IN THE COURT OF COMMON PLEAS

THE STATE OF OHIO COUNTY, OF CUYAHOGA

CIVIL DIVISION

* * * * * * * *

JOHN L. SWIFT, *

Executor of Estate *

of SHARON SWIFT, *

deceased, *

Plaintiff * Case No.

vs. * 439620

LYNN TIARA MASON, *

M.D., et al., *

Defendants *

* * * * * * * *

VIDEOTAPE DEPOSITION OF

MARY JANE MARTIN SMITH, RN

JUNE 19, 2002

Sargent's Court Reporting Service, Inc.
(814) 536-8908

VIDEOTAPE DEPOSITION

OF

MARY JANE MARTIN SMITH, RN, taken on behalf of the Plaintiff herein, pursuant to the Rules of Civil Procedure, taken before me, the undersigned, Shannon C. Fortsch, a Court Reporter and Notary Public in and for the Commonwealth of Pennsylvania, at Sargent's Court Reporting, 429 Forbes Avenue, 1300 Allegheny Building, Pittsburgh, Pennsylvania, on Wednesday, June 19, 2002, at 1:06 p.m.

A P P E A R A N C E S

HARLAND M. GORDON, ESQUIRE
DAVID M. PARIS, ESQUIRE
Nurenberg, Plevin, Heller & McCarthy Co., L.P.A.
1370 Ontario Street, First Floor
Cleveland, OH 44113
COUNSEL FOR PLAINTIFF

TIMOTHY G. SWEENEY, ESQUIRE
Bonezzi, Switzer, Murphy & Polito, Co., L.P.A.
Leader Building, Suite 1400
526 Superior Avenue
Cleveland, OH 44114
COUNSEL FOR DEFENDANT,
ASHTABULA COUNTY MEDICAL CENTER

LESLIE JENNY, ESQUIRE
Reminger & Reminger
113 St. Clair Street
Cleveland, OH 44114
COUNSEL FOR DEFENDANT,
DR. KONDRU

JONATHAN MENUEZ, ESQUIRE
3600 Erieview Tower
1301 East 9th Street
Cleveland, OH 44114
COUNSEL FOR DEFENDANT,
ASHTABULA CLINIC AND DR. CHILCOTT

I N D E X

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ATTORNEY MENUEZ: 153, 171, 200

ATTORNEY JENNY: 167, 171, 174, 209

P R O C E E D I N G S

VIDEOGRAPHER:

My name is Michael Sullivan. I am employed by Sargent's Court Reporting Services. The date today is June 19th, 2002. The time is 1:06 p.m. This deposition is being taken at 429 Forbes Avenue, Pittsburgh, Pennsylvania. The caption of this case is: In the Court of Common Pleas of Cuyahoga County, Ohio, John L. Swift, Executor of the Estate of Sharon Swift, deceased, Plaintiff, versus Lynn Tiara Mason, M.D., Defendant, Case Number 439620. The name of the witness is Mary Jane Smith. Will the attorneys present state their names and the parties that you represent.

ATTORNEY PARIS:

David M. Paris and Harland M. Gordon represent the Plaintiffs.

ATTORNEY SWEENEY:

Timothy G. Sweeney on behalf of Ashtabula County Medical Center.

ATTORNEY PARIS:

You folks in Cleveland want to state your name for the record?

ATTORNEY MENUEZ:

Jonathan Menuez on behalf of Asthabula Clinic and James Chilcott. I also say that I'm hearing the court reporter typing, but that's about all I'm hearing from you guys.

ATTORNEY PARIS:

And Leslie?

ATTORNEY JENNY:

Leslie Jenny appearing for Doctor Kondru.

VIDEOGRAPHER:

The court reporter may now administer the oath.

COURT REPORTER:

Would you raise your right hand to be sworn?

MARY JANE MARTIN SMITH, RN, HAVING FIRST BEEN DULY SWORN, TESTIFIED AS FOLLOWS:

EXAMINATION

BY ATTORNEY PARIS:

Q. Will you state your full name for the record, please?

A. Mary Jane Martin Smith.

Q. Ms. Smith, I'm taking your discovery deposition today because you have been identified as an expert witness on behalf of Ashtabula Medical Center. Are you familiar with that?

A. Yes.

Q. And you have some opinions about the care and treatment rendered to Sharon Swift; is that right?

A. Correct.
Q. You're aware that she was born on January 22nd, 1933, and died on June 16th, 2000?
A. Yes.
Q. And she died at the age of 67 years old?
A. Yes.
Q. All right. In connection with your services for Ashtabula County Medical Center, you prepared a report; is that correct?
A. Yes, it is.
Q. And that's a report that has been marked as Exhibit Three in this case?
A. That's correct.
Q. And it's dated May 6th, 2002, and it consists of four pages; is that right?
A. Yes, it is.
Q. Is this your first and only report that you drafted for this case?
A. Yes, it is.

Q. Did you draft any rough drafts?
A. I did not.
Q. Does this report embody all of the opinions that you embrace in this case?
A. Yes, it does.
Q. Do you intend to state any additional opinions that are not contained in your report?
A. Not unless I receive additional information.

(Exhibits One and Two marked for identification.)

BY ATTORNEY PARIS:

Q. And I've also been provided with a copy of your Curriculum Vitae, which I've marked as Exhibit One, and a copy of your fee schedule, which has been marked as Exhibit Two. Is your CV up-to-date and current?
A. Yes, it is.
Q. And your fee schedule is marked as Exhibit Two. Is that

up-to-date and current?
A. May I look at it? I'm not certain.
WITNESS REVIEWS DOCUMENT
ATTORNEY PARIS:
And by the way, Mr. Videographer, any time I'm holding something up that blocks the view of the witness, will you please let me know so we have an accurate video and history of this? Okay?
A. This is correct, except that there's been a mileage change, I think as of March of this year. That's all.
BY ATTORNEY PARIS;
Q. What's your mileage now?
A. I think it's .345 rather than .31.
Q. Tell me a little bit about your educational background. Let's start with high school and move on to college.

A. I graduated from Mount Lebanon High School in Pittsburgh, Pennsylvania, and went to college at the University of Michigan, where I received a Bachelor of Science in Nursing. In 1976, I returned to college and received a Master's of Arts in Higher Education, with a minor in nursing, from the University of Pittsburgh. And in the late 1980s I returned to college again and took Ph.D. courses at the University of Pittsburgh in exercise physiology. I completed the course work and took and passed all the exams for the doctorate in physiology approximately 1992 or '93 and did not write a dissertation.

Q. So sitting here today, what degrees do you have?

A. Bachelor of Science in Nursing, Master of Arts in Higher Education, and as part of the educational process, in addition, I have a certificate from the American

Nurse Association in medical/surgical nursing.

Q. Let's start with your employment history. Are you currently employed?

A. Yes, I am.

Q. Actually, let's go back to when you first got into nursing and move forward. Tell me about your first nursing job and let's move forward.

A. I was first employed at St. Clair Memorial Hospital in Pittsburgh and worked there for approximately two years, full time.

Q. When was that?

A. 1956 to 1958.

Q. And what were your duties there?

A. I was a staff nurse.

Q. And your reason for leaving?

A. I was married and left the country for about four months.

Q. All right. And then when you came back?

A. When I came back I was asked to teach at St. Joseph's Hospital School of Nursing, which was a diploma program in Pittsburgh. And I taught there full time for about a year and a half, I believe, two years, and had my first child.
Q. That was from 1958 to 1960?
A. Yes.
Q. And your reason for leaving was that you had your first child?
A. That's correct.
Q. And how long did you stay out of the work environment?
A. Approximately a year or so, and then I went back to work part time.
Q. Where?
A. At St. Clair Memorial Hospital and also intermittently back at St. Joseph's.
Q. In what capacity, a staff nurse?
A. Well, at St. Clair I was a staff nurse. At St. Joseph's

Hospital I was an instructor.
Q. And you were instructing nursing students?
A. That's correct.
Q. And when we say part time, we're talking about maybe ten hours a week at St. Clair Hospital and ten hours a week at St. Joe?
A. No. At St. Clair Hospital I worked primarily weekends. I would work an eight-hour shift, usually 11:00 to 7:00 a.m. on weekends. At St. Joseph's it varied a lot, depending upon when they needed me to teach. But generally speaking, I would teach one or two days a week when I was there.
Q. Were those full days of teaching?
A. No. They were classroom and clinical instruction, so the allotment of hours varied from semester to semester.
Q. How long did you continue working part time at those two jobs?

A. Until I had my second child, which was in 19 --- late 1963, December of '63.
Q. Then what happened?
A. And then I took time off after my second child and didn't work either full time or part time for about a year, year and a half.
Q. And when did you return to work?
A. Approximately 1960 --- late '65 or '66. I did occasional work before that for a pediatrician who was a friend of mine that asked me to help him in his office, so I did stay active to some degree.
Q. And where did you return to work?
A. I returned to St. Joseph's Hospital School of Nursing.
Q. Where you taught?
A. Correct.
Q. Full time or part time?
A. I returned full time.
Q. And how long did you continue

to work there full time?
A. Until 1968, the fall of 1968.
Q. What happened then?
A. I was asked to join the faculty at the Community College of Allegheny County here in Pittsburgh.
Q. In what capacity?
A. As a full-time instructor.
Q. An instructor of nursing?
A. Correct.
Q. And you accepted that position?
A. Yes, I did.
Q. And how long did you --- do you continue to work there?
A. I'm still there.
Q. And that's full time?
A. Yes, it is.
Q. Between 1968 and the present time, have you engaged in other employment?
A. Yes, I have.
Q. Tell me about your other employment.
A. I've worked for the Visiting

Nurse Association of Allegheny County for seven to eight years on a regular or part-time basis, that is I would work full time in the summer and intermittently throughout the year, either on weekends or evenings as a nursing supervisor. That was for approximately eight years. And I also worked for a temporary staffing agency as a staff nurse in the late 1980s, in the summer, approximately three days a week during the summer.

Q. How many summers did you work for the temporary staff agency?

A. I believe it was two summers.

Q. When you worked for the Visiting Nurse Association for that seven or eight years between 1980 and 1987, you were just supervising nurses that would go from location to location?

A. The primary responsibilities were supervising nurses. We also were required to take call on weekends, so I also made home visits

as needed on weekends.
Q. Primarily, though, your job at the college is not hands-on nursing care for patients on a day-to-day basis?
A. Well, that's not entirely correct because I do clinical instruction. And the nature of the program is that we provide direct care with the students to patients in the hospital.
Q. At which hospitals?
A. It depends on where I'm assigned on any given semester. I can name those that I've been sent to for you if you'd like.
Q. Yes.
A. Allegheny General Hospital, Bellevue Suburban Hospital, North Hills Passavant, University of Pittsburgh Medical Center, Montefiore Hospital, John J. Kane Regional Centers, Divine Providence Hospital, which is also now called Providence Mercy, I believe, since the name

change. I believe those are the primary hospitals I've been assigned to.

Q. As a full-time instructor, how much of your curriculum of teaching, percentage-wise, is done in a classroom versus in a hospital?

A. Do you mean how much of my time as opposed to curriculum time? How much of my time?

Q. Yes.

A. What I do on a weekly basis or a ---

Q. Yes.

A. --- monthly basis? I spend between 12 and 18 hours a week in the hospital, depending upon the semester and the assignment, doing clinical instruction and giving care to patients, about --- between three and five hours a week in the classroom instructing, teaching classes. In addition, I may have responsibilities and often do for clinical laboratory demonstration practice, that is

skills practice in the campus lab on campus, and occasionally teach an additional one to two hours a week on assessments and other types of nursing instruction at the college.

Q. And if you can, give me a ballpark in the clinical lab per week? Is that a matter of an hour or two?

A. Yes. It's a two-hour block of time.

Q. Per week?

A. Correct.

Q. And what do you do with the rest of your time?

A. Well, faculty members have some additional responsibilities for meetings, faculty meetings, occasional assignments that have to do with the curriculum or other aspects of the nursing program. And we have some responsibilities, obviously, as most teachers do, for correcting papers and preparing exams, administering exams, doing

grade work and other kinds of functions like that.

Q. Okay. So the rest of your time, when you're not in the hospital, in the classroom or the clinical lab or teaching assessments, because you quantified those four areas for me, the rest of your times make up the full time, which I assume is 40 hours or thereabouts per week?

A. No, that's not correct. Calendar --- or clock-wise, faculty members don't generally get assigned to 40-hour blocks of time during the work week because I think it's generally understood that you spend a lot of time outside the classroom and outside of the campus doing activities that relate to your teaching, such as preparing exams and correcting exams and papers and things of that nature that don't keep you in your office.

Q. That's what I was getting at. I was trying to understand how much

of your time, including the faculty meetings and the correcting exams and crafting exams, that you, quote, work, closed quote.

A. Well, I have a full-time job as is defined by the college. I don't know how else to answer that.

Q. Do you find yourself devoting more than 40 hours to this or less than 40 hours to ---?

A. It really depends --- it really depends upon the assignment for any given semester.

Q. On average?

A. Very difficult to say. I would say between 30 and 50 hours a week probably, depending upon the semester or the assignment.

Q. Fair enough. And do I understand that you no longer are involved in the Visiting Nurse Association or temporary staff nursing?

A. No, that's correct. I'm not.

Q. Have you published any

articles, books, that deal with your profession?

A. Yes.

Q. And these are located in what part of your CV? On page five, publications?

A. Yes.

Q. Have you published anything that touches on the issues in this case, the diagnosis and/or treatment or management of the patient with acute pancreatitis?

A. I think the 1981 publication is probably the only one that would relate in any direct fashion. I think you see it on page five there, where it states 1981.

Q. And that is published in a journal called Applied Nursing Consultation and Educational Resources?

A. It was a teaching module. There were nurses in Ohio who established a nurse consulting firm in the '80s, and they employed nurses

to write teaching modules that they then presented to hospitals as part of the hospital's continuing education program for the nurses. And I was contacted by them and asked to write this module, which I did. They published it, and it was presented by myself and I believe by other nurses in various hospitals in Ohio, West Virginia and Pennsylvania.

Q. Is it still in print?

A. It hasn't been reprinted. I still have my copy, I think.

Q. Would you have any objection to making a copy of that and providing it to Mr. Sweeney so that he can give it to me?

A. No, none at all.

Q. All right. Thank you. Have you, in your experience, while taking care of patients, managed those with acute gallstone pancreatitis?

A. Yes.

Q. And about how many patients, if you had to quantify that?

A. You're asking me to quantify the number of patients that I have provided care to over my entire nursing career? I don't believe I can do that.
Q. Okay. Can you tell me the last time that you have been part of the treatment time in managing a patient with acute gallstone pancreatitis?
A. Yes. It would have been within the year.
Q. And where was that patient located?
A. At Allegheny General Hospital.
Q. You were not the nurse assigned to that patient, though; is that right?
A. My student was assigned to that patient, and therefore we provided care to the patient.
Q. Was your student a registered nurse?
A. No, a student.
Q. So your student would have

been assigned to a registered nurse who was taking care of that patient?
A. My student is assigned to me, and in conjunction with our care, we work with a registered nurse who is also assigned to the patient.
Q. How do you provide care to the patient in conjunction with the care that is provided by the hospital and the nursing staff?
A. Well, I can explain to you how it works. I come to the hospital the day before the students do and I meet with the supervisor and/or head nurse or charge nurse of the unit. I read the patient's charts, I review them. Sometimes I interview the patient. Sometimes I actually go in and speak with them. And in conjunction with the nursing supervisor and/or charge nurse, I select patients that I think would be suitable for the nursing students to take care of on the following day. When we --- the students come then either at the same

time I'm there or later and they review the patients' charts. They introduce themselves to the patients, and they become familiar with their information that's on the chart. When we arrive the next day, I usually get there 15 or 20 minutes before the students do to determine if there's any changes in the patient's condition or assignments that I need to make. And the students get reports for their patients that they're assigned to from the nurses on the previous shift, which would be the nurses leaving at 7:00 in the morning, generally speaking. And I listen to some of the reports and on the others that I don't personally listen to, the student comes to me and gives me a report before they provide care. And then we spend the entire clinical day --- or I spend the entire clinical day going with the students from room to room, giving care,

whatever is required, medications, treatments, dressing changes, assessments, monitoring and all the rest. The nurses who are assigned to those patients are available to us, and we report to them if we have things we need to tell them about during the course of the day. We also communicate frequently about the patient's status throughout the day, and the primary nurses usually also will visit and do their own assessments on the patients during the course of the day. But we basically assume the care for the patient and keep very close communications with the primary nurse that's assigned to the patient.

Q. Have you completed your answer?

A. I think so, if that's what you were asking me.

Q. And is that typically, that experience, a one-day experience?

A. Well, it depends on whether

we're on a 12-hour day, which would be one day from 7:00 in the morning 'til 7:00 p.m., or if we're on a 16-hour two days, which would be two eight hours, a total of 16.

Q. How often are you on a one-day versus a two-day?

A. On any given semester I might be on a two-day for the entire semester. It might be 16 hours from beginning to end. On some other semesters it would be 12 hours. When we have those 12-hour days, we have a two-hour assessment the day before so it really works out to 14 hours.

Q. Did the patients that you referred to last year at Allegheny General Hospital have gallstone pancreatitis?

A. Yes. And I should probably clarify that just somewhat. This year, that is from September of 2001 until May of 2002, which was just last month, I was on a sabbatical leave. So the reason I said last

year is because my last contact with the patients would have been in May of 2001. But when I'm working full time, taking care of patients with gallstone pancreatitis is a regular part of what I do, and I see many patients with that condition during the course of any given semester.

Q. In the past --- in the past 12 months do I understand that --- that you've worked basically four months?

A. Well, no, that --- I need to elaborate a little bit. When I was on the sabbatical leave for those two semesters I worked part time for the college as a clinical instructor. The sabbatical leave didn't require me to do that, but I chose to do that. What I did not do was teach classroom or labs during that sabbatical year, which has now expired, but I continued to do the clinical instruction.

Q. At the hospital?

A. Correct.

Q. On a part-time basis?
A. Correct.
Q. But how often?
A. Every week. It would either be the 12-hour clinical day or it would be the 16-hour two-day each week, those semesters.
Q. Twelve (12) to 16 hours a week?
A. Continued through the sabbatical year, that's correct.
Q. And what are you doing this summer?
A. I'm not teaching this summer.
Q. What are you doing this summer? Are you working?
A. No, I'm not.
Q. As we sit here today, I take it school is out; is that right?
A. School is out until August 14th, I believe.
Q. As we sit here today, you are not actively in the clinical practice of nursing?
A. Today?

Q. Right, or for the rest of the summer.
A. Correct. Up until August 14th about.
Q. And you're not teaching --- and you're not teaching either?
A. Not this summer, no.
Q. The patient last year who had the gallstone pancreatitis, did that patient die?
A. Not that I can recall. I don't believe so.
Q. In the years that you have been involved with patients with gallstone pancreatitis, first of all, can you estimate or quantify the number of patients that you've been responsible for caring for with acute pancreatitis?
A. I see those patients and help care for them on a regular basis, so I would say at least two patients a week for the past five years, if that helps. I don't know that I could go back much further than that and

recall that specific diagnosis, but it's a regular part of the medical/surgical population of patients that I take care of.

Q. And when we're talking about in that five-year period, you're involved in their care during a small window of time during their confinement at the hospital? You're coming in there with students. You're responsible for managing the students' time and having them liaison with the RNs who are actually taking care of the patients, too; is that right?

A. That's part of it.

Q. And you don't follow the patient on the floor from the day of admission to the day of discharge, typically?

A. Well, I don't know that any nurse would because of the way work schedules are organized. But it wouldn't be uncommon for me to see the same patient two days in a row or

to see that same patient the following week.
Q. Well, two days in a row you would see the patient if you were on a double shift; right?
A. If I were on a 16-hour assignment week, ---
Q. Correct.
A. --- yes.
Q. And why would you see the same patient the following week?
A. They might still be hospitalized.
Q. But would that be the same patient that you would select for your students to see again?
A. Quite often I do, yes.
Q. Can you tell me how many patients over the past five years that you've seen, there are approximately two a week, how many of these patients with gallstone pancreatitis have died?
A. I couldn't tell you that. I don't know.

Q. Is it that you don't know because you haven't followed them from beginning to end or what is the reason you don't know?
A. Well, a few may die in the hospital during their care. Is that what you're referring to?
Q. Correct.
A. Well, if a patient becomes that ill, then they may be transferred to an intensive care unit, for example. And if they were transferred to a different unit, I wouldn't really have any way of knowing what their outcome was.
Q. Is that uncommon to see patients with gallstone pancreatitis transferred to ICU?
A. I guess you would need to define for me what you mean by uncommon.
Q. Well, is it --- in your experience, have some of your patients been transferred to ICU?
A. I have seen patients

transferred to ICU with acute pancreatitis. I have also seen patients admitted to ICU with acute pancreatitis because part of my duties sometimes involves teaching students in intensive care units. so I have seen patients cared for in those units with acute pancreatitis as well.

Q. And I guess you would agree with me, would you not, that the accepted standard of care for a nurse caring for such a patient would be that they know the signs and symptoms of acute pancreatitis?

A. Yes.

Q. And for example, the causes of acute pancreatitis, gallstone versus alcohol related?

A. Yes.

Q. It would also be the accepted standard of care for such nurses to understand the signs and symptoms that demonstrate a worsening of that acute pancreatitis?

