
A. Somebody wrote down my initial vital signs. That's not my handwriting. So I am usually at the head of the bed. I wrote down the

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

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that section is your handwriting?
A. Yes.
Q. I misunderstood what you were telling me.
What was your understanding in regard to James Long's systolic blood pressure as to what level it was to be maintained at?
A. I don't know if I understood the question.
Where would the surgeons like the blood pressure to be kept at or where was the blood pressure actually at?
Q. What was your understanding as to what level his blood pressure was to be kept at?
A. His systolic was supposed to be kept around 100.
Q. Now, as a nurse in the unit, do you have any responsibilities for keeping the blood pressure at that area in regard to titrating any of the medications?
A. Yes.
Q. And what responsibilities do you have in regard to titrating medications?
A. There are standard orders for Nipride and nitroglycerin and if a patient is hypertensive, which it appears that he must have been in the initial time frame, because he is on Nipride, we

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

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

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can't tell you specifically what the protocol says, but I do know what we do with the chest tubes for protocol.
Q. Okay. In August of 1996, what were you doing for the chest tubes?
A. We were hooking them up to negatives 20 degrees centimeter suction, monitoring the output hourly or more. It depends if the patient was bleeding or not. Making sure that they weren't clotting. And draining them.
Q. How did you make sure that they weren't clotting?
A. At the top where they are inserted, there would be large clots in the area that would accumulate there and then you would have to squeeze them to get the clots out.
Q. That would be a term like milking the tubes?
A. Milk the chest tubes, right.
Q. Did you use any type of an instrument to assist in stripping tubes at all?
A. Not usually. **A** lot of times surgeons don't like those being used. They just like you to apply squeeze and manipulate the tube to get the clot to come down.

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Q. Did you do that on a regular basis with all the patients or only if in your assessment it was indicated?
A. It just depended upon the patient, **if** they were clotting in that area. If it looked like there was no clots in the area, I wouldn't do that.
Q. If there was no drainage coming out of the tube, would you milk the tubes at all?
A. If there appeared that there was clots up at the site.
Q. So you would have to actually see a clot before you would go through the motion of milking the tubes or squeezing the tubes?
A. Correct.
Q. Okay. Now, in James Long's case, did you have to squeeze the tube to remove any clots?
A. I could not tell you. I do not remember.
Q. If you do that, is that something that you routinely chart in your notes?
A. No.
Q. What's the usual or expected amount of chest tube drainage per hour for a cardiothoracic chest surgery patient?
A. That just depends upon the patient, but

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usually it's anywhere from minimal to 100 would be acceptable. It depended if you had turned the patient, suctioned the patient. The initial suction on the chest tubes from the OR, usually some patients will have a larger amount come out because that drainage was sitting in their chest cavity from the OR, so it's not unusual to see a large amount initially post-op too.
Q. And when you say initially, how much after they arrive in the ICU would you expect to see that increased drainage? For how long a period?
A. With the initial large amount?
Q. Yes.
A. Probably an hour time frame.
Q. Now, you have recorded a number of hemodynamic parameters for James Long on the flow sheet.
Were all of James Long's hemodynamic parameters within the normal or expected ranges for him that you recorded?
(Pause.)
A. Yes, other than this on line E the blood pressure being a little bit low, 75 over **46.** It looks like we initiated Levophed on the next line for that blood pressure.

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Q. The systemic vascular resistance recorded at the time of admission of 559, is that an expected normal range for this patient?
A. It would depend upon the patient. And with the cardiac output and cardiac index being very good, and us using Nipride to get the SVR down, that would be an acceptable number.
Q. What about the central venous pressure of 17?
A. Well, I would have to ask what they were running in the OR as far as central venous pressure, where they were trying to keep it and where it was. But 17 would be a normal number, especially how big he is, if he was a very large patient.
Q. What's the normal systemic vascular resistance range?
A. I couldn't tell you exactly the numbers, but from what we are taught, it could range anywhere from 500 to 1500, or even up to 2000, we get numbers from 500 to 2000.
Q. Now, at 1830 hour, the mean arterial pressure is recorded at 59.
Would that be a value that you, as a nurse, would report to a physician that much of a change

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

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

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

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

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

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

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

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

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Q. That's something that you commonly do in the intensive care on the cardiothoracic patients?
A. It depends on the patient. Their age, what is going on with them. But a lot of times patients will be unstable as far as their temperatures. They either spike a temperature right after surgery and it causes them to dilate and their blood pressure to fall and then we have to shut off the Nipride and start of Levophed.
Q. Did you have any concerns about this patient in that his blood pressure dropped and during that same hour or just around that time, he had a 250 cc dump into his chest tubes?
A. That was documented after I left. That's not my handwriting, so, no, I wasn't concerned until the time I left. I documented the **41,** the crit of 35. That's my handwriting. So the next line is not my handwriting, the 600 and 250. So I probably left by that time.
Q. So that 250 cc's was after you left the unit?
A. Yes. That's not my handwriting, so it must have been her assessment.
Q. Who assumed care of James Long after you left? Who did you turn the care over to?