A. Well, they should be aware of __- in general, of what signs and symptoms would be clinically apparent if the patient's condition was getting worse, yes.

Q. You have been involved in the medical/legal experience for some time?

A. Yes.

Q. When did you first get involved in consulting as an expert in medical/legal matters?

A. About 1991, '92.

Q. And was it at that point in 1991 or 1992 that you started reviewing cases for lawyers?

A. Well, I started because an attorney friend of my husband's wanted some research done on a case that he couldn't figure out, so he called me and asked me for some help. And subsequent to that, I received some additional calls from other attorneys and over time I began reviewing records.

Q. And about how many cases per year, say over the past six, seven years, have you been reviewing?
A. Reviewing, probably 20 perhaps, 15 to 20. That is reading records.
Q. Understood. And I take it after you review the records, you get a hold of the attorney that sent you those records and discuss the issues with him or her?
A. Yes. Correct.
Q. And do you typically provide that individual with an opinion as to what the records disclose?
A. Yes.
Q. Are these opinions that are sought from you typically --- go to the question of whether or not a particular part of the treatment team departed from the accepted standard of care?
A. No. I confine my opinions strictly to the nursing issues. so I only review the records in relation

to the nursing standards of care.
Q. So the questions that are put to you by the attorneys are did the nursing staff comply with the accepted standard of care or somehow depart from that accepted standard of care?
A. Sometimes those are the questions I'm asked. Sometimes I'm also asked to review the records to determine if there is any negligence on the part of the nurses at all. Sometimes I'm asked to perform research, which doesn't really involve much review of the records. It just isolated a particular issue and asked to do some research on it. But by and large, the majority of what I do involves reading the medical records.
Q. In order to see whether or not the nursing staff complied or did not comply with the accepted standard of care?
A. That's correct.

Q. And when you are called by attorneys over the past ten years to perform this task, how does it shake out in terms of percentage for the Plaintiff, the patient's attorney and how many for the defense?
A. It actually comes out very even, about 50/50.
Q. Do you work with any lawyers here in the Pittsburgh area?
A. Yes, I have and do.
Q. Can you tell me some of the plaintiffs' lawyers that you've worked with in the Pittsburgh area?
A. I'll try to recall their names. Craig Fishman. I believe he's with the Tarasi firm. I've worked with Gary Lang, Ed Feldstein, Grinberg, Stein and McKee. I've been asked to work with Jerry Myer. I think it's Myer, Luen (phonetic), Luick (phonetic) and Perry. I believe that's the name of the firm. I was recently contacted by another attorney from his firm named Thomas

Ballard. I have to think for a moment. There's an attorney named Carl Moses, who does live in Pittsburgh, he lives in Sharon, but perhaps that's close enough to qualify, who is a plaintiff's attorney.

Q. How about in Cleveland, have you ever consulted with any plaintiffs' attorneys in Cleveland?

A. Yes. Plaintiffs' attorneys, let me think for a moment. I've consulted with Martin White, who is Warren, Pennsylvania --- I'm sorry, yeah, Warren, Pennsylvania. That's not Ohio. Yes. I've done some work for Jack Landskroner in Cleveland, for Becker and Mishkind (phonetic). I believe the attorneys are Michael Becker and Howard Mishkind. And there's a woman named Jean Tusty (phonetic) who works for that firm that I've done some work for. Those are the ones that come to mind.

Q. Let's talk about defense firms

in Cleveland. Have you ever worked for Mr. Switzer's office before?
A. Yes.
Q. How many occasions?
A. I believe twice.
Q. And when I say Mr. Switzer's office, there's a predecessor firm to that called Jacobson, Maynard, Tuschman and Kalur. Have you ever worked for that firm before?
A. It sounds familiar, but I'm not certain. I may have.
Q. How about the law firm of Reminger & Reminger?
A. I believe I have.
Q. How many occasions?
A. I think just once that I can recall.
Q. Can you recall the lawyer who you worked with?
A. I don't. I'm sorry.
Q. Have you ever worked with Mr. Rodell or Mr. Joseph Frashone (phonetic) before?
A. No.

Q. Other firms that you may have worked with in Cleveland, how about the firm Arger (phonetic) and Haddon (phonetic)?
A. Yes, I have. That was when Mr. Moscarino (phonetic) and Mr. Troy worked for them.
Q. They now have their own firm called Troy & Moscarino?
A. That's correct.
Q. Have you worked ---?
A. Moscarino & Troy. I think he would correct you.
Q. I'm not as up to it --- up on it as you are, but --- have you performed any work with Moscarino & Troy since their departure from Arger & Haddon?
A. Yes, I have.
Q. On how many occasions?
A. Several.
Q. And how about the law firm of West & Hurt?
A. Yes.
Q. Who have you worked with over

there?
A. John Jeffers and one other attorney, but at the moment the name is not coming to mind.
Q. Deidre Henry?
A. No.
Q. Can you think of any other defense firms in Cleveland that you've worked for that I haven't mentioned?
A. I can't offhand.
Q. Have you consulted over the past eight or nine years since you've been doing this on any cases involving the management of the patient with acute pancreatitis?
A. I can't recall any specific cases, but I can't exclude the possibility that I may have. I just can't recall.
Q. Have you given depositions before today?
A. Yes, I have.
Q. About how many times have you given depositions?

A. Since 1992 or whenever?
Q. Sure.
A. Probably 20, in that range.
Q. Did you give any depositions in the cases in Cleveland?
A. Yes.
Q. Both when you were retained by the plaintiffs and when you were retained by the defense?
A. Yes, both.
Q. Have you gone to Court to testify?
A. Yes.
Q. On how many occasions?
A. In Ohio?
Q. Anywhere.
A. In the vicinity of 15 times, probably 12, 15 times.
Q. Have you ever given testimony in the Cleveland area?
A. Yes.
Q. How many times?
A. Two or three times, I believe.
Q. At trial?
A. Yes. I thought that's what

you were asking me.
Q. That was. Do you remember the parties involved?
A. I will try to remember.
Q. I mean the lawyers involved.
A. I remember one was Mr. Moscarino, Mr. Lanscrover. It was not tried in Cleveland, however. It was in --- let me think for a moment.
Q. One of the neighboring counties?
A. I want to say Mansfield or Massillon or somewhere in that area.
Q. Can you recall any other individuals that you testified for in the Cleveland area?
A. In Cleveland, I can't recall. I believe there was one other trial, but I can't recall the specifics.
Q. All right. Have you ever come to learn that ---?
A. I just thought of it. Do you want to know it?
Q. Sure.
A. It was with the firm of Amer

Cunningham Brennan, and the attorney was Theresa Tarchinski (phonetic). But I can't recall the case at all.

Q. And that was in Akron?

A. I thought it was tried in Cleveland, but I could be wrong. It was several years ago.

Q. Sure. Have you ever come to learn that your name is in an expert service bank?

A. No.

Q. Have you ever been approached by anybody to list your name with a company that helps lawyers find experts?

A. Yes.

Q. And I take it you rejected that offer?

A. Yes.

Q. Are there any publications in your personal library or at the school library that you use routinely to help you and your students comply with the appropriate nursing standard of care?

A. No, there's no specific text or references that I would use.
Q. Do you consider The Lippencott Manual of Nursing to be an authority which is reasonably reliable?
A. I don't know that I would use the word authority. I don't think it's authoritative in any sense. But it is a reference that's considered to be a fairly standard reference among others that are used.
Q. Well, is The Lippencott Manual of Nursing a reference material which you believe is reasonably reliable?
A. It depends upon what you're looking up and what you're referencing because those manuals have multiple authors, and it really depends upon the issue and what you're referencing and so on. I think it has good information in it. I don't know that I would call it anything other than a standard reference among others.
Q. Would you agree that nurses

are the eyes and the ears and sometimes the hands of the doctors as it relates to caring for patients in the hospital?

A. You know, I'm not really comfortable with that phrase because I think it's a cliché that stereotypes nurses and doctors. SO it isn't something that I would teach students.

Q. You've read --- let me go back a little bit. You have reviewed what documents --- strike that.

All the documents and records that you have reviewed in this case are listed on page one of your report; is that right?

A. Yes. I'll just take a quick look to make sure that that --- yes, I saw one additional document this morning briefly with Mr. Sweeney, and that, I think, was titled laboratory ___ laboratory response time, something to that effect.

Q. And what did that document

inform you of?
A. It defined what stat meant and what ASAP meant and --- in terms of the laboratory's interpretation.
Q. And what is that?
A. I believe --- I just looked at it briefly, but my recollection is that stat meant within 45 minutes for the laboratory.
Q. And ASAP?
A. My recollection is it said within two hours.
Q. And routine?
A. I believe that was four hours. Other than that, this is what I have reviewed, what's listed there.
Q. The terminology that nurses are the eyes and ears of the physicians is terminology that I gleaned from some of the other medical care providers in this case. That is not a concept that you would embrace; is that right?
A. It isn't a term that I would use.

Q. What would you use to characterize --- what characterization do you feel is appropriate?
A. For what?
Q. If they're --- if the nurses are not the eyes and ears of the doctors in a hospital setting, what are the nurses?
A. They're registered nurses who practice under the scope of practice of the state in which they're practicing, which defines what that scope of practice is. So they have duties and responsibilities that fall under that related to assessment and monitoring and evaluation of patients and use of the nursing process.
Q. And from the standpoint of monitoring the patients when the doctors are not present, is it reasonable to assume that these nurses are acting as the eyes and ears of the doctors to the extent that they're conducting monitoring of

the patients?
A. You can use that term if you wish. Obviously, the nurses are there and they're looking at the patient and they're obtaining data on the patient, and they use their eyes and ears to do that, partly. But I think the implication of they're the eyes and ears of the doctor means that the doctor is not able to access information, except when the nurse calls them, and that's not correct. So I think --- I think it's a cliché, as I said, that I'm just not comfortable with.
Q. You're not comfortable with it because it seems to --- it seems to take away the responsi --- a certain amount of responsibility from the physicians who also have an obligation towards the patient?
A. Correct.
Q. And places too much responsibility --- at least the cliché seems to put more

responsibility on the nurses than is appropriate; is that your objection to the cliché?
A. I think it puts --- I think what it does as a cliché is exclude the doctor's responsibility, and that's not something I'm comfortable with.
Q. Do you agree that the physicians rely on the nursing staff to provide significant information to them, ---
A. Yes.
Q. --- such as changes in the condition of the patient?
A. Yes.
Q. And is it the accepted standard of care for a nurse to advise a doctor of changes in the condition or status of a patient?
A. It depends on the kind of change it is and what the nurse's judgment is at that time. Change in general can mean something that's very slight or insignificant and

wouldn't have to be reported. So it just depends upon the nature of the change and the context in which it happens.

Q. Since you used the term significant, I'll use the term significant, too. But the standard of care requires that a nurse advise a physician of any significant changes in the patient's status?

A. Yes.

Q. And therefore, would a failure of the nurse to do that be a deviation from the accepted standard of care?

A. If the change is significant, yes.

Q. Does the standard of care also require nurses to convey information to doctors that a patient's condition is not improving when supportive care is being given, despite supportive care?

A. It would depend upon the time frame and the patient's overall

clinical presentation, and the nurse would make a judgment about that during her care. But it isn't --- it isn't a simple matter of saying at this point in time there is or there isn't improvement. It would depend upon the total clinical picture as the nurse saw it.

Q. Certainly we can agree that the accepted standard of care for a nurse is to notify a doctor immediately when that nurse puts a patient in restraints?

A. I believe the nurse is required to notify the doctor within an hour of placing the patient in restraints. I believe that's what the regulation requires.

Q. Doesn't the regulation --- the ACMC protocol that was in effect at the time of Mrs. Swift's demise, didn't that require immediate notification if the reason for the restraint was cognitive impairment?

A. May I refer to that again?

Q. Sure. I'll be happy to hand you Exhibit Three --- I'm sorry, it's an exhibit that was marked as Number Three in one of the nursing depositions. Did I give you the right one?

A. I think so. May I just compare it with --- to make sure it's the same that I ---

Q. Yes.

A. --- have looked at?

WITNESS REVIEWS DOCUMENT

A. I don't believe I have this copy. I have this, which is cognitive impairment protocol.

BY ATTORNEY PARIS:

Q. Well, let's take a look at what I handed you.

A. Sure.

Q. All right. This was an exhibit that was marked during Head Nurse Petrochelle deposition. It was marked as Exhibit Three. It's titled use of restraints. And you're saying this I a document that has not been

provided to you by Mr. Switzer's office?

A. It appears to be. I don't believe I have a copy of it.

Q. I'm going to --- the last page of the document is a document that you have.

A. I do have the last page, correct.

Q. All right. The second to last page indicates the date that the protocol was approved, apparently?

A. Yes.

Q. That being April and/or May 2000?

A. Correct.

Q. And the second page of this protocol, if you can just read what is highlighted?

A. This is (3)(b), and what you've highlighted is, if the initiation of restraint is based on a significant change in the patient's condition, the RN will immediately notify the physician.

Q. That says immediate notification of the physician; correct?
A. If the initiation of a restraint is based on a significant change in the patient's condition.
Q. Okay. And you're aware that the accepted standard of care is for a nurse to request a physician to see the patient for a face-to-face evaluation within one hour after the patient is placed in restraints?
A. I'm aware of that, yes.
Q. And that is a rule that was in effect as early as the summer of 1999; is that correct?
A. I believe that's correct, yes.
Q. And the Ashtabula County Medical Center protocol does not have that requirement; does it?
A. Well, as I said, I haven't seen this document before. I'd be glad to read it if you want me to take the time to do that.
Q. I do.

ATTORNEY PARIS:

Let's go off the record while you read that.

A. Okay.

VIDEOGRAPHER:

Two o'clock p.m., off the record.

OFF VIDEOTAPE

WITNESS REVIEWS DOCUMENT ON VIDEOTAPE

VIDEOGRAPHER:

2:03 p.m., back on the record.

BY ATTORNEY PARIS:

Q. Does the Ashtabula County Medical Center protocol on restraints that was in effect when Mrs. Swift died require that the nurses notify --- request that a doctor see the patient for a face-to-face evaluation within one hour after the restraints are placed on the patient?

A. It does not say that.

Q. And that was the requirement that existed as of the summer of

1999; is that right?
A. I believe that's correct.
Q. And that requirement is embodied in the Code of Federal Regulations; is that correct?
A. Yes.
Q. And it applies to all hospitals throughout the United States?
A. Yes.
Q. Thank you. Is this yours or mine? I think this is yours. And were you aware when you reviewed this case that the restraint issue was an issue of some importance in this case?

ATTORNEY SWEENEY:

Objection.

A. I was aware that there had been questions about the restraint placement, yes.

BY ATTORNEY PARIS:

Q. And did you request of Mr. Switzer's office to send you the --- his client's restraint policy so that

you could review it?
A. He sent me the cognitive impairment protocol and he sent me a restraint policy, which apparently is a revision of the restraint policy that you just showed me, because the date is 2001.
Q. So he never sent you the restraint policy that was in effect at the time --- that would apply to Mrs. Swift's situation?
A. Well, when I reviewed this, my understanding was that that was in effect. But you showed me this, so ---
Q. Mrs. Swift died June of 2000?
A. That's correct. But there are oftentimes revision dates which don't show the other dates of the policy's effectiveness. All I can tell you is that I did not see this policy that you just showed me until today.
Q. And does the new and improved restraint policy at Ashtabula Medical Center that came into effect a full

year after Mrs. Swift died, because that says effective June 2001, ---

A. Yes, it does.

Q. --- does that new restraint policy comply with the federal law?

A. Yes, it does.

ATTORNEY SWEENEY:

Same objection.

BY ATTORNEY PARIS:

Q. Do you know why it took them two years, from '99 until 2001, to implement the appropriate restraint policy that was in compliance with the federal law?

A. I would have no way of knowing that.

Q. Thank you. Just to go back over a couple of things, on your report it's titled RN Consulting. Is that a name of a company?

A. It's the name that I filed with the State of Pennsylvania in about 1992 or '93.

Q. And that is the --- that portion of your time that you devote

to the medical/legal field; is that right?
A. Yes.
Q. And so that when you receive fees for your medical/legal consulting, you file it under this corporate name?
A. What do you mean? I'm not sure I understand your question.
Q. This is your business name; right?
A. That's correct.
Q. RN Consulting?
A. Yes.
Q. All right. And how much time do you devote to your medical/legal consultations?
A. About 15 to 20 percent of my time, I would say. It depends on the week and the month. It could be 25 percent in a given week or it could be less than ten percent. It just depends.
Q. On average, it's 15 to 20 percent?

A. I would say, yes.
Q. You would agree that nurses are part of the treatment team of any given patient?
A. Yes.
Q. And you mentioned that --- strike that.
Nurses are actually a significant part of the treatment team; are they not?
A. They are.
Q. Do you plan on coming to Cleveland to testify in this case in mid July?
A. I would be available if I'm asked to.
Q. Have you been asked?
A. I have not.
Q. You mentioned earlier that physicians are free to access information on their own without necessarily relying on the nurses to call him. In what, from your experience, are doctors capable of accessing information about a

patient?
A. By telephone.
Q. Who do they call?
A. Whomever they wish to speak to or whatever department they wish the information from.
Q. If they want to know the vital signs, who would they call?
A. If they wanted to know the vital signs, they would call the unit and ask to speak with one of the nurses.
Q. If they wanted to know lab values?
A. They could call the laboratory, depending upon how quickly they wanted them. If they wanted them quickly, they would call the laboratory. Or if they wanted a report, they could call the nursing unit and obtain a report from one of the nurses on the unit.
Q. And if they wanted to know the results of a CT scan?
A. They could call the radiology

department and speak with a radiologist. If they wanted a report after the report was in print form, they could call the unit and have the report read to them if it was available on the chart. And in some hospitals, all this information is computerized and available on the computer, so they can access through computers.

Q. You mean that the radiologist's dictated report can be accessed on a computer?

A. I don't know. It depends on the hospital. In some hospitals that's possible, but I don't know.

Q. And can doctors also call down to the radiology department and get what's known as a wet read ---

A. Yes, they can.

Q. --- of the film?

A. Yes.

Q. What is a wet read?

A. It's an interpretation before the film has completely dried.

Q. And are you aware that that happens from time to time?
A. Yes, I am.
Q. I used the term significant conditions when we were talking about changes in the patient's condition. How do you define significant conditions, changes in the patient's condition?
A. How would I define the term significant?
Q. Yes.
A. It would be something that deviates in a major way from the patient's baseline or from the previous findings.
Q. Either/or?
A. It could be either.
Q. And when you talked about nursing judgments, certainly you would agree that nursing judgments still has to comply with the accepted standard of nursing care; correct?
A. Well, nursing judgment is like anyone's judgment. It's a call.

It's a decision that you base on your analysis of the facts and the information that you have available to you at the time. So it's possible, as it would be for anyone making a judgment or a decision, to be totally accurate. It's possible to be less than totally accurate in your clinical judgment because it's based on analysis.

Q. When I was younger I sometimes used my judgment to try to make it through a red light, as it was changing from green to yellow to red, and had it explained to me many times that I used poor judgment and my judgment didn't comply with the rules of the road. Are there circumstances when nursing judgment does not comply with the accepted standard of care?

A. That's a very difficult question the way you phrased it because your analogy really isn't correct. I mean, you made a decision at the red light ---.

Q. Well, it was green when I made the decision, turning to yellow.
A. Well, whatever. A clinical judgment is based upon objective evidence to some degree because you have data available to you. And it's also based on, to some extent, the art of nursing or intuition or your feeling or sense and your experience in taking care of patients like this. So I really don't know that I could make an analogy with your example and, ---
Q. Well, let me ask you this then.
A. --- you know, I'm struggling because I don't think I can answer the question the way you phrased it.
Q. Is it your position that every --- all nursing judgments complies with the standard of care?
A. But they're two separate issues. That's the problem I'm having with the way you've put the question. The standard of care is

what a reasonable, prudent nurse would do given the same training and experience in a similar situation. A nursing clinical judgment involves the nurse's analysis of the facts as she has them, in combination with her experience and her intuition about what's going on. So they're really two separate things. It's like asking me to say an apple fits with an orange. It might not. I can't answer it any other way, I don't think.

Q. So you're saying judgment and the standard of care have nothing to do with one another?

A. No, no. I didn't say that at all. Of course they have something to do with each other, but they're not the same.

Q. One can exercise --- a nurse can exercise judgment and still --- her conduct can fall beneath the accepted standard of care?

A. I have to think about your

question for a minute. A nurse can exercise judgment and her judgment could be beneath the standard of care, is that what your question is?

Q. Correct.

A. It's possible, because at the end of the day her analysis could be faulty, correct.

Q. Thank you.

ATTORNEY PARIS:

Can we go off the record one minute?

VIDEOGRAPHER:

2:15 p.m., off.

OFF VIDEOTAPE

OFF RECORD DISCUSSION

ON VIDEOTAPE

VIDEOGRAPHER:

2:19 p.m., back on the record.

BY ATTORNEY PARIS:

Q. Exhibit --- the document that I've marked as Exhibit Four, that is the restraint protocol that Mr. Switzer sent you from Ashtabula

Medical Center?
A. Correct.
Q. That was revised in June 2001; is that correct?
A. I don't know if it was a revision or ---.
Q. Not revised, that was effective June of 2001?
A. Yes.
Q. And the transmittal letter, when were you first contacted about this case?
A. I believe in April of this year.
Q. Do you have the letter there in front of you?
A. I'm'sure I do. You just handed the stack back to me, so I'll have to look for it.
Q. The one with the --- there it is.
A. The letter is dated April 17th, 2002, so I think it's reasonable to say I was probably contacted in the week or two

preceding that.
Q. And then you probably received that letter and all of the documents listed in that letter and your report sometime within a few days after April 17th?
A. Would you repeat your question?
Q. You received all the materials that you reviewed sometime --- a few days after April 17th, along with that letter? I assume you didn't get the letter on April 17th?
A. I would imagine so.
Q. Okay. And you were able to read all the depositions, go through the charts and review all the protocols and craft an expert report by May 6th?
A. Correct.
Q. The accepted --- strike that.
A hospital protocol directed to the nursing staff established a standard of care with the Ashtabula County Medical Center staff; is that

right?
A. Can you --- are you referring to a specific protocol that I have here?
Q. Well, let me --- let me rephrase the question. I'm sorry. A hospital protocol generally directed to the nursing staff establishes the accepted standard of care for the nursing staff at that particular hospital?
A. Well, not necessarily. The protocol is basically a guideline for the nurse to follow. I don't know that it would establish the standard of care. Hospitals have different ways of communicating their protocols and guidelines and standards and they use different terms in doing so. so I don't think it's correct to say that a protocol is the same as a standard of care.
Q. So the reason that this hospital, ACMC, establishes protocols is to give the nurses guidelines on

how to handle a particular situation?
A. Well, in general, that's what protocols are, they're guidelines.
Q. And they want the nurses to follow those guidelines; is that right?
A. Right. You have to ask them what their intent is. But in general, the intent of protocols or guidelines is to provide guidance to nurses so that in clinical situations or in particular patient situations they have something they can reference if they need guidance.
Q. And what is the difference between using protocols as guidance versus using protocols as standards?
A. Because a standard is much more generalized. A protocol generally includes steps of a procedure, for example. And in some clinical situations that the nurse might be faced with, it might not be possible to follow the steps as they're outlined in the guidelines,

and/or there might be an issue of clinical judgment that would cause her to deviate from the guideline with reason. So that would not be interpreted and should not be interpreted as a deviation from the standard of care.

Q. Is it your opinion then that the ACMC protocols do not require the nurses to follow those step-by-step procedures?

A. Are you referring to a specific protocol?

Q. Let's take the restraint policy, for example, that was in effect at the time of Mrs. Swift's demise.

A. The one you just showed me?

Q. Right. Did that protocol require Nurse Berry to call the doctor immediately upon placing Mrs. Swift in restraints?

A. If she could. With any protocol there's an understanding, because it's basically a guideline

that you do so if you can, if it's humanly possible to do so. But in any clinical situation where the nurse has more than one patient to take care or even sometimes when she only has one, it may not be possible to call the doctor immediately.

Q. You knew by five o'clock whatever emergency Nurse Berry had was over; you're aware of that?

A. She said so, yes, that the emergency that she had had to deal with was over at about five o'clock.

Q. You're not aware of any reason why it was not possible for Nurse Berry to make a phone call to the doctor at five o'clock about the fact that she had initiated restraints; correct?

A. Well, I think she initiated the restraints at or around five o'clock. So within a short time after that she could have, yes.

Q. I mean, there are phones all over the hospital; right?

A. Yes, but I'm --- you know, I'm uncomfortable with your saying she should have called at five o'clock. If she just put the restraints on at 5:00, it's unreasonable to think that she's going to go and pick up a phone at exactly the same time. I think within a short period of time after that ---

Q. Is it reasonable ---

A. --- she should have called.

Q. Is it reasonable for her to pick up the phone at five after 5:00?

A. It may have been, yes.

Q. And that would have been the standard of care as well; correct?

A. The standard of care would have required her to call the doctor within a short period of time as soon as she could because the patient had been placed in restraints. And that was the guideline that she was working under.

Q. And if she failed to do that, that was a departure from the

accepted standard of care?
A. Yes.
Q. As well as the violation of ACMC's protocol?
A. That's correct.
Q. And as it turns out, it was also a violation of the federal law on restraints?
A. Well, that's always the case because the hospital's restraint policies follow the federal. The federal is what initiates it in most cases.
Q. But Ashtabula's Medical Center protocol on restraints didn't comply with the federal restraint policy, did it?
A. The one you just showed me?
Q. Right, the one that was in effect when Mrs. Swift died?
A. It didn't appear to in relation to the notification of the physician. It appeared to be comprehensive aside from that.
Q. Do you agree that the nursing

staff at ACMC had a duty to document significant events and changes in the patient's status?

A. Yes.

Q. And documentation is important by the nurses who care for patients because subsequent medical care providers rely on the nursing documentations in terms of making treatment decisions?

A. Not always and not necessarily. Doctors often, frequently, do not read nurses' notes at all, ever. So I don't think they rely on written documentation by nurses nearly as much as they do conversations or verbal reports. Subsequent nurses rely much more heavily on the verbal reports they receive from the nurses who are leaving their shifts and who have taken care of the patients than they would on the nurse's written documentation.

Q. Then why are there protocols

on documentation? Why don't we just --- why don't we forget about documentation as it relates to hospital charts and just rely on word of mouth?

A. Well, I think you realize that there are legal requirements for --- for documentation. We have to keep records of patients' treatment for reimbursement purposes as well. Third-party payers and all of those folks require proof, written proof of what has been done for the patient. And it's important to keep a record of patterns and trends and the course of the patient's treatment while they're in the hospital. But that's not the same as an oncoming nurse relying on that for what she's going ot do for her patient during her shift.

Q. Isn't good documentation --- won't good documentation give subsequent medical care providers an opportunity, if they wanted to, to

see what the patient's course was before ---?
A. Yes, it would have --- it would give them that opportunity.
Q. Anybody who wants to look to see what the patient's course was before they came on shift could look at a record and should have that opportunity; shouldn't they?
A. Yes, they should.
Q. And that's the reason for documentation besides financial matters; right?
A. Well, I mentioned things in addition to financial matters, so I don't think you're including some of my answer when you say that. But the main purpose for keeping records is so that we have a pattern of the treatment and care the patient received for whoever needs to have that information.
Q. And that benefits the patient, doesn't it?
A. Hopefully.

Q. And it also takes out --- strike that.

And you train your students at school to document; don't you?

A. Yes.

Q. And you train them to document for the reasons that we just discussed?

A. Yes.

Q. To give doctors and other people coming on shift after they leave an opportunity to go back and look at patterns and vital signs and whether or not there's been any changes in the patient's condition?

A. That's part of the reason.

Q. And like I said before, that does benefit the patient; doesn't it?

A. Well, it should. The benefits that the patient receives from other health care providers that come after the nurse who has done the documentation, however, is based a lot more on that person's individual assessment and their own findings and

the report they got from the previous person who took care of them.

Q. Doesn't good contemporaneous charting and documentation remove the possibility that an important point is going to be left out during the verbal exchange at shift change?

A. No, I don't think so. First of all, contemporaneous, as I understand the definition of the word, means at the same time. And nurses frequently do not have the opportunity to chart at the same time that they're giving the care and obtaining their data.

Q. At or near the same time. Let's change that.

A. Well, that may not be true either. The --- the other part of it is that the important data would be transmitted in a verbal report. The nurse gives that verbal report based upon what she has in writing, what she has taken as notes on her clipboard or her notes as she's gone

through the shift and what she recalls, as well as what she has written. So I don't think anything significant would not be transmitted to the nurse through a verbal report.

Q. You hope that's the case anyway?

A. Well, I've seen it in practice. In my practice, which has been rather extensive, I've listened to many, many hundreds of reports and the significant data consistently is transmitted.

Q. Relying on the written word in the chart eliminates the possibility of important information being left out of the verbal exchange; would you agree with that?

A. Well, you're making the assumption that there is significant information that the nurse isn't going to convey verbally, and I just don't agree with that.

Q. I'm just saying it eliminates the possibility.

A. I don't even know that you can say that because you're assuming that everything is going to get documented. It's conceivable that the nurse would say things in report that are significant that aren't even documented. I mean, it just doesn't work the way you're presenting it.

Q. Okay. Would you agree that the accepted standard of care for a nurse is to call a consultant when a reasonably prudent nurse believes that the patient should be seen, evaluated and/or examined by a consultant?

A. No.

Q. Why not?

A. Because the consultant would be notified when the order is placed by the physician. The consultant is notified that the consult has been requested. And unless there's a time frame with the order indicating when the consultant is supposed to come or when the physician who's requesting

the consult wants him to come, the consulting physician would simply come within the time frame that he normally makes consults. The nurse doesn't have a duty to interject herself in that time frame unless she's asked to.

Q. So for example, if a nurse sees the patient's condition changing significantly and/or deteriorating and she knows that a consult has been requested but there's no time frame for it, she's under no obligation to get a hold of either the attending or the consultant?

A. No, that's not what I said. Certainly if the nurse has a situation presented to her at a point in time when the patient's condition has deteriorated or when there's been a significant change in the patient's condition, she would have a duty to contact the physician, the attending and/or the consultant.

Q. And why --- why is that?

A. Because the patient would need medical evaluation and possible treatment.
Q. And that's based on the clinical change?
A. It's based on a significant change.
Q. All right. And we've already established that a nurse is a significant part of the treatment team of the patient; right?
A. Sure.
Q. And do you agree that the nurse acts as an advocate for the patient in her dealings with other medical care providers, including a doctor?
A. Certainly.
Q. Nurses make diagnoses; don't they?
A. Nurses make nursing diagnoses not medical diagnoses.
Q. And certainly you would agree that nurses, in exercising their judgment with the care of a patient,

must comply with the accepted standard of care?
A. Sure. Yes.
Q. Is it your opinion that a nurse has the obligation or duty to review a chart of a patient either before or after she assesses the patient?
A. No, she does not have a duty to review the chart.
Q. Ever?
A. What do you mean ever?
Q. Does she ever have the obligation to review the chart of the patient?
A. Not necessarily. She would rely on the verbal report she gets and the information on a cardex or some other form of communication, that is a brief composite of the patient's diagnosis and/or treatments and ordered tests and things of that nature. She wouldn't have a duty to read the chart, if you're talking about the chart in total, at any time

necessarily, because a lot of the information in the chart would not really impact her shift care of the patient. She can and often does reference the chart or portions of the chart during the course of her shift, but wouldn't have a duty to read it before she took care of the patient.

Q. How about after she takes care of the patient?

A. You mean at the end of the shift?

Q. During the shift.

A. She may and often does look at various parts of the chart during the shift.

Q. Is that an obligation that a nurse has to do?

A. Not necessarily.

Q. It's entirely discretionary with the nurse?

A. Correct. It depends upon what she needs to know and why she needs to know it.

Q. Well, is there a possibility that information on the cardex --- strike that.

Is there a possibility that the cardex may not be reliable because it may not necessarily be up to date?

A. In what respect? The cardexes are changed as --- as orders change and as lab tests are changed, and they are updated frequently.

Q. They're supposed to be; right?

A. Correct.

Q. But as you said before, sometimes significant things don't get put in the chart. And wouldn't you agree that sometimes significant things don't wind up on the cardex?

A. Well, first of all, I didn't say significant things don't get put in the chart. I said it's possible ---

Q. Right.

A. --- that something might not.

Q. And I'm talking about isn't it

possible that the cardexes may not be up-to-date?
A. It's possible, theoretically.
Q. And do you agree, theoretically, that it's possible that during a shift --- that a shift report may not be complete and may contain missing information?
A. Highly unlikely.
Q. Is it possible?
A. Highly unlikely.
Q. Just so we're clear, on shift change, when one nurse is telling the oncoming nurse what happened on the previous shift, you've got a nurse giving a verbal description of what happened to, in this case, all six of her patients during an eight-hour shift; is that right?
A. Yes. But not from memory necessarily.
Q. The accepted standard of nursing care is what nurses are taught, what are found in nursing textbooks and hospital protocols; is

that a true statement?
A. Partly.
Q. What else is comprised in the accepted standard of care?
A. There are general standards promulgated by the American Nurse Association. There are standards promulgated by specialty nursing organizations for specialty areas of nursing practice, like the emergency room and intensive care and critical care. And then there is a general standard of care that simply falls into the definition of what a standard of care is.
Q. Can you tell me --- and I'm not testing you. I'm just trying to get a baseline of agreement here on some terms, what is acute pancreatitis?
A. You want me to define it?
Q. Yes.
A. It's a sudden inflammation of the pancreas, sudden in terms of occurring over a period of hours or

perhaps a day or so.
Q. And one of the most common types of --- or causes of acute pancreatitis is gallstone pancreatitis?
A. It is one of the causes, yes.
Q. Do you know that it's one of the most common causes?
A. Second, I think, to alcoholic pancreatitis.
Q. And how does the --- how do the gallstones cause the acute pancreatitis?
A. They obstruct the duct that carries bile to the duodenum, and it backs up into the pancreas, to the pancreatic duct, and it activates enzymes in the pancreas which are not supposed to be activated until they flow through the duodenum. And when they activate in the pancreas, they destroy pancreatic tissue.
Q. In this particular case, Sharon Swift didn't drink alcohol; is that right?

A. I understand that's correct.
Q. And that would seem to rule out alcohol, that her acute pancreatitis was related to her alcohol?
A. Correct.
Q. Acute pancreatitis due to gallstones occurs predominantly in elder women?
A. I don't know if predominantly, but it's not uncommon to find it in older women, over the age of 55.
Q. Are you aware that it occurs in older women perhaps as much as two times --- twice as frequent as in men?
A. Yes, I think that's true.
Q. And typically, do I understand that patients with acute pancreatitis improve with supportive care in the hospital?
A. Usually they improve, unless they have a severe form.
Q. But acute pancreatitis can also be life threatening; right?

A. It can be, yes.
Q. And a nurse who's caring for a patient with acute pancreatitis has to look for the development of respiratory distress; is that right?
A. Well, respiratory distress is often part of the presentation of acute pancreatitis.
Q. And nurses who are looking for ___ who are taking care of such a patient also have to be on the lookout for signs and symptoms of sepsis; is that right?
A. It's a potential problem, but it would be low on the list because patients with acute pancreatitis are often not infected and would not be septic. So the nurse would not have that as the number one or two thing in her mind when she's taking care of a patient with pancreatitis.
Q. And what is cholangitis?
A. It's an inflammation of the biliary tract.
Q. Is it an infection?

A. It is often associated with infection, yes.
Q. How do you determine a patient in respiratory distress?
A. Distress is a general term, but if you are monitoring a patient and you see signs of increased respirations or labored respirations or shallow respirations, that would indicate to you, to some extent, that the patient was in respiratory distress.
Q. Well, in the pancreatitis protocol that was issued by ACMC to its nurses one of the standards, and I'm looking at standard number three, is that nurses were required to assess pulmonary status at least every four hours to detect early signs of respiratory complications; is that right?
A. Help me reference that again. What number were you looking at?
Q. Number three.
A. Yes, I see that.

Q. And that's a nursing standard as established by that hospital?
A. As established by that hospital, correct.
Q. Is measuring the respiratory rate sufficient?
A. No.
Q. What else would one need to do to assess pulmonary status?
A. Listen to lung sounds with a stethoscope and look at the patient to assess the depth of the respirations.
Q. And what about using a pulse ox --- pulse ox?
A. That's not included in their standard of care.
Q. Why is it important to watch the patient breathe?
A. Because you want to know if their respirations are deep or if they're shallow, and you want to know if they're using any accessory muscles of respiration, like neck muscles or abdominal muscles.

Q. And if they're shallow and they're using any accessory muscles, what does that indicate?
A. That they're needing to work at it a bit, that they're needing to work with their respirations, it's not easy and comfortable.
Q. Is that something that's part of a developing picture of respiratory distress?
A. It depends upon the patient's baseline and how they presented to begin with and what they looked like when they first presented.
Q. What is sepsis?
A. Sepsis is a systemic inflammatory response usually to an infection.
Q. And what do the signs and symptoms of sepsis include?
A. Well, it depends upon whether you're looking at early signs or late signs. But in general, the patient, early on, may have an increased heart rate, increased blood pressure.

They're usually dehydrated and hypovolemic. The respiratory rate may be a little above what you would consider a normal range. Their temperature may be slightly elevated or could be normal, not always elevated. In general, those are the primary early signs.

Q. Is confusion and agitation a part of that early sepsis picture?

A. Well, it can be, but it's very difficult to separate restlessness and confusion as a sign of sepsis from restlessness and confusion that occurs due to many other reasons when a patient is real sick.

Q. The signs and symptoms of respiratory distress, would those include elevated respiratory rate?

A. It could.

Q. Elevated heart rate?

A. As a sign of respiratory distress, an elevated heart rate?

Q. Yes.

A. Not always, no. It could be,

but you can have respiratory distress without an elevated heart rate.

Q. What about confusion or agitation?

A. Again, confusion and agitation are really general terms that are associated with many, many different kinds of clinical situations. So it can be associated with respiratory distress, but it would have to be to the extent that it would affect the oxygenation of their brain.

Q. How about radiographic evidence of atelectasis infiltrates?

A. What about it? What's your question?

Q. Would that be a part of the picture of respiratory distress?

A. Not necessarily. You can have radiographic evidence of effusions or partial atelectasis without the patient being in significant distress. But I'm not a radiologist, so you'd have to ask them, you now, how clearly that's defined or under

what circumstances.
Q. Can a patient who presents at a hospital with acute pancreatitis deteriorate quickly?
A. Yes, they can.
Q. Would you agree then that since a patient with acute pancreatitis can deteriorate unpredictably soon after admission, a nurse must monitor that patient closely?
A. Well, I didn't say unpredictably. You said --- I think your question was can they deteriorate suddenly.
Q. Right.
A. So could you rephrase your second question?
Q. All right. Well, is it predictable then that a patient who is admitted to the hospital with acute pancreatitis can deteriorate suddenly?
A. I don't think that's predictable. I think it happens.

Certainly patients with severe, acute pancreatitis can deteriorate suddenly.

Q. And because of that, do you believe that it's important for a nurse to monitor such a patient closely?

A. If you're using closely to mean according to the physician's orders and based upon the clinical presentation of the patient, yes, they need to watch them, but I don't know what exactly you mean by closely.

Q. Are there certain standard variations of vital signs that are considered to be normal? For example, temperature?

A. Are you asking me if there's as normal range?

Q. Yes.

A. Generally speaking, yes.

Q. What is the normal range for temperature?

A. Depending upon the patient,

the normal range would probably be between 97 and 99.

Q. What about heart rate?

A. Again, it depends on the patient and what their normal baseline is, as well as whether or not they have underlying clinical conditions that could affect that. But generally, 60 to 90.

Q. And what about respiration rate?

A. Sixteen (16) to 24 probably would be a reasonable range.

Q. Is there a typical range for _-- or normal range for blood pressures?

A. Theoretically, between 100 systolic to 140 systolic. The American Heart Association guidelines are somewhat lower for the systolic. I think it's 135 or 36.

Q. And diastolic?

A. Diastolic, generally between 60 and 80, somewhere in that range.

Q. Have you seen any

documentation from Ashtabula County Medical Center as to the normal ranges for vital signs for the nurses to follow?

A. No.

Q. Is it your opinion that it is good practice to leave it to the judgment of the nurses as to what constitutes normal vital signs, normal ranges of vital signs?

A. Well, nurses, by virtue of their license and their education, have a basic understanding of what ranges are considered to be acceptable. And I think the hospital, all hospitals understand that nurses would reference the patient's baseline in analyzing whether or not a particular finding would be acceptable or not or reasonable, given the patient's clinical condition.

Q. Is it your recollection from Nurse Berry's deposition that she initiated the restraint because there

was a change in the cognition of Mrs. Switz?

A. My recollection from her deposition is that she was concerned that the patient would pull her tubes because she was attempting to pull out her tubes. And she also, I believe, was concerned about her judgment at the time.

Q. Didn't Ms. Berry --- Nurse Berry testify that she felt that the patient was confused and cognitively impaired?

A. Yes. She implemented the cognitive impairment protocol.

Q. And that was part and parcel of her decision to initiate the restraints; correct?

A. Yes, along with the things I already said.

Q. And do you agree that Nurse Berry departed from the accepted standard of care when she failed to contact a physician immediately or within a short time thereafter of

applying those restraints?
A. Yes. I think I stated in my report that I believe she should have called around five o'clock.
Q. And is it your opinion that Nurse Berry departed from the accepted standard of care when she failed to call a physician to conduct a face-to-face evaluation within one hour of placing those restraints?
A. Yes, I think that's true.
Q. Arid is it your opinion that Ashtabula County Medical Center, as an entity, departed from the accepted standard of care by failing to have in place a restraint policy that was in compliance with the federal law in June 2000?
A. Yeah. I think their policy should have included the statement about the time frame for contacting the physician.
Q. And their contact was a departure from the accepted standard of care in that regard?

A. Unless they have an explanation which is reasonable as to why it wasn't in the policy, because the policy was, as I understand it, developed by the medical staff and the nurses, so there may be some explanation for it that I'm not privy to. I don't know.