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A. Documented at Angelique Young.
Q. Do you recall having any conversations with Dr. Muellbach during the time that you were in the ICU on August 20th?
A. No.
Q. Now, there is a dose of Vecuronium given at 1850 hour, I believe.
A. Yes.
Q. Did you give that to the patient?
A. Yes.
Q. Do you know why he required that medication?
A. It's not documented, but either the ABG's, something is going on with the patient as far as his ABG's are changing or the patient is shaking, or just to stabilize. A lot of times we will paralyze a patient just so they become more stable as far as their blood pressures going up and down and sedating and paralyzing them.
Q. There is a notation at 1910 about the lines being leveled and zeroed. Is that in your handwriting?
A. No.
Q. Was that after you left the unit?
A. That was Angelique. I had written down

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that I had given that calcium, so she might have at that time, while we were talking, might have leveled the lines while we were giving report to each other. I might have been giving some calcium, so at that time she might have been leveling the lines and I was giving the drug, so I documented -- it's hard to see -- six, so around 7:10 I was giving calcium and she was leveling her lines. That's an initial assessment to do after you come on to see a patient, level and zero lines.
Q. Was this Nurse Young, you believe? Does that look like her handwriting?
A. I do not know her handwriting, honestly, but --
Q. How do you level lines and zero them in the unit?
A. You go by their axillary, mid axillary line, and you level the line to that, and you will open the lines to air, and zero it on the monitor to where all your numbers will go to zero, and then close them off to air.
Q. And how often is that done?
A. You are supposed to do it, I think our protocol is Q 24 hours, but years ago when I

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started, it was every shift that you started to rezero them, or if the numbers are off and they are not seeming right, you can rezero your lines and make sure it's not a zeroing problem.
Q. And do you know any reason why it was done at 1910 hour here?
A. Probably because she started her shift and it was a habit,
Q. Okay. Did you at any time on the 20th, when you were in the ICU, make a request that a physician look at James Long?
A. No, not that I'm aware of, no.
Q. And other than Dr. Cosgrove, that's noted, do you know of any other physicians that came in and assessed James Long during the time that you were in the unit?
A. Dr. Yared must have, because he was at the bedside to sign this, but other than that, I do not know. Dr. Muellbach could have, but I don't know if he was at the bedside or not. I did get these orders from him, but I don't know if that was over the telephone or at the bedside.
Q. Now, did you give a report to the nurse that was coming on after you?
A. Yes.

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Q. And in this instance, do you know what information you provided in that report?
A. Yes.
Q. Could you tell me what that was.
A. I always go from left to right. Start with the surgery, where they went.
MR. JACKSON: When you say left to right, so she understands.
A. Left to right on the flow sheet with the cardiothoracic intensive care record. The surgery, where they want to keep the blood pressures, temperatures, how they were running, how the blood pressures were running, the heart rates, their ventilation, their cardiac outputs, the drips that they are on.
If I had given any medication, given any fluids, which I did, 500 of LR two times, gave the Amicar bolus, had sedated and paralyzed the patient.
I would tell her how my urinary output has been, which is very good. The chest tube drainage went from 50 to 100. I would tell her his neuro status, how he was for me. His potassium levels, glucose, if they were significant, which they weren't, and hemoglobin, hematocrits, and anything

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pertinent as far as orders, which I would go over the orders that I had gotten. And his history, which is at the top here, plus we look at the history sheet, They do a preoperative assessment for history sheet. We would go over that.
Q. Where is the ICU located in relation to the operative suites?
A. Two floors above.
Q. Have you assisted or transported patients between the ICU and OR?
A. Yes.
Q. How long does it take to get from one place to the other?
A. It depends. You mean by the time I am ready to pull out of the bed space with the patient after I attached and detached everything?
Q. Yes.
A. Probably five minutes, if that.
Q. If you have to transport a patient back to surgery, what do you do with all of the hemodynamic lines, the pulmonary artery lines and that?
A. What we do when they bring them up, we have a little portable metal slot that the tram slips into. There is a monitor that attaches on a bar,

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like comes down, so they can see the screen and see the blood pressure and PA pressure and everything. It's still all monitored and connected. Put all the drips on the side of the bed. There is a special lever that it drops down into and just disconnect your suction from the bed, from the wall for your chest tubes, and that's about it.
Q. So the pressure monitoring continues in transport then?
A. Right, correct.
Q. Did you have any conversations with anyone after August 20th in regard to what happened to him?
A. No.
Q. Was James Long's case ever discussed in a staff meeting?
A. No.
Q. Do you have any criticisms of anyone that rendered care to James Long?
A. No.
MS. TOSTI: I am done. I have no further questions.
MR. JACKSON: She will read it.

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(Deposition concluded at 2:05 o'clock p.m.; signature waived.)

Denise Hrobat, R.N.

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 DENISE HROBAT, 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.

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

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

My commission expires May 22, 1999.

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