Q. Are you aware, from your experience, of any situations where it would take a full year to implement a restraint policy from the time that it's put out by the federal government?

ATTORNEY SWEENEY:

Show an objection.

A. Well, I can't cite you a specific example, but I can tell you that when federal regulations are published, it can take a while before that filters down to becoming a written policy because of all the procedures and committees that those things go through and hospitals. But I'm not able to explain to you why

this hospital does not. You would really need to ask them.

BY ATTORNEY PARIS:

Q. Nobody has come forward and provided you with an explanation from the hospital; right?

A. That's correct.

Q. By the way, in advance of these federal changes in the law, the government puts out alerts to the hospital communities, don't they, we intend to change these regulations and they're going to be effective several months down the road.

A. Yes.

Q. And from your experience, the hospitals have departments which monitor the potential for those changes; right?

A. Yes, they do.

Q. So that they can be ahead of heart of the curse?

Q. They tried to?

A. And they're supposed to?

A. Yes, to the best of their

ability. But the regulations sometimes change their deadlines and other things occur that cause those deadlines to not become effective then they say they're going to become effective.

Q. Would you agree that placing a patient in restraints is very significant in the care of a particular patient?

A. In what respect?

Q. Well, number one, you're restraining the liberty of that patient. That's a significant event; is it not?

A. Yes. In that context, sure.

Q. I mean, it's an extreme measure in patient care; is it not?

A. No, it's not an extreme measure. It's relatively common to protect a patient and to safeguard their condition. So it's not extreme.

Q. Doesn't the use of restraints really demonstrate that there's some

serious underlying problem in the patient that has to be addressed?
A. No, not always. We restrain patients and nurses restrain patients frequently simply to protect them from pulling out their IVs or damaging their condition in some way. It's not extreme, and it doesn't necessarily mean there's been any major event going on with the patient. There just is a concern at that point in time that they could hurt themselves.
Q. Isn't it so extreme, in fact, that the regulations in effect a year before Mrs. Swift died required that there be continuos monitoring of that patient who's placed in restraints?
A. Which regulation?
Q. The ones that were supposed to be in effect at Ashtabula Medical Center.
A. Well, because when you use the term restraint, you're encompassing all forms of restraint. Mrs. ---

Q. Swift.
A. --- Mrs. Swift had soft wrist restraints. She was not in a vest. She didn't have leather restraints. She didn't have the kinds of restraints that normally have been known to cause injury to patients, which is what was part of the reason for the initiation of these very strict regulations because patients had been injured in vest restraints and other forms of restraints over time. And anecdotally there have been problems, in isolated circumstances, but in terms of Mrs. Swift's situation, she just had soft wrist restraints on to keep her from pulling her tubes.
Q. The regulations that require continuous monitoring of all patients in restraints. It doesn't distinguish between leather vests or iron chains or soft wrist restraints; does it?
A. Well, we don't use iron chains

today.
Q. No distinction is made as to the type of restraint?
A. That's true.
Q. Confusion or agitation which causes any nurse to place the patient in restraints is a significant change in condition of the patient; is it not?
A. Say that again, please.
Q. When the patient is put into wrist restraints because of cognitive impairment, that signifies a significant change in the patient's condition; correct?
A. It may not. The patient may have been restless and confused or somewhat disoriented, but at that particular point in time something about the patient's behavior caused the nurse to feel that without the restraints the patient might injure herself.
Q. You reviewed the chart in this case; is that correct?

A. Yes.
Q. Mrs. Swift came into that hospital and she was not cognitively impaired, was she?
A. She was alert and, as I recall, she was oriented, but ---.
Q. She was communicating her wants and needs easily?
A. No. When the nurse did the admission assessment to the unit, the patient was unable to respond to some of the questions, and the daughter provided the information to the nurse.
Q. Excuse me, Nurse Smith, but the only thing that the daughter provided information about that the patient couldn't was about her Pap smears.

ATTORNEY SWEENEY:

Show an objection.

BY ATTORNEY PARIS:

Q. *Go* to page 39. Is your chart Bates stamped, by the way?
A. No.

Q. It is not?
A. No.
Q. Okay. If you'll go to the ---.

ATTORNEY MENUEZ:

Here, let me give her my ---.

ATTORNEY SWEENEY:

Well, why don't we wait for the record since we have pages that are named and described. She can use her chart. You use your chart. Just describe the patient you're looking at, and we'll find it, David.

A. I believe I have the page you're referring to.

BY ATTORNEY PARIS:

Q. Okay. You have that?
A. Yes.

ATTORNEY SWEENEY:

And David, for the record, we're referring to the nursing admission assessment

at this point.

ATTORNEY PARIS:

The only part that I'm referring, if you'll turn the page, mine was Bates stamped 39.

A. That doesn't help me. I don't have a Bates stamp.

BY ATTORNEY PARIS:

Q. You have that?

A. Yes.

Q. That's the nursing assessment?

A. I'm looking at your chart, and that's the same page I'm looking at.

Q. And to satisfy Mr. Sweeney, what are we going to call this document?

ATTORNEY SWEENEY:

Well, it's called the nursing admission assessment. That's what it's called in the record. That's what the record says.

ATTORNEY PARIS:

I'm just asking the

witness to characterize the document for us.

ATTORNEY SWEENEY:

I'm just asking you to look at the page before because that's what the record says.

ATTORNEY PARIS:

Can I conduct the examination the way ---?

ATTORNEY SWEENEY:

That's fine, but you're not satisfying me in any sense. I'm just trying to be accurate.

ATTORNEY PARIS:

I'm not trying to satisfy you.

ATTORNEY SWEENEY:

I'm just trying to be accurate.

BY ATTORNEY PARIS:

Q. What document are we looking at together?

A. The line on the top says

nursing admission assessment, page one.

Q. If you'll turn the page, is that still part of the assessment?

A. Page two.

Q. If you go to the bottom it indicates that the patient communicates her wants and needs easily; correct?

A. Yes.

Q. The patient communicates ideas and complex information adequately; correct?

A. Yes.

Q. The patient understands information easily and follows directions easily; ---

A. Yes.

Q. --- is that right?

A. Yes.

Q. Do you have a page that's --- what's the next page that we have?

A. Page three.

Q. Page three. In the center of the page, patient has been provided a

written copy and verbalized his understanding of the patient's rights and responsibilities; ---

A. Yes.

Q. --- is that right?

A. Yes.

Q. Now, down at the bottom ---.

A. Patient or significant other. It's not circled which.

Q. Down at the bottom you have a section on the psychological examination; is that right?

A. Correct.

Q. They wanted to know about her Pap smears in the past 12 months?

A. Correct.

Q. And it indicates that she's unable to answer the information concerning her Pap smear as received by the daughter, Dawn Phillips?

A. Well, wait a minute. You're --- you're saying the patient is unable to answer, which *is* what the nurse has written opposite the psychological examination.

Q. Right.
A. But at the bottom where you're reading information received from patient's daughter, Dawn Phillips, nurse in ICU, refers to this document in total.
A. Well, that would seem kind of inconsistent with what we've just read, that the patient does communicate her wants and needs easily.
Q. No, that's not inconsistent at all. This refers --- this communication block refers to the patient's baseline, in other words, does she have a problem with communication under normal circumstances? Does she have a problem understanding information or following directions. And the nurse checked that she can do these things because he daughter tells her. My interpretation of his is that the daughter is saying, no, she doesn't have a problem with this kind of

interaction. It doesn't mean that she doesn't have a problem then. And in fact, the statement at the end, information received from the patient's daughter, Dawn Phillips, because it's at the end and where the patient's signature would normally be, indicates to me that this patient cannot sign and cannot provide the information and the daughter has to.

Q. Well, will you turn to that page of the chart? And what is that that we're looking at? What is that called?

A. Functional screen.

Q. And once again, the nurse, as it relates to speech therapy, has said --- indicates that the patient communicates her basic daily needs adequately; is that correct?

A. Right. Correct.

Q. And she also indicated that the patient, Mrs. Smith, communicates abstract ideas adequately; is that right?

A. Correct.
Q. That she answers and asks questions related to current hospitalization, discusses current events and states opinions; is that right?
A. That's what it says. But you have to understand what the purpose of the functional screen is. It's a tool that the nurse is required to fill out on the patient's admission to determine if she needs as referral for discharge planning. So if used --- not to say this is what the patient is doing now, even though it says current. The nurse uses it to determine if, in a discharge planning, she needs to make a referral to somebody early on.
Q. I understand that's your interpretation, but when we look at this record together with the jury, what this record is saying is that Sharon Swift answers and asks questions related to her current

hospitalization, and Sharon Swift discusses current events and states her opinions. Am I stating that correctly?

ATTORNEY SWEENEY:

Show an objection.

BY ATTORNEY PARIS:

Q. Is that what that document says?

A. Well, it would seem to say that, but it ---.

ATTORNEY SWEENEY:

Show an objection.

Allow the witness to finish her answer, please.

BY ATTORNEY PARIS:

Q. I think I've heard your explanation.

ATTORNEY SWEENEY:

Please go ahead and finish answering the question.

ATTORNEY PARIS:

She can answer the question at trial.

ATTORNEY SWEENEY:

Show an objection.

ATTORNEY PARIS:

And actually, we can go off the record now because we're --- we've got five minutes to video. We might as well change it now.

ATTORNEY SWEENEY:

Show an objection and move to strike the entire answer and response since Claimant's Counsel refuses to allow the witness to answer the question in full.

VIDEOGRAPHER:

3:06 p.m. p.m., off record.

OFF VIDEOTAPE

A. Can we take a break at this time?

ATTORNEY PARIS:

Sure.

SHORT BREAK TAKEN

ON VIDEOTAPE

VIDEOGRAPHER:

3:18 p.m., tape two, back on the record.

BY ATTORNEY PARIS:

Q. Nurse Smith, Doctor Chilcott examined Mrs. Swift at approximately 8:30 a.m. that morning; is that right?

A. 8:35, I believe, yes.

Q. And Doctor Chilcott, in his note, made no mention **of** the fact that, in his estimation, the patient was confused; correct?

A. I don't recall that he did.

Q. And he made no mention of the fact that in his estimation the patient was cognitively impaired; correct?

A. Correct.

Q. In fact, he stated that the patient was alert and oriented?

A. Yes, he did.

Q. Which would be consistent with what the nursing assessment was a few hours earlier?

A. In the emergency department or

---?

Q. Correct.

A. Yes.

Q. In fact, throughout that chart you don't see the word --- the words confusion or cognitive impairment anywhere until approximately 5:00; correct?

A. Correct.

Q. By the way, the protocols that were sent to you from Mr. Switzer's office, the sepsis protocol ---

A. Yes.

Q. --- and the pancreatitis protocol, ---

A. Yes.

Q. --- he just provided you with page one, is that correct, multiple pages?

A. I have one page of pancreatitis and one page of sepsis.

Q. Thank you. and by the way, has anybody showed you the cardex on Mrs. Swift?

A. No.

Q. Do you know where it is?
A. I do not.
Q. Do you know what's on there? Has anybody told you what's on there?
A. No, no one has told me what's on it, if it exists.
Q. What does the term chart check mean?
A. It's been used to mean a number of different things, but generally it's used to mean that a nurse who has been designated to do that has looked over the orders on the chart and made sure that they were all transcribed or taken off.
Q. And does it have any other meaning other than what you've just described?
A. In some hospitals it means that the nurse who has been designated to do that has checked to see if there --- if a nursing plan of care is in there as part of the chart and if it's been reviewed or updated.
Q. I asked you a question before

about respiratory distress and whether or not just checking the respiratory rate, respiration rate, was sufficient, and I think you told me no. And I think I forgot to ask you why. Why is it not sufficient?

A. I think you asked me what else should be included, and I interpreted that to mean what you're asking me now.

Q. Thank you. When Mrs. Swift came to ACMC Emergency Room, she got there about 2:15 in the morning?

A. True.

Q. She was complaining of abdominal pain?

A. Yes.

Q. Constant and severe in nature?

A. Yes.

Q. And she gave a history that that stated at about 3:00 p.m. the previous afternoon?

A. Correct.

Q. That would be June 14th?

A. It would.

Q. She gave a history of vomiting and being nauseous?
A. Yes.
Q. And she was assessed as alert and oriented; is that right?
A. Yes.
Q. Her abdomen was evaluated and she did not have a distended abdomen at that time; did she?
A. May I refer to the emergency ---
Q. Absolutely.
A. --- room notes again?
Q. This is not a memory --- this is not a memory test.
WITNESS REVIEWS NOTES
A. Her abdomen was assessed as tender with guarding and decreased bowel sounds. There is a diagram that shows where the pain that she complained of was located in the abdomen.

ATTORNEY PARIS:

Now, I'm going to ask to go off the record.

VIDEOGRAPHER:

3:23 p.m., off the record.

OFF VIDEOTAPE

OFF RECORD DISCUSSION

ON VIDEOTAPE

VIDEOGRAPHER:

3:25 p.m., back on the record, tape two.

BY ATTORNEY PARIS:

Q. Nurse Smith, can you tell me what page you're referring to and tell me about the abdomen assessment?

A. It says at the emergency physician record, abdominal plane --- excuse me, abdominal pain, slash, flank pain.

Q. And what document is that from, the emergency room?

A. Yes, it says emergency physician record.

Q. Okay. And if you go to the second page of that record, do you see that ---

A. Yes, I do.

Q. ... there's an area for abdomen?
A. Yes.
Q. And one of the specific questions that is asked is whether or not the abdomen is distended; is that right?
A. Yes.
Q. And it is not checked off?
A. Correct.
Q. If it was distended, that would be checked off?
A. Presumably, the emergency room physician would have checked it if he found it, presumably.
Q. That's what the doctor is supposed to do; correct?
A. That's what he's supposed to do, yes, according to this.
Q. And on the record that we were looking at before, the nursing assessment in the emergency room, do you have that document handy?
A. That's a nursing admission assessment. Do you want me to turn

to that?
Q. Yes.
ATTORNEY GORDON:
What page is that, David?
ATTORNEY PARIS:
Bates stamp 38 for those who have a Bates stamp.
BY ATTORNEY PARIS:
Q. Her abdomen was assessed to be firm and painful in the right upper quadrant and epigastric region?
A. Correct.
Q. And aside from her pain level, no one noted her to be restless in the emergency room; is that correct?
A. You mean no --- are you asking if anyone documented that she was restless in the emergency room?
Q. Correct.
A. I don't believe anyone documented that she was restless.
Q. Doctor --- I'm sorry, Nurse Smith, would you agree that Mrs. Swift came to the emergency room with

a severe case of acute pancreatitis?
A. Well, she certainly was diagnosed with acute pancreatitis. The severity of it would really be a medical opinion at that point in time, how severe it was.
Q. In the emergency room her vital signs were taken?
A. Yes.
Q. She had a temperature of 98.4?
A. Correct.
Q. Respirations were 24?
A. Correct.
Q. Heart rate was 90?
A. Right.
Q. And her blood pressure was 152/95?
A. Correct.
Q. Some lab work was ordered in the emergency room and came back showing some elevations in her lipase and amylase?
A. That's right.
Q. And that would be consistent with acute pancreatitis?

A. Correct.
Q. Along with her clinical presentation?
A. Yes.
Q. Now, her white blood count was 11.9. That was high; is that right?
A. Slightly above what is normally considered to be an acceptable range.
Q. And C02 was at borderline low?
A. Her CO2, at that time, I think was 18.
Q. Is that borderline low?
A. Yes, it would be borderline low, if that's what it was. And I need to check the lab ---.
Q. I think it was 21, wasn't it, ---
A. Excuse me.
Q. --- in the emergency room?
A. Well, I'd like to look at that because I don't recall the specifics of the C02 for that time frame. c02 was 21 the first time it was taken in the emergency room and then it went

to 18.
Q. So it was borderline low in the emergency room?
A. Yes, very borderline. Some would consider that normal.
Q. The medications that she was given in the emergency room included Demerol at 2:20 a.m.?
A. Yes.
Q. Dilaudid ---
A. Dilaudid, yes.
Q. ___ at 2:45 a.m.?
A. yes.
Q. What's Dilaudid?
A. It's a narcotic.
Q. And morphine was given to her twice, once at 3:00 a.m. and once at 3:35 a.m.?
A. That's true.
Q. And morphine, of course, is a narcotic as well?
A. It is.
Q. And at 3:35 a.m. she was admitted to the hospital per Doctor Chilcott; is that right?

A. Yes.
Q. And he gave a list of orders, which included a CBC with differential; is that right?
A. Yes.
Q. A CT scan in the morning?
A. Yes.
Q. And a consult with a gastroenterologist by the name of Doctor Kondru?
A. Correct.
Q. And he didn't time that consult, did he?
A. He did not. In terms of timing, you mean did he put a time parameter of when he wanted the consult done, he did not.
Q. And do you know when those orders were taken off by the nursing staff?
A. 5:30 a.m. that they were noted. It looks as though they were again noted subsequent to that, but the time frame --- the first time frame I see is 5:30 a.m., and then

there's an additional time frame of 8:35 a.m.

Q. Is that signature --- or the signature of 8:30 a.m., is that Doctor Chilcott's signature?

A. It appears to be based upon what else I see in the chart. It's indecipherable in terms of reading it, but it appears to be his signature.

Q. So that wouldn't --- the 8:30 a.m. wouldn't be any indication of when these orders were taken off?

A. No. I think it --- I think it refers to when he signed them off, when he cosigned them because this was initially a telephone order, so he would be required to sign it. And it looks like that's when he signed it.

Q. So the 5:30 a.m. notation, what does that mean to you?

A. That means that's the time at which the nurse actually --- and sometimes this is done by a unit

secretary, but in this case there's an RN after it, actually signed that all these orders had been transferred in writing to wherever they needed to be transferred and that implementation of the orders had occurred, in other words, the paperwork had been initiated.

Q. And what paperwork that you're aware of is initiated in order to get Doctor Kondru in to see this patient on a consultation?

A. There would be a paper written out indicating consultation and/or a telephone call made to his answering service or his office.

Q. At 5:30 a.m.

A. Not necessarily.

Q. Do you know what time Doctor ___ the nursing staff --- strike that.

Do you know what time the staff at ACMC notified Doctor Kondru's office?

A. He testified that he first

became aware of it around ten o'clock the following morning. I'm checking the nurse's notes now to see if there's anything in addition that would clarify that. There doesn't seem to be anything that would clarify that, so something was in the works by 5:30 a.m. to have caused the nurse to sign it off at that point in time relative to the consult.

Q. Are you aware of any protocols or standards at that hospital that creates a paper trail of how a consult is initiated?

A. Standards?

Q. Protocol.

A. No, I'm not.

Q. Are you aware of any protocols at ay hospitals that describe the manner and method to obtain a consult?

A. The manner and method of how to obtain --- in other words, what the time frame is for a response, is that what you're asking?

A. Yeah, the paperwork --- we have a situation here where a doctor says I want a consult and we don't know when it was called in, how it was communicated to the doctor or what information was given to Doctor Kondru. Are you aware at any hospitals of a method by which that information is written down?

ATTORNEY SWEENEY:

Show an objection.

A. At any hospitals?

BY ATTORNEY PARIS:

Q. Any hospital that you work at.

A. Yes.

Q. Tell me what your experience is at the hospitals that you worked at.

A. Well, consults are transmitted in various ways, depending upon the hospital. But I have seen hospitals in which the consult is written on a paper form that is put on the chart and a telephone call is made to the physician's office or answering

service. And when the physician sees the patient, he completes the form that's already been placed on the chart. And sometimes the chart --- or the consultation form, rather, will say for or about and indicate what the physician wants the other physician to consult about.

Q. Does it also have information about the status of the patient?

A. Usually not, not in my experience. It may have the patient's diagnosis or preliminary diagnosis and it may not. It depends upon how the order is written, really.

Q. Would you know from Doctor Kondru's deposition that he was in procedures in the morning and somehow a message was gotten to him between 10:00 and 11:00 a.m. about Mrs. Swift?

A. Yes.

Q. But we don't know if that's when the call was initially made to

him or whether that's when he just happened to receive the message?
A. Well, we don't know for certain. But based on my experience and the way that order is signed off, I suspect and I believe that the call was probably placed earlier than that to his office or answering service.
Q. And what is it about the way that was signed off that leads you to that conclusion?
A. Well, it's signed off at 5:30 a.m. And the nurse would have had to have done something to initiate the consult before she signed it off.
Q. And in your experience, one of the ways --- a couple of ways of doing that would be calling the doctor's office and leaving a message ---
A. Correct.
Q. --- at the office or answering service?
A. Correct.
Q. Any other ways?

A. You can page them in the hospital and notify them of the consult, and that's been done many times. Those are the only ways that I'm aware of. Oh, well, I should add there are times when a physician will call the consulting physician directly and request a consult, but it still has to be part of the chart eventually. It still has to be documented eventually that he requested it.

Q. At 4:45 a.m. that morning vital signs were taken again?

A. Yes.

Q. At that time her temperature, and feel free to look at whatever records you need to, her temperature was 96.4?

A. Correct.

Q. Heart rate was 104?

A. Yes.

Q. Her respiration rate was 28?

A. Yes.

Q. And her blood pressure was

171/96?

A. Yes.

Q. At 6:30 in the morning I take it her blood was drawn for some lab work?

A. Yes.

Q. And at 7:10 a.m. the nurses called Doctor Chilcott; is that right?

A. That's correct.

Q. And they called him because the patient had increased pain and constant vomiting around her NG tube?

A. I don't think I would call it constant. She had had a couple of episodes of vomiting around the tube.

Q. I was trying to read the nurse's writing there. I wasn't sure if that said constant or continues emesis.

A. I read it as continues.

Q. Okay. At 8:00 a.m., according to the pancreatitis protocol --- strike that.

At 7:10 a.m., in response to

that call, Doctor Chilcott ordered anesthesia provided with a PCA morphine pump?

A. That's right.

Q. And at 8:00 a.m., according to the pancreatitis protocol form, she had a large and tender abdomen?

A. Yes.

Q. And she was tender now in all quadrants, not just the right upper quadrant?

A. Yes.

Q. By the way, up to this point, had anybody measured her abdominal girth?

A. There's no documentation of it up to this point in time, no.

Q. Isn't that required for the ACMC pancreatitis protocol?

A. The protocol requires it to be measured once a day. I don't think that a time is specified in the protocol.

Q. Was it ever measured on June 15th?

A. No, not that I'm aware of.
Q. Would it be fair to state then that the nursing staff at ACMC did not follow the pancreatitis protocol in that respect?
A. It's difficult to say because the protocol would require them to measure it once a day, which would mean once within a 24-hour period of time. And of course, later that night she went to the operating room when it really becomes a moot point at that point in time as to whether or not it's really --- I mean, it's almost irrelevant at that point in time. So I think it would have been appropriate for them to do it, but I can't really say that it was a deviation from the protocol not to do it when they have that large time frame to work with, 24 hours.
Q. Nurse Wilson didn't do it at all during her shift; is that right?
A. Right.
Q. Nurse Berry didn't do it at

all during her shift?
A. That's true.
Q. Did you get the impression that had Mrs. Swift not gone to ICU, Nurse Berry was going to do it?
ATTORNEY SWEENEY:
Objection.
A. I have no way of knowing that.
BY ATTORNEY PARIS:
Q. Did anyone assess her respiratory status by pulse ox per that protocol?
A. I don't believe so. What protocol are you referring to?
Q. The pancreatitis protocol.
A. Just a minute, please.
Q. I thought it was in there.
A. I don't see the pulse oximetry as part of the protocol.
Q. Then I'll withdraw that question. I stand corrected. At 8:00 a.m. Mrs. Swift's vital signs were taken?
A. Yes, they were.
Q. And her temp now was 98.4?

A. Yes.
Q. Her heart rate was up to 118?
A. Her heart rate was 118, correct.
Q. Her respirations were now up to 40; is that right?
A. Correct.
Q. And her blood pressure was 212/80?
A. Right.
Q. These are all markedly elevated vital signs; are they not?
A. Well, the respiratory rate is and the blood pressure is. The heart rate is elevated. I don't believe I would characterize it as markedly. It's elevated.
Q. You're aware that Doctor Chilcott thought that these were markedly elevated? Did you read that?
A. I'm aware that he said that.
Q. Was Mrs. Swift put on oxygen that morning?
A. Yes. I think two liters were

ordered, nasal canula.
Q. And was she on it all day?
A. As far as I know.
Q. I saw it in the orders, but I didn't see it any other part of the chart that it that that had actually been delivered to her. Did you?
A. I will be happy to check that if you will wait a moment, please. Other section of the chart that I want to look at for a moment. Bear with me here. Written as --- in the nursing notes.
Q. So other than the fact that the oxygen was ordered, we don't know from the nursing notes whether or not it was delivered?
A. We don't know from the nursing notes, that's true.
Q. Where would you expect to see it?
A. If it were in the nursing notes it would be under the systems review, under respiratory.
Q. Doctor Chilcott came to see

her at about 8:35 or thereabouts?
A. Yes.
Q. And based on his examination, he felt that she was marked distress despite receiving Demerol; is that right?
A. Yes.
Q. She was alert and oriented; is that right?
A. Yes.
Q. And he was thinking that this was either gallstone pancreatitis or pancreatitis brought on by her triglycerides; is that right?

ATTORNEY MENUEZ:

You're asking her what he was thinking?

ATTORNEY PARIS:

I sure did.

ATTORNEY MENUEZ:

Okay. Well, show an objection.

BY ATTORNEY PARIS:

Q. That's what he put in his chart; right?

A. That's what he documented.
Q. And you saw that the nurses were in the room when he was examining the patient and talking to the patient, too?
A. Correct. May I add something to my previous answer, because I was looking for documentation of the oxygen therapy being in use as you asked me to. Under the respiratory care oxygen therapy record there's a notation by the respiratory therapist that there were two liters of nasal canula oxygen in place at 8:00 p.m. on 6:15 and again at midnight on 6/16, for what it means to you. I just wanted my answer to be complete, that's all.
Q. But what time was it ordered?
A. Well, it was ordered that morning.
Q. And according to the record, it wasn't delivered until 8:00 p.m. in the evening?
A. Well, that doesn't mean that

it wasn't delivered. It just means that that's when he respiratory therapist documented.
Q. And does that document it was being delivered earlier than 8:00 p.m. that evening?
A. It's not --- I can't find any documentation of it ---
Q. Okay.
A. --- other than the fact that the nurse signed the order off at 10:12.
Q. As a nurse taking care of a patient with acute pancreatitis, which is either due to gallstones or triglycerides, what's the importance of having a CT scan?
A. From a nursing perspective?
Q. Yes.
A. Well, a nurse would simply view it as a diagnostic test that might be helpful to the physician.
Q. In terms of ruling in or ruling out gallstone pancreatitis?
A. Yes, as one part of his

differential diagnosis.
Q. And that's something that you would expect the nurses to understand and appreciate?
A. In what context?
Q. In this context.
A. I mean, I would expect the nurses to understand that a CT test may be ordered and performed as part of the physician's differential diagnosis or as part of his arsenal of information.
Q. To rule in or rule out gallstone pancreatitis versus triglycerides?
A. Well, I don't know. I mean, that would really be a medical evaluation. I don't know to what extent they would use that in their diagnosis. I just know it would be another piece of information for them.
Q. At 8:30 in the morning, how is Mrs. Swift's pain level?
A. 8:30?

Q. Yes. Wasn't it a ten out of ten?
A. What sheet are you looking at when you're asking me that, please?
Q. The PCA flow sheet.
A. Thank you. Yes.
Q. And in response to that ten out of ten pain she was given a morphine bolus of five milligrams?
A. In response to that, the anesthesia service, I think, was called and they responded by issuing an order for additional medication.
Q. And that reduced her pain level to six out of ten?
A. Correct.
Q. And in that time frame her respiration rate came down from 40 to 30?
A. Well, at 8:30 it was 30 and it came down to 28, between 8:30 and 9:00.
Q. We know at eight o'clock her respiration rate was 40?
A. Right.

Q. And then it came down to 30 at 8:30?
A. Right.
Q. And then at nine o'clock it came down to 28?
A. Right.
Q. And by nine o'clock she was given another bolus of five milligrams of morphine; is that right?
A. Correct.
Q. And her pain level was further reduced to four out of ten?
A. Correct.
Q. And at 9:30 a.m. her pain was four out of ten again?
A. At 9:30.
Q. And her respiration rate was 24; is that right?
A. Yes, it is.
Q. Are you aware at 9:30 that the CT --- the CAT scan folks called or the nurses called the CAT scan folks and told them that the patient had just gotten comfortable and that

there's going to be a delay in the CAT scan until the oral contrast is given?
A. Yes, I'm aware of that.
Q. And they thought maybe another 30 minutes or so ought to do it?
A. I don't recall that part of it, but I recall that there was a communication there.
Q. That was in the late entry chart?
A. Yes, I understand.
Q. But at 10:00 a.m. Mrs. Swift's pain level increased to five out of ten?
A. Correct.
Q. And her respiration rate again was 24?
A. Yes.
Q. And in the late entry the nurses indicated that by 10:10 a.m. she was infusing her contrast in anticipation of the CAT scan.
A. That's right.
Q. And at 11:00 a.m., her pain

was five out of ten?
A. Yes.
Q. Again, her respiration rate was 24?
A. Right.
Q. And according to the late entry nursing notes, the last cup of contrast had been infused, they called the CT, CAT scan folks to come get her?
A. Right.
Q. And of course you know from reading the deposition of Doctor Kondru that somewhere between 10:00 and 11:00 he got the message that he had a patient with acute pancreatitis that he needed to see?
A. Yes.
Q. At noon, Mrs. Swift's vital signs were taken?
A. Yes.
Q. And now her temperature was elevated to 100.3; correct?
A. Correct.
Q. Her heart rate was 114,

according to the graphic flow sheet; is that right?

A. Yes.

Q. But if you look at the telemetry sheet, doesn't it record a heart rate a few minutes later of about 131?

A. Yes.

Q. And why the difference?

A. Well, I think at that point in time she was either on her way to or was in the CT and would have been moved from her bed to a cart and possibly onto and off of the CT table. So I think some of that heart rate --- I think that heart rate increase has to be seen within the context of her chart.

Q. Okay. Well, the reading according to the flow sheet the recorded reading is 28?

A. Yes.

Q. If you look at the PCA flow sheet it shows 24?

A. I see that.

Q. What is the reason for the discrepancy?
A. Well, these times are not precise and somebody would have taken measurements before that, the PCA would have been recorded and taken after that and marked a reading of 24, represents permanent short amount of time is not significant.
Q. Blood pressure noted was 137/130 over ---?
A. That is correct.
Q. 12:13 p.m., her labs came back. The labs that were drawn at 6:30 in the morning?
A. That is correct. Came back. They were completed. Now, well, I don't --- that is correct. Just one moment, please. You were referring to the lab sheet.
Q. I want to hand you a --- there is a Bates stamp which is Bates stamped in my chart as 30Q, I think --- no, no, 30G.

ATTORNEY SWEENEY:

And Dan, for those of us who don't have a Bates stamped copy of it, can you indicate what it reads at the top of the page?

ATTORNEY PARIS:

It says final report collected, 6/15/2000, 6:30 a.m., completed 6/15/200, 12:15, chemistry, hematology, another page.

BY ATTORNEY PARIS:

Q. Did Mr. Switzer's office provide you with that document?

A. I have not --- I don't believe this is in the chart that I have.

Q. And 30F, indicating the white blood count and differential?

A. Your question, I'm sorry?

Q. Have you seen these documents before?

A. No.

Q. Do these documents indicate that these labs were collected at 6:30 that morning?

A. Yes, they do.
Q. And they were completed at 12:13 p.m.?
A. Well, I don't know how the lab --- I don't know what the lab means by completed, if that means that the test was run or that they put the report in the computer or what. I don't know what that means to the lab.
Q. Well, when is it your understanding that these lab results were available?
A. Well, if you look at Doctor Chilcott's progress note of 8:35 a.m., he has some of those labs in his progress note at 8:35 a.m. So he must have had them available to him by some means. He has the CPK, the BUN, this is the creatinine and the hemoglobin and white blood cell count, al of that in his 8:30 a.m. progress note.
Q. Right.
A. So he had that information at

8:35.
Q. That would have been two hours from the draw time?
A. Correct.
Q. And two hours from the draw time under that lab protocol would be a now order?
A. No, it wouldn't work that way. I mean, they would run them not according to a now protocol or a stat protocol. They would just run them. As it happened, those test results must have been available two hours later, which would have been consistent with the routine, which is within four hours.
Q. So then Doctor Chilcott would have had available to him information that her C02 level was worse than it was previously?
A. Yes, he would have.
Q. He would have had available to him that her white blood count was dropping from 11.9 to 6.7?
A. Correct.

Q. That her neutrophils were showing at 85.4 percent total percentile; right?
A. Correct.
Q. Did you see Doctor Kondru's testimony when he indicated that to be consistent with the left shift?
A. I saw that.
Q. Do you agree or disagree?
A. Well, from a nursing perspective, a left shift is indicated by an increase in bands and segs as part of the differential. And then the absolute neutrophil count would be taken into consideration also. If you have --- if you don't have bands and segs differentiated, which is the case with the 6:30 draw, then you have to go with the absolute neutrophil count?
A. Which is a little high in this case?
Q. Slightly high.
A. Which is why Doctor Kondru

testified that he felt this was consistent with a left shift?

A. That's, I believe, what he was basing that on.

ATTORNEY JENNY:

Objection. I'm sorry. I didn't hear half the question.

BY ATTORNEY PARIS:

Q. The temperature of 100.3, according to Head Nurse Petrochello, was a fever. Did you read that in her deposition?

A. Yes.

Q. You would agree that that temperature is abnormal? 100.3 is not normal?

A. It's above normal.

Q. And does an elevated temperature, generally speaking, raise one's index of suspicion about an infection?

A. Not necessarily. A fever --- I would disagree with her on that point. From a nursing perspective,

fever starts with 101, not with something below 101. So I would disagree with her on that. I think a rise in temperature to 100.3 is something that would be considered to be above what one looks at as a normal range, but it doesn't rise to the level of being a fever.

Q. The ACMC sepsis protocol which Mr. Switzer sent to you, early signs consistent with sepsis would include fever; is that right?

A. Yes, that's what this says.

Q. Rapid pulse?

A. Correct.

Q. Rapid respirations?

A. Correct.

Q. Normal or slightly decreased blood pressure?

A. Yes.

Q. And restlessness; is that right?

A. And warm, dry, skin, apprehension, headache and confusion, yes.

Q. Does this protocol require the nurses to assess the patient for these findings and report these findings and document the complications related to this condition?
A. Only if the patient's been diagnosed as having sepsis. The patient would have to be diagnosed as having sepsis before this protocol would be triggered by the nurses.
Q. At 1:00 p.m. Mrs. Swift was back on the floor from the CT scan; is that right?
A. Right.
Q. And according to the late entry authored by the nurses, she was very restless and moaning at that point?
A. Yes.
Q. Have you looked at the CT scan itself, the actual film?
A. No.
Q. Has anybody told you that the film has a time on it indicating that

it was taken at 12:40 --- I think it's 12:41 p.m.?

A. No. I just have the report. And I don't believe the report has a time on it.

Q. It does not. But assume that the film was done somewhere in that time frame, somewhere between 12:30 and 12:45, would you agree that the results of the CAT scan would have been available by the time she came back from the floor?

A. Would have been available to whom?

Q. Anybody who wanted to call down for a wet read?

A. If the test had been completed and someone wanted to know what the results were as soon as the test had been completed, they could have called the radiology department to get that information.

Q. And you would agree that the results of the CAT scan, in this setting, is an important diagnostic

--- would provide important diagnostic information which might dictate treatment decisions?

ATTORNEY MENUEZ:

Objection. *Go* ahead.

A. Well, from a nursing perspective I would look at it as another weapon in the physician's arsenal of information. But to what extent that would be helpful to the physician would really be a medical opinion.

BY ATTORNEY PARIS:

Q. I understand. But nurses understand that as an additional weapon in the arsenal, it may be important to treatment decisions that the doctors make?

A. It might be. It might be, depending on how ---

ATTORNEY JENNY:

Objection.

A. --- it was interpreted.

BY ATTORNEY PARIS:

Q. Sure. In your opinion, did

the nurses, as part of the treatment team, need to know when the CT scan was completed?

A. In terms of when the patient would be expected back up in the unit?

Q. Yes.

A. Not necessarily. Generally, the nurses would rely on the radiology department indicating when the test was done so that someone could go down and get the patient or bring her back up and they would be ready to take care of her again, but only to that extent.

Q. In your opinion, did the nurses, as part of the treatment team, need to know when the results of the CT scan would be available?

A. It isn't something that nurses would seek out.

Q. Given the effect that you have a patient who is returning to the floor, returning to the floor from a CAT scan who's got acute pancreatitis

with elevated temperature, elevated heart rate, elevated respiration rate, whose condition is not improving, doesn't the standard of care require the nurses to notify Doctor Chilcott and/or Doctor Kondru that the CT scan is done and the results are available?

A. No.

Q. Why?

A. Because it's the responsibility of the physicians involved in this --- in these matters. First of all, if --- I can't provide you with an opinion as to what the radiologist's standard of care is or the physician's standard of care. I can only tell you that it's not the nurses' responsibility to follow up on tests in terms of notifying physicians when they're completed and/or when the results are available to them, unless they're requested to do that. If they're requested to or ordered to, then they

do. Otherwise, they do not.

Q. So under that scenario the nurses do not act as an advocate of the patient when she's back from the CT scan?

ATTORNEY JENNY:

Objection.

A. I think that's an inappropriate question, with all due respect. I don't think the standard of care requires the nurse to follow up to determine and seek out as to when a test if finished, when the results are available to the physician and to notify the physician. I think that's something that the physician has ordered and that the nurse would rely on the physicians involved to be communicating with each other about.

BY ATTORNEY PARIS:

Q. And the physicians involved include who in this case?

A. The radiologist and the ordering physician and/or the

consultant, depending upon what was expected of the consultant and what he knew at that point in time.

Q. You would agree, would you note, that by one o'clock the standard of care required the nurses to monitor this patient more closely and have vital signs taken more than once per shift; correct?

A. Well, they were taking them very four hours up to that point in time is my understanding, at 8:00 and 12:00, and it appears as though they were also, at least according to this, at two o'clock, a late entry note.

Q. Well, the late entry note doesn't say anything except they thought that the vitals were taken at two o'clock, but that's not borne out by the graphic record, is it?

A. It's not documented on the graphics, that's correct.

Q. Which would be more reliable, the graphic record or a nurse's

memory from a day later?
A. Well, the vitals that were taken at two o'clock should be on the graphic sheet.
Q. And they're not?
A. Correct.
Q. So doesn't that lead you to believe that the vitals were probably not taken at two o'clock?
A. No. No, it doesn't.
Q. Well, what vitals were taken supposedly at two o'clock?
A. Well, first of all, you have to remember this person is on a continuous heart monitor, so you always know what the heart rate is just by looking at the monitor, and _-- that is the nurses who were there would always know the heart rate because they'd just have to glance at the monitor, which provides a continuous display of the heart rate. It appears as --- she's documented, the nurse has in her late entry, that the temperature was 100.3 at two

o'clock, and the blood pressure was within normal limits, but no numbers are charted.

Q. Well, the 100.3 is the temperature at 12 o'clock, is that right, according to the ---?

A. It's at 12:00 and at 2:00, according to the way I read her late entry.

Q. What was the blood pressure?

A. She doesn't chart it.

Q. Why not?

A. I can't explain it.

Q. What was her heart rate?

A. Her heart rate would have been on the monitor, but she did not chat it in her note.

Q. What's the respiration rate?

A. I would have to see if it's charted on the PCA note to ---.

Q. What does the note chart at two o'clock as her respiration rate ---

A. Well, just a moment, please.

Q. --- in her late entry?

A. In her late entry she did not.
Q. Okay. So the fact of the matter is ---.

ATTORNEY SWEENEY:

Well, David, show an objection here. Allow her to answer the question. She has an answer she needs to put on here.

BY ATTORNEY PARIS:

Q. You're looking at a PCA flow sheet which tells us what the respiration rate is.
A. For two o'clock and three o'clock.
Q. I understand that. But on the late entry you don't have the blood pressure?
A. That's true.
Q. When was the next time that the temperature was supposed to be taken, according to the accepted standard of care?
A. It should have been taken approximately four or five o'clock.

If it were taken at two o'clock, it wouldn't have to be taken, according to the standard of care, until 6:00. But if we were going by 8:00, 12:00, 4:00, it would be at 4:00, so it's hard to say.

Q. Well, let's back up. Actually, because of the elevated temperature, her temperature should have been taken more often than every four hours; correct?

A. No, only if it's 101 or higher.

Q. Well, according to you, the nurse took her temperature at 12:00 and then again two hours later at two o'clock?

A. Well, she chose to do that, but it wasn't required by the standard of care to take it until 4:00.

Q. When there's abnormalities in vitals, aren't you required to monitor the patient more closely?

A. Again, her temperature would

only have to be taken more frequently than every four hours if it was 101 or higher.

Q. Why did she do it again then at two o'clock then?

A. She probably did it as a nursing measure. She chose to do that.

Q. Okay. Under the standard of care, was she required to take her temperature again at 4:00?

A. No. She could have waited until 6:00, because it was still below 101.

Q. Did Nurse Berry take her temperature at 6:00?

A. It doesn't appear on the chart anywhere.

Q. Did she take her temperature at 8:00 p.m.?

A. No. It's not documented.

Q. Did she take her temperature at 9:00 p.m.?

A. It's not documented.

Q. How about 10:00 p.m.?

A. My answer is the same.
Q. Did anybody take this woman's temperature again before 11:50 p.m., around midnight?
A. I can't find any documentation that they did.
Q. And the standard of care requires that this woman's temperature be taken long before midnight; correct?
A. Correct.
Q. And the nurses departed from the accepted standard of care by failing to do that; didn't they?
A. By failing to document it. I can't say with certainty they didn't take it, but it certainly isn't on the chart.
Q. And if they didn't take it, they deviated from the accepted standard of care; correct?
A. If they did not take it, yes.
Q. And if they did take it, they should have documented it; right?
A. They should have.

Q. Even though you disagree with Head Nurse Petrochello at ACMC about what 100.3 elevated temperature represents, if you just assume for the moment --- I know you don't agree with it, but assume for the moment that 100.3 represents a fever, does the standard of care require that the temperature be taken more often than every four hours?

ATTORNEY SWEENEY:

Show an objection.

A. Well, my answer is the same as it was before. If the temperature were 1001, it should be taken more often than every four hours. It never reached 101 that I'm aware of.

BY ATTOREY PARIS:

Q. By two o'clock, is there any indication that the patient's condition is improving?

A. No, not by the documentation I have available to me.

Q. At 3:00 p.m. Mrs. Swift's condition changes for the worse; does

it not?
A. In what sense?
Q. Well, at that point her pain level goes from five out of ten to seven out of ten?
A. Her pain has increased at three o'clock.
Q. And at that point didn't the standard of care require Nurse Wilson and/or Nurse Berry to call Doctor Chilcott and report that change?
A. No. No, it did not.
Q. Didn't it require them to call Doctor Chilcott and report her elevated temperature, elevated heart rate, elevated respiration rate and the fact that the CT was bad?
A. Let's take those one by one if you don't mind, ---
Q. Sure.
A. --- and start at the beginning with your question. I think I answered your question relative to the pain level. Could you go on from there and ask me ---?

Q. Well, I'm now talking about the whole constellation of the patient.
A. At what --- at what time?
Q. At three o'clock.
A. Okay.
Q. She's been back from CT for two hours.
A. Correct.
Q. Nobody has come --- no physician has come and seen her. Her pain is increasing from five out of ten to seven out of ten. Her heart rate is still elevated. Her temperature is elevated. Her respiration rate is elevated. She's not improving. Doesn't the standard of care require the nurses to call Doctor Chilcott and report those things?
A. You're leading out the CT report coming back because ---.
Q. I said that.
A. You omitted that.
Q. She's back from the CT scan.

A. Right. But the first time you asked the question ---.
Q. Let's include it.
A. You want to include it?
Q. That the CT --- that she's back from the CT scan. Doesn't the standard of care require the nurses to call Doctor Chilcott and report this information?
A. No.
Q. Why?
A. Because there is nothing in the chart, aside from her pain level which has gone from a five to a seven and within the context of her pain before she was originally a ten. There's nothing within the context of the documentation I see that shows that she's had any kind of abrupt or significant change in her condition. She's relatively the same as she's been all day.
Q. In the late entry of two o'clock, Nurse Wilson says that she called anesthesia for another five-

milligram bolus of morphine?
A. Right.
Q. That's not an accurate statement, is it?
A. No, it really isn't. She --- I don't believe it is anyway. If you look at the orders, I don't know exactly when she called, but the order --- there are two orders from anesthesia, one in the morning and one that's noted is a telephone note at 4:30.
Q. The only order from anesthesia was taken off at 10:30 a.m.?
A. That's correct. And then there was a subsequent order.
Q. And how is it that you explain the discrepancy in what Nurse Wilson is telling us in her late entry versus the orders by the anesthesia department?
A. I'm looking at her late entry right now. If you'd bear with me for one moment, please. She's saying at two o'clock anesthesia ordered

another bolus of five to ten milligrams. Is that the entry you're referring to?

Q. Yes.

A. And then the order over here is indicating a telephone order at 4:30. Is that your ---?

Q. Right.

A. Is that what you're questioning?

Q. Right.

A. Well, she would have to explain that. I can't.

Q. Mrs. Swift did get a bolus of morphine at 3:00 p.m.; didn't she?

A. According to the PCA sheet, she did.

Q. And there's no order from a doctor that allows them to give a bolus of morphine at 3:00 p.m., is there?

A. Unless the earlier order, bolus five to ten, would include the separation of that, but it's not clear to me. The order is not clear

that it could be implemented. The only other explanation which is possible is that this was transcribed at 1630, but actually she spoke with the anesthesiologist earlier than that.

Q. So it's perhaps the situation that Nurse Berry did not talk to the anesthesiologist at 4:30 p.m.; is that true?

A. It's possible she talked to the anesthes --- correct, it's possible.

Q. It's possible that she talked to the anesthesiologist before 4:30 p.m.?

A. Correct.

Q. And do you know what time would be more consistent with what we see in the record?

A. Well, she has written down 1630, which is 4:30. But I don't know if that's the time she actually spoke with him or the time that she transcribed the order. I don't know.

Q. In any event, what we see in the orders and what we see delivered to the patient are not consistent?
A. Not entirely consistent. But it may not be inconsistent either. I just can't tell.
Q. And it's certainly not consistent with what Nurse Wilson wrote in her late entry about what occurred at two o'clock?
A. In what sense?
Q. In the sense that she called anesthesia for a bolus of morphine.
A. It's possible that she called at 2:00 and it just didn't get written until 4:30. It's possible, but it's not clear to me.
Q. At 4:00 p.m., having given the patient a five-milligram bolus of morphine --- or strike that.
At four o'clock, the patient had already received her five milligram bolus of morphine that had been given at three o'clock; is that right?

A. Yes.
Q. And one would expect her pain to decrease; correct?
A. At three o'clock or four o'clock you're referring to?
Q. At four o'clock.
A. Excuse me. Well, one would hope that --- she's now on a continuous PCA because anesthesia has ordered that the PCA be continuous as opposed to the patient pushing when she wants it.
Q. The pain didn't get better?
A. It did not get better. That's true. It did not.
Q. In fact, it got worse?
A. What makes you think it got --- I'm sorry. I shouldn't ask you a question. But I don't see any evidence that it got worse.
Q. Didn't it go up to seven out of ten instead of ---?
A. It was seven. It was seven at 3:00. It states seven at 4:00.
Q. So the pain didn't abate?

A. No. As far as ---.
Q. And seven out of ten, by the way, is the highest it had been since 8:30 in the morning; correct?
A. Right. But if I could also say that when you're running these numbers down, you're doing it on the hour. And in between times, the patient could be resting or sleeping and not have that pain. You're only asking them to rate the pain on an hourly basis. So in between doses, patients can frequently, and often do, doze or rest or get some relief. So to see a seven at 3:00 and seven at 4:00 doesn't mean that it was seven for that entire hour. It doesn't mean that. It just means that at that point in time when the nurse asks the patient, that's what she told her.
Q. At three and four o'clock in the afternoon, Mrs. Swift rated her pain at the highest it had been since 8:30 that morning; correct?

A. That's true.
Q. And that was her way of changing her condition; was it?
A. No. I don't see that as a --- I mean, it's a change to go from five to seven. But I'm talking about what a significant change is. And from a nursing perspective, you wouldn't consider going from five to seven significant within the context of the fact that she's been moved around, going to CT, that she had a ten when she came in. You know, obviously, she has severe pain. I don't think there's any question about that. But in response to your question about whether or not that's a change, technically that's a change but not significant from a nursing perspective.
Q. Mrs. Swift could no longer operate the PCA pump on her own; is that right?
A. Right.
Q. And the anesthesiologist was

called and ordered that the pump infuse continuously; is that right?
A. He chose to do that. That's the way he ordered it.
Q. Vital signs were taken at four o'clock, except her temperature, of course?
A. Yes.
Q. Her heart rate was 114?
A. Yes.
Q. Did you notice on the telemetry unit at 3:23 p.m. her heart rate was 120?
A. Yes.
Q. Is there any reason for the difference?
A. Well, the monitors will show you what the heart rate is during a six-second period of time, which is very brief. So it may not correlate exactly with what you're timing when you take it personally at the bedside. It indicates 114 or 120 is still elevated; correct?
A. It's elevated, yes.

Q. Her respiration rate was 20?
A. Yes.
Q. According to the graphics sheet?
A. Yes.
Q. But on the PCA pump sheet it was 36; is that right?
A. At four o'clock?
Q. Yes.
A. I see 30.
Q. Thirty (30)?
A. Yes.
Q. And the reason for the discrepancy?
A. Well, again, the times are not precise and they may also be taken by different people at slightly different periods of time. So to get a difference of 20 to 30 may simply be a reflection of the fact that there was a difference in terms of when it was done. It could have been a four o'clock --- for example, a four o'clock respiration count could be done as early as 3:30 or as late

as 4:30 and still be within the standard of care. So there could be a difference in not really being a discrepancy.

Q. What do you believe her blood pressure was at four o'clock?

A. It's 136 systolic, I believe. And the diastolic is very difficult to read. I really don't --- I think it's an 80 but it's difficult to read.

Q. Nurse Berry, who was on shift at four o'clock, testified about what she thought that said. Did you read her deposition?

A. I did read it. I don't recall exactly what she said.

Q. I believe she's testified that the blood pressure at that time was either 156/130 or 136/130.

A. Well, it could be 156, it could be 136 in terms of the systolic. It's hard to read. It could not have been 130 diastolic.

Q. If that was, that would be

extremely abnormal; is that right?
A. It couldn't possibly be because of what the diastolic reflects. It couldn't be.
Q. Why couldn't it be that?
A. Well, because the diastolic reflects what the pressure is during the resting phase of the heart, before the heart pumps blood out again. And you couldn't have a pressure that high in the chambers at a resting level. It's not physiologically possible, unless you have a patient in extremous. It's not possible.
Q. In your opinion, does the staff at ACMC have an obligation to report the vital signs clearly and accurately in the chart?
A. Yes, you should be able to read it.
Q. And was that done in this particular instance?
A. I really can't read the four o'clock blood pressure precisely.

I'm not certain what it is.
Q. The staff did not carry out their obligation in that regard; right?
A. Right.
Q. Now, Nurse Berry assessed Mrs. Swift at about 4:00 p.m.; right?
A. Yes.
Q. And it was Nurse Berry's determination that Mrs. Swift's abdomen was distended at that time?
A. That's what she said in her entry.
Q. And no one had ever noted a distended abdomen prior to 4:00 p.m. in this patient; is that right?
A. No one had used that term before.
Q. And Doctor Chilcott testified that when he examined her at 8:30, he did not find a distended abdomen. And had he, he would have noted it. Do you remember reading that?
A. Yes, he said that in his testimony.

Q. This was a new finding; correct?
A. Maybe. The term distention means different things to different people in the health care profession. And they're not --- it's not always used as precisely and doesn't always mean the same thing to one person as it does to another. For example, when a nurse charts firm, to another nurse that could be distention. And also this patient weighed over 200 pounds. So it's very difficult to assess that when you have someone who is heavy and who has extreme abdominal pain. It's very hard to know.
Q. Well, isn't that one of the reasons you measure abdominal girth, so that one can get a baseline and make a determination whether or not somebody's abdomen is getting distended; correct?
A. It might be helpful to do that, sure.

Q. And isn't that one of the reasons you want to measure the abdominal girth at admission rather than late in the shift so that you can get that baseline?
A. It would be preferable.
Q. And one of --- the importance about distention in an acute pancreatitis case is the distention could either be as a result of an ileus or of fluid collection; correct?
A. Could also --- or food collection?
Q. Fluid.
A. Fluid collection, yes. Correct.
Q. And that's more information that the doctor would need to know in assessing the patient and treating the patient; right?
A. It would be another piece of information, sure.
Q. Certainly, that would be important if that is reflective of a

changing condition in the patient; correct?

A. Can you rephrase that? I'm not sure I really understand it.

Q. Well, if somebody is going from an abdomen which is not distended to an abdomen which is distend and it's distended because of fluid collection or ascites formation, wouldn't that be information that a doctor would want to know?

A. You're asking me hypothetically?

Q. Yes.

ATTORNEY MENUEZ:

I'm going to make an objection.

A. Hypothetically, it might be.

BY ATTORNEY PARIS:

Q. And by the way, without actually reviewing the chart, under nurse sections, Nurse Berry, who is assessing a new patient wouldn't be able to make a determination whether

or not this patient had a distended abdomen previously or not?
A. Yes, she would.
Q. How?
A. The nurse who preceded her would have given her a report.
Q. What did the nurse tell Nurse ... what did Nurse Wilson tell Nurse Berry about her abdomen during the first shift?
A. I don't know exactly what she would have told her, because the nurse would have told her what she charted but could have told her things other than and in addition to what she charted.
Q. But certainly the information that we went through in the admission documents and the emergency room where distention was not checked off would have been available to Nurse Berry if she wanted to look at the chart?
A. She could have looked at that if she chose to and felt she needed

to.

Q. At four o'clock, wasn't there also a change in Mrs. Swift's mental status?

A. There was at five o'clock when the restraint was applied, apparently. But again, --- I'm sorry.

Q. That's all right.

A. Again, that would be based upon the cognitive impairment protocol.

Q. Did you read Nurse Berry's deposition where she testified that at four o'clock she felt that Mrs. Swift's medical condition was confused?

A. Yes. She said that in her deposition.

Q. Certainly that is a change and a significant change from her prior condition; correct?

A. Depending upon what she meant by confusion, you know, it can mean different things to different nurses.

If it meant she was disoriented, it was a change because she had been oriented prior to that.

Q. Well, she didn't seem disoriented. She said confused.

A. I understand what she said. But I'm just saying that confusion means different things to do different nurses.

Q. And without reviewing the chart, Nurse Berry would not be able to make a determination that this patient had --- had not been confused or might have been confused earlier in the day?

A. She would have gotten a verbal report that she was very restless, agitated and dozing off and on, which was part of the documentation. so whether or not she interpreted that as being confusion or not, she would have to tell you. I don't know.

Q. **I** saw the term restless. I don't recall seeing the term agitated in the chart prior to four o'clock.

Can you point that out to me?
A. I will look. I thought it was.
Q. And if it is there, I'll stand corrected.
A. And if it's not, I will. Right. It may be simply restless. But I'll double check here. I think it's just restless.
Q. Prior to four o'clock, the only term that we see which describes --- we see the term restless describing her condition, not agitated?
A. Restless and, I think at another point it was documented as very restless. But restless is the adjective.
Q. Not agitated?
A. Correct.
Q. And in fact, do you recall Nurse Berry's deposition when she testified about her observations at 4:00 p.m., the fact that Mrs. Swift was confused and that after I gave

her the opportunity to look through the chart, Nurse Berry concluded that this was a change in her condition from the time she was admitted. Do you recall reading that?

A. Yes.

Q. And do you agree with that?

A. I think there was a subtle change. I don't think it was a dramatic but I think there was a subtle change. She hadn't been pulling on tubes before that, as far as I know.

Q. And she hadn't been described as confused before?

A. That word has not been used, correct.

Q. And in fact, confusion along with fever is one of the early signs of severe infection; is that right?

A. Confusion and fever?

Q. Yeah.

A. That's one of the possible correlations. But in accordance ---.

Q. It's within the constellation

of symptoms in the ACMC protocol for sepsis; correct?

A. But the patient had been diagnosed as sepsis.

Q. I understand. But it's within the constellation of symptoms in the ACMC protocol for sepsis?

A. It's there, yes.

Q. In your opinion, did the standard of care require Nurse Berry to call Doctor Chilcott and report this change in her condition at four o'clock?

A. She, as I recall her testimony, said that she had an emergency at that time and had to attend to a patient who was hemorrhaging. I think in my report I stated that she should have called Doctor Chilcott as soon as she had control of that emergency situation, which would have been around five o'clock.

Q. Should she have called her nursing supervisor at four o'clock?

A. I believe the nursing supervisor was involved in the emergency at some point. So if she was involved herself in the emergency, as I recall, supervisor.
Q. Did you get --- did you review this census data for Two North at ACMC on that day?
A. No.
Q. Did Mr. Switzer's office send you that?
A. No.
Q. Do you know whether or not they were short handed that day?
A. I don't know. I believe the nurses testified or there was some testimony to the effect that there would be one nurse to about six patients, something to that effect. But I don't know. I don't have the data.
Q. And if there was no emergency ... if there was no emergency at 4:05, the standard of care would have been for Nurse Berry to call Doctor

Chilcott and report these findings?
A. I think it would have been appropriate, had there not been an emergency, for her to call him between 4:00 and 5:00 because --- I can't pin her down to four o'clock because those times have to be somewhat flexible, based on the clinical situation she's faced with in multiple other patients. Even though she has access to the supervisor, it just doesn't happen at precise times because of the condition of other patients that could be involved.

If there had not been an emergency, then between 4:00 and 5:00 I think she should have notified him because of a constellation of things that seemed to indicate that it would have been appropriate.

Q. And at that telephone call at that time, would the standard of care have required Nurse Berry to report to him that not only had there been a

change in the level of her medication but that there's a distended abdomen, that there's an elevated temp, that she's back from the CT Scan and the consultant hadn't been there to see her yet?

ATTORNEY JENNY:

Objection.

A. Well, from a nursing perspective, the elevated temp is not ... I mean, it could be part of the report. But it's not essential because it's not high enough. In terms of the CT results, the nurse, if she were calling to report other things, could have reminded the physician that the CT scan had been completed. But that would be a reminder only. It's not a duty of hers to do that. In terms of the ... what was the third thing you included in that group?

ATTORNEY SWEENEY:

Distended abdomen.

BY ATTORNEY PARIS:

Q. Distended abdomen.
A. She could certainly tell the physician what she believed she was feeling. She could certainly include that. She felt the patient's abdomen was distended.
Q. In fact, the temperature could have been higher than 100.3 at four o'clock? You don't know because nobody bothered to take it; right?
A. Well, we don't know if anybody took it after two o'clock because it's not documented. But that doesn't mean it wasn't done.
Q. Nurse Berry, while she was attending to this emergency at four o'clock, she could have asked one of the other nurses to call Doctor Chilcott; couldn't she?
A. I don't know what the other nurses were doing at that time. It may not have been possible for anyone to have gone to a phone and called.
Q. Or one of the unit clerks, one of the secretaries?

A. Well, I mean, the unit secretary can place a call but can't speak with the physician. So that wouldn't have been very helpful, I don't think.
Q. Certainly by five o'clock or thereabouts, the standard of care required Nurse Berry to initiate contact with Doctor Chilcott?
A. Yes, I agree with that.
Q. And she didn't; correct?
A. She did not, that's correct.
Q. And in that she didn't, that was a departure from the accepted standard of care?
A. In my opinion, yes.
Q. By five o'clock, in what way was Mrs. Swift's condition not improving?
A. Well, by five o'clock, you have a time frame with one entire nursing shift having passed by. And by five o'clock, you have no medical evaluation of a patient, bedside medical evaluation, aside from the

telephone orders throughout the day.

And you've moving into the evening hours when it may be more difficult to reach physicians and/or access resources that you might need and soon. So at that point in time, it was important that that physician be contacted and be made aware of the fact that the consultant hadn't been there at that point in time, even though there was no order of time limited in terms of when he was required to go. But from a nursing perspective, there would certainly be a level of concern.

Q. And that's at five o'clock but not necessarily four o'clock?

A. Well, we have the emergency problem. In the absence of the emergency, we can say between 4:00 and 5:00. But to say precisely at 4:00, I can't do that. Somewhere between 4:00 and 5:00, in the absence of an emergency.

Q. The earliest being 4:00, the

latest being 5:00, thereabouts?
A. The very earliest being 4:00 that she's doing an assessment and she would need a little bit of time after that to document --- not to document necessarily but to put the restraints on, which she felt were necessary, and soon. She would do that first.
Q. I think you noted in your report that her condition was not improving?
A. That's true. And that seems to be of some importance to you?
A. It is because of the fact that the nursing shift had been completed by that point in time. And by that point in time, you would hope to see a trend that would indicate some response to treatment.
Q. And she was still in significant pain; is that right?
A. Yes.
Q. The CT Scan was available; right?

ATTORNEY SWEENEY:

Objection. I mean, David, how many times are going to ask the same question? I mean, you've already covered that.

A. Well, I don't know if the results were available or not. I know when the CT was performed about precisely when the results were available. I can't tell because they were transcribed by the radiologist apparently around 4:30.

BY ATTORNEY PARIS:

Q. But by wet read they were available earlier?

A. Excuse me? By what?

Q. By wet read.

A. Oh, certainly, and by telephone.

Q. And why is it important to you that the patient had not been evaluated by a physician since 8:35 a.m.?

A. Because we're not seeing an

appropriate or adequate response to treatment by that point in time, from a nursing perspective.

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Q. And therefore, in that time frame that we talked about between 4:00 and 5:00 p.m., the duty of care imposed on Nurse Berry required that she contact Doctor Chilcott?

A. In my opinion, she could have contacted either Doctor Chilcott or Doctor Kondru. But that would really depend upon what she knew about --- or what the pattern or procedure or practice is at that hospital. But one of the physicians should have been contacted.

Q. Why would it have been her obligation at that point to contact Kondru and not just Chilcott exclusively?

A. Well, she didn't have an

obligation to contact Doctor Kondru necessarily. But if she had reason to believe that he was in the hospital, it would have been more efficient or quicker or efficacious probably to see if he were there and if he were available and if he were ready to see the patient rather than call Doctor Chilcott who may not have been in the hospital at that point in time.

Q. And her obligation then was to contact Chilcott in that time frame; is that correct?

A. Yes, I think so, yes.

Q. And also, according to the accepted standard of care, Nurse Berry could have paged the consultant, Doctor Kondru, in the hospital if he was there?

A. She could have.

Q. And make a determination --- give him an update on her status and make a determination of when he was planning to come see her?

A. Correct.
Q. And why is it important for her to have an understanding of when Kondru was planning to make that visit to see her?
A. Well, only to the extent that if it were going to be relatively soon, then that might be the quicker way of getting a bedside evaluation rather than calling Doctor Chilcott at some other location.
Q. And why would it be important for the nurse to advise Doctor Kondru of the patient's status at that point in time? Now I'm talking about in the five o'clock time period, if she opted to contact him?
A. If she opted to see if he were available?
Q. Right.
A. And the question is why ---?
Q. Why would it be important for her to advise him of the patient's status as we've described over and over?

A. Well, because if she provided Doctor Kondru with the information as to how the patient had been throughout the nursing shift that preceded her, it might have been helpful to him in knowing how soon he needed to be there.

Q. Did you review the expert report of a Doctor Emil Dickstein (phonetic)?

A. Emil Dickstein?

Q. He was an expert hired by Mr. Switzer's office.

A. No, I have not.

Q. Did Mr. Switzer or anybody from his office reed Doctor Dickstein's opinion to you over the phone which stated that there is nothing in the records or from the depositions of the nurses present in caring for Mrs. Smith that the changes she exhibited were so extreme that any physician could have been contacted earlier than when the gastroenterologist saw her, which as

you know was 9:30 p.m.?
A. No. They did not read that to me.
Q. And certainly you disagree with that statement; don't you?
A. From a nursing perspective. Obviously he has a medical perspective.
Q. From a nursing perspective, Doctor Dickstein is plain wrong in that regard?

ATTORNEY SWEENEY:

Show an objection.

A. I can't say that he's wrong. That's his medical opinion. I'm not providing a medical opinion.

BY ATTORNEY PARIS:

Q. In your report you indicate ___ you make comment about Dawn Phillips, Mrs. Swift's daughter. Do you remember that? You state of note, Mrs. Swift's daughter was an intensive care nurse, testified that she saw her mother at 6:30 p.m. and did not believe it was necessary to

call a physician at that time. Is that right?

A. Yes, she did.

Q. Is it your opinion that family members are required to conduct a nursing assessment of their family when they come to visit?

A. No, it's not.

Q. Is it your opinion that the hospital should violate the physician/patient privilege and make a patient's records available to family members?

A. No.

Q. Is it your opinion that the family should have provided medical care to Mrs. Swift?

A. No.

Q. Is it your opinion that Mrs. Swift's daughter was at fault in regard to her mother's care?

A. No.

Q. Is it your opinion that the family of Mrs. Swift was a cause or contributor to their mother's demise?

A. No, not at all.
Q. Mrs. Swift's daughter testified that she asked Nurse Berry the status of her mother and was assured by Nurse Berry that her mother was doing fine and Doctor Kondru had been notified. Do you recall that?
A. Yes.
Q. Is it your opinion that Mrs. Swift's children should not have lied on the assurance of Nurse Berry because the nurse was providing substandard question?

ATTORNEY SWEENEY:

Show an objection.

A. Could you rephrase it, please?

BY ATTORNEY PARIS:

Q. I will rephrase it. Is it your opinion that the Swift family should not have relied on the assurances of Nurse Berry?
A. I don't think I have an opinion about what the family should or should not have relied on.

Q. Well, do you think it's appropriate for family members going to visit their family who is sick in the hospital to rely on the nurses' assurances ---

ATTORNEY SWEENEY:

Show an objection.

BY ATTORNEY PARIS:

Q. --- as to what the condition of the patient is and whether doctors have been notified? Can they rely on that?

A. I think they should rely on what's presented to them as factual information. If the nurse told her Doctor Kondru had been notified, she should have been able to rely on the fact that he was notified.

Q. And if Nurse Berry assured the family that their mother is doing fine, could they rely on that?

A. To some extent. But obviously, you have your own eyes and ears and you can see whether or not you think your family member is doing

okay or whether you have concerns about them.

Q. Well, did your family conduct a head-to-toe assessment on their mom?

A. No. Of course not.

Q. Did they take her temperature?

A. No.

Q. Did they take her blood pressure?

A. Not that I'm aware of.

Q. Did they take her pulse?

A. Well, they could see the monitor.

Q. Was it their obligation to do any of those things?

A. To do ---?

Q. An assessment, a head-to-toe assessment.

A. No, it was not their obligation.

Q. As a matter of fact, family members may tend to be less objective when dealing with a sick family member. Wouldn't you agree?

A. It depends on the family and the family member. It really does.
Q. You're familiar that some physicians won't treat their family members?
A. I'm very familiar with that. My father was a physician.
Q. And some nurses won't get involved in the treatment of family members?
A. That's a personal choice.
Q. Is one of the reasons for that choice because you lose objectivity?
A. I think the reason that some people make that choice is because they're fearful of that.

ATTORNEY PARIS:

Let's go off the record.

VIDEOGRAPHER:

Off the record.

OFF VIDEOTAPE

OFF RECORD DISCUSSION

ON VIDEOTAPE

VIDEOGRAPHER:

4:56 p.m., back on.

BY ATTORNEY PARIS:

Q. You make a statement in your report that nurses are not required by the standard of care to initiate contact with doctors concerning vital signs or restlessness. Do you recall that? In paragraph one.

A. I said nurses were not required by the standard of care to initiate contact with physicians concerning vital signs or restlessness, correct.

Q. And what's the basis for that statement?

A. Because the restlessness had been a feature of her presentation since she came in. It wasn't a new change or a change. And because the vital signs had not gone into areas where they were extreme, except for the 2:12, which Doctor Chilcott knew about.

Q. And how abnormal do the vital signs have to be in order to require

a nurse to call a doctor of a patient with acute pancreatitis?
A. Well, it depends on the patient's baseline and it depends what the other aspects of the clinical presentation are. But there was nothing in the variation in her vital signs. And there were variations that would have indicated an extreme or significant change.
Q. Well, let's take each vital sign and you tell me what elevations would there have to be before the nurse had the obligation to initiate a call to the doctor? Let's start with temperature.
A. 101, as I think I mentioned.
Q. Heart rate?
A. Well, heart rate would be taken in context of what the pattern was. The one episode of 131 was documented on what I think was a portable telemetry unit at CT. You would have to look at that to see if it stayed at that level or if it

started coming down, which it did. So you wouldn't report that if it started coming down and appeared to level off.

Q. Respiration rate?

A. Again, the 40 Doctor Chilcott knew about. And from that point on, they were in the 20s, for the most part, with a couple episodes of 30.

Q. So is 38 a respiration rate that is abnormal?

A. Yes, it's above normal.

Q. And the heart rate above 114, 115, is that abnormal?

A. You mean the 131 that was documented or the 125 that was documented subsequent to that? It's high.

Q. Well, I'm going to bring it down lower to, let's say, 114. Is that high?

A. It's elevated.

Q. If you've got vital signs in the range of 115 heart rate and 30 respiration rate and an elevated

temperature of 101, does that require a call to the doctor?

A. Well, a temperature of 101 would, in and of itself.

Q. Let's take the elevated temp out of the equation. What about elevated heart rates and respiration rates, as I've mentioned 115 and 30?

A. No. Because the patient has acute pancreatitis. That's her diagnosis. And part of the presentation of that disease is that patients are tachycardic and they have rapid respirations in that range because of the pressure on the diaphragm. So it's not unusual. It wouldn't be unusual to have that kind of elevations and heart rate or respiratory rate throughout the day.

Q. And would it be unusual for the patient to be restless all day long?

A. No.

Q. And I think you told me that at the end of the shift, at the end

of the day, that's about how long one would typically want to wait to see if there's any improvement?

A. Yes, because you're looking at the transfer off the shift and moving into the evening hours. And so you want to intervene at that point in time because there hasn't really been an adequate or appropriate response to the therapy.

Q. In paragraph number five of your report, you state that antibiotics were ordered just before the patient was transferred from the nursing to the procedure area for the ERCP. Is that what you wrote?

A. Yes, I did.

Q. And I think it was your indication that the antibiotics were ordered at about 10:00 p.m.?

A. Well, I'm not sure that the times are entirely consistent. There was some documentation that she was in a holding area for the ERCP around 10:30. And in terms of --- I mean,

that's what I was reading in terms of the procedure chart. So it appeared to me that it was ordered just before. But I can't say that with certainty. It could have been ordered after.

Q. Did you read Doctor Kondru's deposition where he testified that he ordered the antibiotics after the procedure?

A. Yes, I did.

Q. So do you stand corrected in the report?

A. Well, my report says that it appears because I wasn't certain with Doctor Kondru's statement that it was ordered after the procedure. Certainly I'd accept that.

Q. You did read Doctor Kondru's deposition before you prepared your report?

A. I did, yes.

Q. And he ordered those antibiotics on a now basis?

A. Yes, correct.

Q. And ordering antibiotics now requires that they be delivered to the patient in what time frame?
A. It depends on the hospital. If the pharmacy is operating, and this is hypothetical, under the same protocols that the laboratory is operating under, the now would mean two hours at this hospital.
Q. And when were the antibiotics delivered to this patient, how long after they were ordered? And assume that they were ordered at about 11:00 p.m.
A. Okay. The record, as I recall, indicates that the dose was administered at 2:00 a.m.
Q. Three hours later?
A. Correct.
Q. What do you --- in your opinion, what is the purpose of late entries?
A. Well, the purpose of late entries it provide a more comprehensive or complete picture of

what occurred during a specified period of time, relative to the nursing notes. Or to add something that the nurse intended to put in and did not at the time, for whatever reason.

Q. In this case, you didn't get a sense that the nurses intended something in the record and that's the reason for the late chart entry?

A. I did not get that ---.

Q. In fact, Nurse Berry said that she had no intention of writing anything in that record, other than what she already wrote?

A. She said that.

Q. The protocol at ACMC requires that the late entries be timed; is that correct?

A. Yes.

Q. And they were not in this case?

A. Yes.

Q. That's a violation of the protocol?

A. It would be.
Q. Would you agree that the primary purpose of documentation and charting has nothing to do with going to court and everything to do with patient care?
A. That's an unusual question. It certainly is done for the purpose of providing a complete picture of patient care and for the benefit of the patient.
Q. The primary purpose is not for purposes of litigation?
A. The primary purpose is not.
Q. And did you read Nurse Berry's testimony when she stated that charting only comes in handy when you have to go to court?
A. I ---.

ATTORNEY SWEENEY:

Objection.

BY ATTORNEY PARIS:

Q. Did you read that?
A. I did read that, yes.
Q. And you disagree with that?

A. I certainly do.

ATTORNEY PARIS:

Thank you. I have nothing further.

ATTORNEY SWEENEY:

I do. Anyone in Cleveland?

ATTORNEY MENUEZ:

Yes, Jonathan Menuez.

EXAMINATION

BY ATTORNEY MENUEZ:

Q. Nurse Smith, I appreciate you've been here for four hours. I'm going to be very brief. Throughout your testimony today, you have given a number of opinions And because I am attending by telephone and because there's a delay, I didn't want to interrupt each time, although I know you've clarified your responses numerous times. Can I assume that all the testimony you've given and all the opinions you've rendered today are from the perspective of a nurse's standpoint?

A. Yes, you can.
Q. And that none of your opinions were intended to apply to this doctor's care or doctor's standard of care in this matter?
A. That's correct.

ATTORNEY MENUEZ:

Thank you. I have no further questions.

ATTORNEY PARIS:

Anyone else?

ATTORNEY SWEENEY:

We will ---.

ATTORNEY PARIS:

You're going to read it?

ATTORNEY SWEENEY:

Yes.

VIDEOGRAPHER:

5:00 p.m., off the record.

OFF VIDEOTAPE

ATTORNEY PARIS:

Let's get this on the record. You're going to read

the deposition, you're not going to waive signature. But I take it the expert will waive viewing of the videotape?

ATTORNEY SWEENEY:

We will.

* * * * * * * * *

VIDEOTAPE DEPOSITION CONCLUDED AT 5:00 P.M.

* * * * * * * * *

COMMONWEALTH OF PENNSYLVANIA)

COUNTY OF ERIE)

C E R T I F I C A T E

I, Shannon Fortsch, a Notary Public in and for the Commonwealth of Pennsylvania, do hereby certify:

That the witness was first duly sworn to testify to the truth, the whole truth, and nothing but the truth; that the foregoing deposition was taken at the time and place stated herein; and that the said deposition was taken stenographically by me and reduced to typewriting, and constitutes a true and correct record of the testimony given by the witness.

I further certify that the reading and signing of said depositions were (not) waived by counsel for the respective parties and by the witness.

I further certify that I am not a relative, employee or attorney of any of the parties, nor a relative or employee of counsel, and that I am in no way interested directly or indirectly in this action.

IN WITNESS WHEREOF, I have hereunto set my hand and stamp this 21st day of June 2002.

Shannon C. Fortsch

NOTARIAL SEAL
SHANNON C. FORTSCH, Notary Public
Cranesville Boro, Erie County, PA
My Commission Expires Feb. 9, 2006

MARY JANE MARTIN SMITH, RN,C, M.A., B.S.N.

216 Cherokee Road
Pittsburgh, PA. 15241
Tel: (412) 835-1657 FAX: (412) 835-1862
Email: mjsrnc@aol.com

EDUCATION:

Bachelor of Science in Nursing – University of Michigan, Ann Arbor, Michigan
Master of Arts in Higher Education; Minor in Nursing – University of Pittsburgh, Pittsburgh, Pa.
Completed course and examination requirements for PhD in Exercise Physiology – University of Pittsburgh, Pittsburgh, Pa.
Certification in Medical-Surgical Nursing – American Nurse Association

PROFESSIONAL EXPERIENCE:

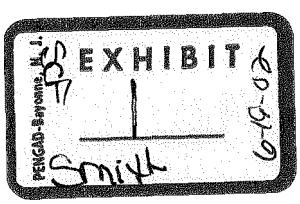
1968-Present **Professor of Nursing** and Faculty member, Community College of Allegheny County, Pittsburgh Pa.

- Responsible for clinical, laboratory, and classroom instruction of registered nurse students in an Associate Degree program in Nursing. **Clinical experience** includes cardiothoracic, orthopedic, trauma, neurologic and general surgery; care of patients with a wide range of medical conditions including infectious diseases and respiratory disorders; care of ventilator-dependent and tracheostomy patients; intravenous therapy and intravenous drug administration. 15 years experience in Maternity Nursing clinical and classroom instruction.
- Instruction of Registered Nurses in an RN. Refresher Program
- Classroom instruction includes intensive care nursing and care of patients with multi-system failure

1980-1987 **Home Health Coordinator and Supervisor,** Visiting Nurse Association of Allegheny County, Pittsburgh, Pa. (Part-time)

- Supervised registered nurses and home health aides; provided in-service education.
- Reviewed client information with physicians and obtained telephone orders; collaborated with interdisciplinary staff to provide continuity of care
- Provided home health care visit supervision as needed

1986-1988 **Staff Nurse, Temporary Staffing Agency** (Part-time)



1979-1986 **Consultant,** Applied Nursing Consultation and Educational Resources, Columbus, Ohio.

Presented workshops to hospital and nursing home employees on a wide Range of topics including gastrointestinal nursing, Pharmacology, Documentation, Professionalism and Crisis Intervention.

1966-1968 **Instructor,** St. Joseph's Hospital School of Nursing, Pittsburgh, Pa.

Responsible for clinical and classroom instruction in Maternity nursing and selected medical-surgical subjects

Staff nurse (part-time), St. Clair Memorial Hospital, Pittsburgh, Pa.
Instructor (part-time), St. Joseph's Hospital School of Nursing, Pittsburgh, Pa. Labor & Delivery and Postpartum Units

1959-1960 **Instructor,** St. Joseph's Hospital School of Nursing

1956-1958 **Staff nurse,** St. Clair Memorial Hospital, Pittsburgh, Pa.

RELATED EXPERIENCE:

1990-1991 **Acting Director of Nursing,** Community College of Allegheny County, Allegheny Campus

Responsibilities included interpretation of State Board of Nursing rules and regulations to the Department of Nursing faculty and college Administration; ensure and monitor faculty and program compliance with Pa. State Board of Nursing rules and regulations; and management of all department operations

1991-Present **Independent Legal Nurse Consultant**

Provide professional services to plaintiff and defense attorneys in medical malpractice, personal injury, and product liability cases. Services include record review and analysis of nursing care, preparation of chronologies and reports, assistance with depositions, and providing expert witness testimony.

CONFERENCE PRESENTATIONS:

1999 "Overview of Product Liability Issues." American Association of Legal Nurse Consultants, Pittsburgh Chapter.

1997 "Why Not Nurses As Experts? The Effect of *Flanagan v. Labe* on Testifying Nurse Experts." Eighth National Educational Conference, American Association of Legal Nurse Consultants, Pittsburgh, Pa.

1996 "Legal Issues for Nurses in a Changing Health Care Environment." Sigma Theta Tau, Pittsburgh, Pa.

1996 "Use of Unlicensed Assistive Personnel: A Nursing Perspective." Pennsylvania Nurse Association, District **Six** Annual Meeting, Pittsburgh, Pa.

"Flanagan v. Labe and John F. Kennedy Memorial Hospital: Nursing Commentary." Allegheny County Bar Association, Health Law Section, Pittsburgh, Pa.

"Why Not Nurses As Experts?' Pennsylvania League for Nursing, Annual Meeting, Pittsburgh, Pa.

1995 "The Nurse Expert in Trial." American Association of Legal Nurse Consultants, Pittsburgh Chapter, Panel Discussion

CONTINUING EDUCATION :

2001 "IV Amiodarone." Allegheny General Hospital In-Service, Pittsburgh, Pa.

"Shrinking Medication Errors Down To Size," The Nursing Institute, Springhouse, Pa.

"Delivering Safer Peripheral I.V. Therapy," The Nursing Institute, Springhouse, Pa.

"Wound Care Standards," AALNC 12th Educational Conference, Denver, Colorado

"Antibiotic Resistant Infections," Nursing Spectrum, Newark, New Jersey

"Caring for the Postanesthesia Patient," Nursing Spectrum, Newark, New Jersey

"Tnfectious Microbes and Diseases," Nursing Spectrum, Newark, New Jersey

"Comprehensive Disease Management of Patients With Asthma," Nursing Spectrum, Newark, New Jersey

"Rethinking Long Term Care," University of Pittsburgh Institute of Politics, Pittsburgh, Pa.

Nursing Education Conference 2001, Hahnemann University, Philadelphia, Pa.

2000 "Maximizing Your Research: What Makes A Good Source." American Association of Legal Nurse Consultants, Pittsburgh, Pa. (National Teleconference)

"Drugs and Devices Products Liability," American Association of Legal Nurse Consultants, Pittsburgh, Pa.

Annual Conference of Pittsburgh Chapter, American Association of Legal Nurse Consultants, Pittsburgh, Pa.

1998 "Infection Control – Standard Precautions." Allegheny General Hospital, Pgh., Pa.

"Assessment and Treatment of Adults Requiring Tracheostomy Care and Ventilators," National Rehabilitation Services Annual Conference, Pittsburgh, Pa.

"Occupational injuries, Repetitive Motion Injuries, and Carpal Tunnel Problems," American Association of Legal Nurse Consultants, Pittsburgh Chapter

"The Pathway To Trial: Preparation of Medical Malpractice Case," American Association of Legal Nurse Consultants, Pittsburgh Chapter

1997 "Critical Care Skills for Non-ICU Nurses," American Healthcare Institute

"Infusion Therapy: Latest Trends, Techniques, and Advances," American Healthcare Institute

1996 "Preventing Crises in Critical Care," American Healthcare Institute

"Cardiac Surgery," American Healthcare Institute

"Advanced Dysrhythmias," American Healthcare Institute

Annual Convention of The American Nurse Association, Washington, D.C.

Annual Nursing Symposium, University of Michigan School of Nursing, Ann Arbor, Michigan

1995 "Health Care Legal Issues," American Association of **Risk** Managers, Allegheny General Hospital, Pittsburgh, Pa.

"The Americans with Disabilities Act," Nursing Faculty Assembly of Community College of Allegheny County, Pittsburgh, Pa.

1994 Annual Medical-Surgical Conference, Mosby Co., Inc., Atlantic City, N.J.

1993 "Expert Testimony," American Association of Legal Nurse Consultants, Pittsburgh Chapter, Pittsburgh, Pa.

1992 Medical-Surgical Certification Review Course, The American Nurse Association, Washington, D.C.

1990 First Annual Conference on Interactive Video for Nursing Education, American Journal of Nursing, Pittsburgh, Pa.

Sportsmedicine Forum, Montefiore-University Hospital, Pittsburgh, Pa.

Conference on Medical and Nursing Informatics, American Association of Medical Informatics, Washington, D.C.

1989 "Interactive video in Nursing," Fuld Institute for Technology in Nursing, Athens, Ohio

1987 Annual Convention of The American Nurse Association, Louisville, Ky.

1986 Annual Nursing Symposium, University of Michigan School of Nursing, Ann Arbor, Michigan

1986 Annual Convention of The American Nurse Association, Anaheim, California

1983 Workshop on Advanced Fetal Monitoring, Provincetown, Massachusetts

1982 NAACOG Section Conference, "Obstetrics, Gynecologic, and Neonatal Nursing," Pittsburgh, Pa.

PUBLICATIONS:

2000 "Overview of Medical Devices." (2000, April). The Journal of Legal Nurse Consulting, 11 (2).

"Pharmacological Update 11-Antimicrobial Agents" (2000, January). The Journal of Legal Nurse Consulting, 11(1), 22-23;25.

1999 "Pharmacological Update: New Medications and the Preventable Adverse Drug Events Initiative" (1999, October). The Journal of Legal Nurse Consulting, 10(4), 22-24.

"Advances in Diagnosis and Treatment" (1999, July). The Journal of Legal Nurse Consulting, 10(3), 20-21.

"Fetal Tissue Transplantation for Injured Spinal Cords" (1999, April). The Journal of Legal Nurse Consulting, 10(2), 24-25.

"Minimally Invasive Surgery" (1999, January). The Journal of Legal Nurse Consulting, 10(1), 22-23.

1998 "Is It Time for a Change in State Nursing Licensure Statutes?: Lessons from *Flanagan v. Labe*" (1998, April). The Journal of Legal Nurse Consulting, 9(2), 2-5.

" Legal Issues in Community Health Nursing," in Community Health Nursing for Associate Degree Nursing Programs. Ed. Ayers, M., Langford, M. and Bruno, A. St. Louis: C.V. Mosby Co., 1998.

1996 "Assignment Despite Objection" (1996, Fall). Linc, 4 (2). 2-3.

1994 "Why Not Nurses As Expert Witnesses?" (1996, Feb.26). Pennsylvania Law Weekly, (19 PLW 262).

"Using AHCPR Clinical Practice Guidelines in Legal Nurse Consulting" (1995, Fall). Linc, 3(1), 1-2.

1981 "Critical Care Nursing; **of** Patients with Acute Gastrointestinal Problems" (1981). Applied Nursing Consultation and Educational Resources (teaching module).

ADDITIONAL PUBLICATION EXPERIENCE:

2001 Columnist, "New Medical Therapies and Devices," The Journal of Legal Nurse Consulting;.

2000 Columnist, "References and Resources," The Journal of Legal Nurse Consulting.

1997-00 Member, Editorial Board, The Journal of Legal Nurse Consulting.

2001 Editor, "Failure to Diagnose Myocardial Infarction," Case Studies. American Association of Legal Nurse Consultants.

1993-96 Contributing Editor, Linc. (Monthly newsletter of the Pittsburgh Chapter, American Association of Legal Nurse Consultants.

HONORS AND AWARDS:

1999 Recipient of Teaching Excellence Award, Student Nurse Association of Pennsylvania, Community College Chapter.

1996 Recipient of Teaching Excellence Award, Student Nurse Association of Pennsylvania, Community College Chapter.

1990 Recipient of Educational Foundation Grant, Community College of Allegheny County

Recipient of IBM Scholarship to the National Center for the Improvement of Teaching And Learning, University of Michigan

1989 Selected as Proposal Reviewer, Corporation for Public Broadcasting/Annenberg Foundation – Distance Education Project

1989 Selected as Focus Group Participant, IMED Corporation

1987 Recipient of Teaching Excellence Award, Community College of Allegheny County, and selected to attend "Great Teacher's Conference," Lake Geneva, Wisconsin

1985 Awarded Cardiac Rehabilitation internship, Allegheny General Hospital, Pgh., Pa.

MEMBERSHIPS:

- Sigma Theta Tau, National Honor Society in Nursing
- National League of Nursing
- University of Michigan Nursing Alumni Association
- American Association of Legal Nurse Consultants

Pennsylvania License: RN 122810

ANA Certification : 240958-04
Re-certification 9/00 – 8/05

FEE SCHEDULE

Professional Services:

Review of records, research, verbal and written reports, depositions, trial preparation, court testimony, interview clients and potential witnesses, assist with independent medical exams, assist in preparation of interrogatories, assist in preparation of courtroom exhibits.

Fees:

For litigation support - (all services listed except deposition and court testimony) - $100.00 per hour plus actual expenses

For deposition and court testimony - $125.00 per hour plus actual expenses incurred, including mileage at $0.31/mile, parking, road tolls, telephone toll charges, photocopy and FAX charges. Out of town travel expenses include transportation, lodging and meals.

Terms:

Fees for completed reports to be paid prior to deposition or court testimony

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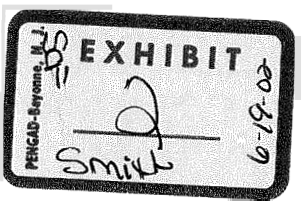
Mary Jane M. Smith, RN,C

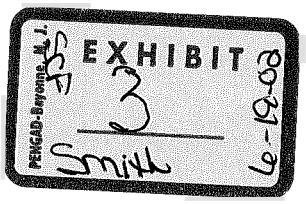
Federal ID #194260438



R.N. CONSULTING
216 Cherokee Road • Pittsburgh, PA 15241 • 412-835-1657 • FAX 412-835-1862

Donald H. Switzer, Esq.
Bonezzi Switzer Murphy & Polito Co., L.P.A.
Attorneys at Law
Leader Building, Suite 1400
526 Superior Avenue
Cleveland, Ohio 44114-1491

May 6,2002



RE: Swift v. Ashtabula County Medical Center
File No.: 220023

Dear Mr. Switzer,

At your request, I have reviewed documents relating *to* a claim that has been made by John L.Swift, Executor of the Estate of Sharon Swift against Ashtabula County Medical Center et al. You have asked me to render an opinion regarding the nursing care provided to Sharon Swift at Ashtabula County Medical Center on June 15,2000 and June 16, 2000. In my evaluation of this case, I reviewed copies of the following documents:

- Ashtabula County Medical Center medical records of Sharon Swift dated June 15,2000 and June 16,2000
- Deposition transcripts of Ashok Kondru, M.D. dated 11/16/01; James Chilcott, M.D. dated 12/4/01; Noreen Petrochello, R.N. dated 12/28/01; Laura L. Wilson, R.N. dated 1/15/01; Patricia Anderson, R.N. dated 12/28/01; Barbara J. Berry, R.N. dated 1/9/02; Renee Greuning dated 12/19/01 ; Robyn Buki dated 2/15/02; Tracy Swift dated 2/15/02; Dawn Phillips dated 12119/01
- Ashtabula County Medical Center Nursing policies: Pancreatitis, Sepsis, Vital Signs, Nursing Documentation, Restraint/Seclusion, Cognitive Impairment, and Notifying Physicians on Off-Shifts
- Reports of Mark Birns, M.D. dated 2/22/02; Neil Crane, M.D. dated 1/27/02; Vicki Turner, R.N. dated 2/18/02; Elizabeth Wolfe, R.N. dated 3/8/02

Plaintiff's experts claim that the nursing care provided to Sharon Swift fell below the standard of care in numerous ways, Specific allegations include failure to contact Ms. Swift's physicians by 4:00 p.m., failure *to* review the chart, failure to chart contemporaneously, and failure to inform the medical consultant of the need to see Ms. Swift sooner. Additionally, plaintiff's nurse experts claim that nurses deviated from the

standard of care by failing to inform the physician and supervisor of need for restraint use, failure to notify the physician of abdominal distention, "new onset" restlessness, and abnormal vita! signs, failing to adequately take and document vital signs, failing to measure abdominal girth, failing to have arterial blood gases drawn "stat," and failing to administer antibiotics in a timely manner. Dr. Wolfe also opines that Ashtabula County Medical Center deviated fkom the standard of care by failing to have a restraint policy in compliance with HCFA May 2000 Guidelines.

BACKGROUND

Sharon Swift age 67, was admitted to Ashtabula County Medical Center on June 15,2000 through the Emergency Department. On arrival, she complained of severe, constant epigastric pain radiating to her shoulders and back. Blood pressure was 132/95, pulse 90, respirations 24, and temperature 98.4. Past medical history was significant for Diabetes Mellitus and Reflux disease. Electrocardiogram was abnormal with anteroseptal Q waves and poor "R" wave progression. On exam, her abdomen was tender with guarding and decreased bowel sounds. Nurses administered Demerol and Phenergan at 2:20 a.m. and 3:30 a.m., Dilaudid at 2:45 a.m., Morphine Sulfate at 3:00 a.m. and 3:35 a.m., and Nitroglycerine at 3:00 p.m. as ordered. Testing revealed elevated amylase and CK. The physician diagnosed acute pancreatitis and Ms. Swift was transferred to the general nursing unit at 4:20 p.m.

Physician admission orders at 3:35 a.m. included nasogastric tube to suction, intravenous fluids, Demerol and Phenergan as needed, CT in the a.m. and consultation with Dr. Kondru. At 7:10 a.m., the physician telephoned an order for anesthesia consult to start PCA pump with Morphine Sulfate. Vital signs at 8:00 a.m. were temperature 98.4, pulse 118, respirations 40, and blood pressure 212/80. The nurse's late entry note states that Ms. Swift was very restless and moaning. At 8:35 a.m. on June 15, Ms. Swift's physician visited and assessed her condition. He noted she was pale, in "marked distress" with severe abdominal pain despite receiving Demerol, and that her abdomen was diffusely tender with guarding. **Me** noted that her N/G tube was repositioned due to nausea and vomiting. The physician ordered IV fluids increased, telemetry, and oxygen at 2 l./min. The records show that anesthesia service telephoned orders for Morphine boluses and PCA increases at 10:30 a.m. and 4:30 p.m.

According to the records, vital signs were measured at 12:00 p.m., revealing temperature of 100.3, pulse 114, respirations 28, and blood pressure 137161. During the day, Ms. Swift reported her pain levels at 9:00 a.m. as **"6,"** 9:30 a.m. as "4," and at 10:00 a.m., 11:00 a.m., 12:00 p.m., and 2:00 p.m. as a "5" with blood pressure ''within normal limits." CT was delayed until mid-day due to vomiting and Ms. Swift's inability to tolerate the contrast until 11:00 a.m. At 1:00 p.m., Ms. Swift returned from CT and was noted to be restless and moaning. At 3:00 p.m. and 4:00 p.m., pain level had increased to "7" and the nurse again called anesthesia. An additional bolus was ordered and given at 4:00 p.m. Heart rate then was 114 with respirations recorded as 20. The nurse's documentation states that the pain medication quieted Ms. Swift until 5:00 p.m. when the

patient was observed pulling at her tubes. The nurse applied soft wrist restraints and following repositioning, the N/G tube drained pink fluid.

Between 9:00 p.m. and 10:00 p.m., the gastroenterologist examined Ms. Swift. He ordered the nurse to prepare Ms. Swift for an emergency ERCP which was performed at 10:38 p.m. Following ERCP, blood pressure was 108/49, pulse 128 and oxygen saturations 88% on 7 liters of oxygen. At 11:45 p.m., Ms. Swift was transferred back to the nursing unit. At 12:00 a.m.on June 16, the nurse's assessment reveaied that Ms. Swift's condition was worsening. Blood pressure dropped to 90/48, heart rate increased 10 133-140, temperature was 102, and respirations 40 with oxygen saturations decreased to 81% on oxygen, The nurse paged the gastroenterologist at 12:15 a.m. and at 12:40 a.m. to report her deteriorating status. At 1:05 a.m., the gastroenterologist and consulting intensivist assessed Ms. Swift and ordered transfer to intensive care.

Throughout the day on June 16, Ms. Swift's condition failed to improve, Temperature increased to 103.8, respiratory rate and heart rate increased and blood pressure and urinary output decreased despite multiple medical and nursing interventions. At 8:22 p.m., Ms. Swift died. Final diagnoses were septicemia, septic shock, acute pancreatitis, and acute renal failure.

FINDINGS

In general, the nursing care provided to Sharon Swift at Ashtabula County Medical Center on June 15 and June 16 complied with nursing standards of care and accepted practice. My opinion is based on the following:

1. Communication with physicians was generally appropriate. The records show that nurses telephoned Ms. Swift's physician at 7:10 a.m. on June 15 and that they called anesthesia service several times when they observed that pain medication was not effective. Nurses were not required by the standard of care to initiate contact with physicians concerning vital signs or restlessness. According to the records, Ms. Swift had been restless since admission with vital signs within normal limits for a patient with acute pancreatitis, except for the findings recorded at 8:00 a.m. when nurses were attempting to reposition her nasogastric tube and she was experiencing significant discomfort.

   Based on the records, it is my opinion that the standard of care required the nurse to initiate contact with Ms. Swift's physician on or around 5:00 p.m. on June 15, but not before. At 5:00 p.m., the nurse knew that Ms. Swift's condition was not improving, that she continued to experience significant pain, that the CT results were available, and that she had not been evaluated by a physician since 8:35 a.m. At 5:00 p.m. or soon after, the nurse should have contacted Ms. Swift's primary physician to update him on her status and inform him that the consultant had not visited. In the alternative, the nurse could have paged the consultant in the hospital to determine when his visit was planned and to inform him of her condition.

2. Nurses are not required by the standard of care to review the patient's chart. It is standard practice for nurses to become knowledgeable about the patient's condition primarily by reviewing the kardex and listening to shift report. The nurse may and often does, review portions of the chart during the course of her shift but is not required to do so as a routine matter.

3. According to Ashtabuia County Medical Center's documentation policy, "late entries" made in the chart by nurses are permitted. This policy does not contradict charting standards of care and failure to chart contemporaneously is not a violation of the standard of care.

4. It is clear from the record, that the nurse placed soft wrist restraints on at 5:00 p.m because she believed that Ms. Swift was in imminent danger of pulling out her tubes if she was not restrained. Under these emergency circumstances, the nurse was not required to request a physician's erder prior to placement. The nurse would have been required to contact the physician to obtain an order for continuation of the restraints within the time period stated in the hospital's restraint policy that was in effect in June 2000.

   Publication of the HCFA May 2000 Guidelines would have preceded this incident by less than one month. I am not aware that all health care institutions would have been required to have an institutional policy developed that was consistent with the new guidelines by June 15,2000.

5. The timing of arterial blood gas draws and administration of ordered antibiotics is dependent on multiple factors that may not be w i t h the nurse's control. It appears the antibiotic in this case was ordered just prior to transfer of Ms. Swift from the nursing unit to the procedure area for the ERCP and thus, it would not have been available for the nurse to give before the procedure. Additionally, the antibiotic was apparently delivered to the nursing unit after Ms. Swift was transferred out to the intensive care unit and then had to be delivered from the unit to intensive care. The nurse would also have been dependent on the availability of personnel in the Pharmacy to prepare and deliver the drug.

In summary, it is my opinion within a reasonable degree of professional certainty, that there were no significant changes in Ms. Swift's condition that required the nurse to notify the physician prior to 5:00 p.m. on June 15. Of note, Ms. Swift's daughter who is an intensive care nurse, testified that she saw her mother at 6:30 p.m. and did not believe it was necessary to call a physician at that time.

If further information becomes available, I request the opportunity to respond.

Sincerely yours,

Mary Jane M. Smith

Mary Jane Martin Smith, RN,C, MA, BSN

ASHTABULA COUNTY MEDICAL CENTER
Department of Nursing

POLICY: Restraint/Seclusion for Behavioral Health Reasons in Non-Behavioral Health Care Settings

The use of restraint or seclusion for behavioral health reasons is limited to situations in which there is an imminent risk of a patient physically harming himself or herself, staff or others, and nonphysical interventions are not effective. Restraint or seclusion may not be used as coercion, discipline, convenience, or retaliation by staff. Patients may not be restrained or placed in seclusion based solely on a history of dangerous behavior or prior use of restraint/seclusion.

DEFINITIONS

Behavioral health reasons: The purpose of restraint or seclusion is to protect the patient from injuring themselves or others **DUE TO AN EMOTIONAL OR BEHAVIORAL DISORDER**, when the patient is receiving medical or surgical care in other than the psychiatric unit. ***WHEN THE PRIMARY REASON FOR RESTRAINT IS TO SUPPORT MEDICAL HEALING, REFER TO POLICY "USE OF RESTRAINTS-ACUTE MEDICAL AND SURGICAL".***

Seclusion: Involuntary confinement of an individual in a LOCKED room.

PHYSICIAN ORDERS

A. A time limited physician order is required for the use of restraint or seclusion. Orders for restraints or seclusion are limited to:
   - 4 hours for patients ages 18 and older;
   - 2 hours for children and adolescents ages 9 to 17; and
   - 1 hour for children under age 9.

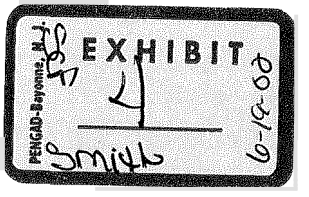
B. **Standing orders and PRN orders are not permitted.**

C. Qualified registered nurses are authorized to initiate the use of restraint or seclusion **before a physician** order is obtained. As soon as possible, but no longer than one hour after the initiation of restraint or seclusion the nurse must notify and obtain an order from the physician. The nurse will consult with the physician about the patient's physical and psychological condition.

D. If restraint or seclusion needs to continue beyond the expiration of the time limited order, a NEW order must be obtained from the physician.

E. Restraint or seclusion will be discontinued as soon as the patient meets the behavior criteria for its discontinuation.

F. If restraint or seclusion is discontinued before the time-limited order expires, the **ORIGINAL** order may be used to reapply the restraint or seclusion if the patient is at imminent risk of harming himself or herself or others and nonphysical interventions are not effective. When the original order expires, a NEW order must be obtained from the physician.



IN-PERSON EVALUATION BY THE PHYSICIAN

A. A physician must see and evaluate the patient in- person within one hour of the initiation of restraint or seclusion.

B. A physician must conduct an in-person RE-EVALUATION at least every eight hours for patients ages 18 years and older and every 4 hours for patients ages 17 and younger.

RE-EVALUATION OF THE PATIENT IN RESTRAINT OR SECLUSION

A. The physician will give a NEW written or verbal order if the restraint or seclusion is to be continued. The patient will receive an in-person re-evaluation by the physician or qualified RN by the rime the order expires. These orders will be limited to the following time frames:
- 4 hours for patients ages 18 and older;
- 2 hours far children and adolescents ages 9 to 17; and
- 1 hour for children under age 9.

B. If restraint or seclusion is continued, and the order is given by a physician who is NOT the patient's physician, the patient's physician will be notified of the patient's status.

C. Re-evaluation of the patient will occur every:
- 4 hours for patients ages 18 and older;
- 2 hours for children and adolescents ages 9 to 17; and
- 1 hour for children under age 9.

PATIENT ASSESSMENT

A. A staff member, who is trained and competent to do so, will assess the patient at the initiation of restraint or seclusion and every IS minutes thereafter. This assessment will include, as appropriate to the type of restraint or seclusion utilized:
- Signs of injury associated with the application of restraint or seclusion;
- Nutrition/hydration:
- Circulation and range of motion in the extremities:
- Vital signs;
- Hygiene and elimination:
- Physical and psychological status and comfort: and
- Readiness far discontinuation of restraint or seclusion.

PATIENT MONITORING

A. A staff person, who is trained and competent to do so, will monitor the patient through continuous in-person observation.

B. After the first hour, a patient in seclusion ONLY may be continuously monitored using simultaneous video and audio equipment, if consistent with the patient's condition or wishes.

STAFF EDUCATION AND COMPETENCY

A. Education for care providers will be included in orientation, annual updates and competency assessment. Education will include:
   - Protecting and preserving the patient's rights, dignity and well-being during use;
   - Use is based on the patient's assessed needs;
   - Least restrictive methods;
   - Safe application and removal;
   - Monitoring, reassessment, and meeting patient's needs;
   - Risks associated with vulnerable patient populations (emergency, pediatric, cognitively or physically limited patients);
   - Requirements associated with physician orders;
   - Documentation of restraint episodes.

<BHRrestraint>

CD
Effective **dare:** June 1, 2001

6025 3 473A

Ashtabula County Medical Center
Restraints/Seclusion Progress Notes

Initial Date & Time Restrained/Secluded | Date & Time Physician Notified | Removal Date and Time

Was patient examined? ___ Yes ___ No | Contusions Found (Specify) | Type of Restraint

Intervention(s) Tried Prior to Restraining/Seclusion (check all that apply)

___ 1 Talking client down/allowing to ventilate (verbal techniques, relaxation techniques).
___ 2. Involving client in a different activity, diverting client's attention from present upsetting situation
___ 3 Removing client from the area (e.g., asking them to go to their room).
___ 4 Reorient and familiarize with surroundings
___ 5 Other (please specify) _____

Reason for Type of Restraint (give full description of client's behavior)

_____

_____

Patient/Family Education Provided

___ Need for restraint explained
___ Assured least restrictive device used
___ Restraints will be removed as soon as possible

Response:

___ Verbalized understanding
___ Indicates understanding by shaking head yes
___ Other _____

Signature & Title of Person Completing This Section | Date | Time AM PM

OBSERVATIONS

___ Restraint ___ Mechanical Support

Record observations at least every 15 minutes if client restrained or secluded. Release restraints and reposition client at least every two hours. Record observation for mechanical support at least every two hours. Record intake and output.

Time	Initials &	15-Minute Observations	Intake	Output	Vital Signs	Circ ✓'s	Rom	Seclusion	Restraints (Wrist)	Restraints 2pt	Restraints 3pt	Restraints 4pt	Progress notes (mental status behavior needs care given-food, bathing, toileting, phone calls smoking etc.)
7 30 A													
45													
8 00													
15													
30													
45													
9 00													
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Patient's behavior that warrants restraint/seclusion removal: _____

Date/Time _____

Initials and Signatures

Aaaressograph