XXX

DEPOSITION SUMMARY OF XXX

APRIL 7, 2017

Venue: 310 South Lake Drive, Prestonsburg, Kentucky

Counsel for the Plaintiff: AAA, Esq

Counsel for the Defendant, ______: BBB, Esq

Counsel for the Defendant, Ohio ________: CCC, Esq

Videographer: Heath Elsensohn

Court reporter: Tamela T. Lewis, CCR

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	Examination by Ms. Spurgeon	
04:06 – 07:25	XXX was duly placed under oath, examined and deposed as followed. XXX stated her full name in the court and she was single. She was born and raised in Prestonsburg. She had lived in Floyd county for her entire life. Her parent's names were Harvey and Margaret Bays. Her father worked in the construction and her mother worked as a cook in the school system. She has two brothers and they were Harvey L. Bays and Tommy Ray Bays. They also lived in Floyd County. She added that neither of them was married. She also one cousin sister named Sammie Kay Bays who also lived in Floyd County. She attended church at the Christ United Methodist Church in Allen, Kentucky. Her current address was Route 1428, Prestonsburg which was between in Prestonsburg and Allen in Kentucky. She completed Bachelor's in nursing. She obtained her associate degree in nursing at the Prestonsburg community College at the time 1975. After her associate nursing graduation she worked for a period of time at the Highlands Regional Medical Center	XXX introduction, her family details and her educational background
08:01 – 11:25	As a charge nurse she began working at the telemetry department which was in the fourth floor of the hospital. She worked until '94 after which she went to persue her bachelor's in nursing. She worked on the postsurgical unit as a relief charge nurse as she transitioned to day shift. In 1980 she became the clinical manager of med/surg and pediatrics. At the Highlands Regional Medical Center she also worked at the Nursing administration and became the director of the nursing operations in the year 2000. As a clinical risk manager at the hospital she performed some of the duties of that role in which she collected the occurrence reports and aggregate the data on the non medication occurrence reports. If any manager had any doubts, they would consult her in that role and ask for her advice in any situation. She explained that when an occurrence report was completed, it was submitted to either the manager or the house director. After 3:00pm it would eventually	Her service at the Highlands Regional Hospital Her duties as clinical risk manager Her involvement in the patient safety committee

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	end up in her desk. She had to make sure that they go to the appropriate discipline that would need to respond to that. Then once they were completed and addressed with the employee they would come back to her. She continued that if it was a medication occurrence, then she would make sure that that was routed to the pharmacy or pharmacist, because that was their area of expertise. If it was a non medication occurrence then she would review it and the manager would sign off the response. Every month she would aggregate that data and report it to the patient safety committee. In March 2015 she did serve the patient safety committee. She was on physical environment committee, infection control, emergency preparedness pharmacy and therapeutics. Whenever there was a decision to be made in the committee, she mentioned that it was always a collaborative response and not on voting basis. Currently she was in the patient safety committee.	
12:01 – 15:25	The representative from administration was Susan Ellis and from the pharmacy it would be the director of pharmacy or the clinical manager the member of the committee. The director of safety Kevin Tussey was also in charge of the physical environment. There was a discussion about the nursing operations and the organizational structure at Highlands. As on March 2015 XXX was directly reporting to VP of the nursing that was Susan Ellis. She added that the clinic managers or directors of the departments also report directly to Ms. Ellis. Also in March 2015 the house directors were the one who reported to her. She explained the role of the house director was to oversee the day-to-day staffing for that current shift that they were on. They serve as a resource to the other nurses. They respond to emergencies and crisis management. They coordinate with other facilities as far as transfers or receiving a patient, and they were involved in sending records to other facilities after hours. During March 2015 the house director would have been VanHoose. Until 03:00pm the mangers of the department fulfill those roles and handling issues on their own. After 03:00pm a house director comes in duty.	The members of the patient safety committee The duties of house director
16:01 – 19:25	The house director would be from 03:00pm until 07:00 am the next morning. The house directors in 2015 were VanHoose and Shirley Neice. If the department manger was absent, then they would make arrangements with another nurse manager to cover for them on that given day. On March 2, 2015 Richard Pinson was off or not working in the ER. He was the director of the emergency department, the nurse director. When the manager was absent, he would usually substitute someone else for his position for the day and this was not usually documented. The nurse mangers do not clock in or out. When the nurse manager would be on leave he would have to notify the VP about the date of absence. This would be in verbal only which usually occurred in the meeting that would happen in the evening before they left.	The house directors and the nurse manger on the day of incident
20:01 – 23:25	XXX explained that in the mornings there would be a discussion about the bed availability and anticipated discharges for the day. Then in the evening there	The director of the nursing operations

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	would be a meeting about what work need to be done further. These meetings usually take place right outside her office which was located in the second floor. Her office was adjoined to the house director office. The quality department consists of performance improvement director Tanya Slone and Rebecca Osborne who was the social worker in that suite also. The role of the performance improvement director was to do reviews and oversee the quality. They review various processes, documents, charts and also keep data both for physicians. They maintain score card of quality indicators for various diagnoses. The information in the score card was related to information from the emergency department. As a director of the nursing operations, XXX was involved in investigations when an issue or a concern arises regarding a nurse's performance. She mentioned that she was aware that Rich Pinson did investigate the nurse involved in the administration of the promethazine to Geneva Jude on March 2, 2015. XXX was not directly involved in the investigation and added that if any issue was ongoing and a trend was being followed that created a problem, then she would be involved. If the investigation involved an individual, then that can be solved by the nurse manager it self	office Involvement of XXX in the case that occurred on March 2, 2015 Involvement of XXX in investigations
24:01 – 27:25	XXX added that Rich did make her aware of the problem verbally that he spoke to the nurse and did coaching for her. This conversation was no documented. She did not have any independent recollection of the information that Mr. Pinson provided to her regarding Martha Brooks. All that XXX could recall was that after the day of investigation, Rich informed her that he was going to talk to her and do a coaching and she was early in her employment in the ER. XXX described that it was usually the director of the unit of the emergency department who would have had to document such incident occurrences and corresponding investigations. She was not aware if Rich Pinson was fired from any other hospitals and was hired there by Susan Ellis. She had known Rich before when he was the LPN in the critical care for many years. As per the standard picture, XXX mentioned that Rich should have been interviewed before getting hired. Rich spoke to XXX about the events that occurred regarding Geneva Jude the next day after the incident. XXX still maintained her nursing license in the State of Kentucky. She mentioned that if she felt that there was a nurse that violated a practice intentionally or intentionally did harm then it would be reported. She added that she would have reported if a nurse falsified a medical record also. If there was a decision to report a nurse to Kentucky Board of Nursing, that would be the VP of the patient care in conjunction with the HR director.	XXX interactions with Rich about the incident involving the nurse and Geneva Jude. Documentation of the incident
28:01 – 31:25	XXX was not aware if there were any reports regarding any of the events that occurred with Martha Brooks from the time that she was hired in 2015 until the time she was terminated in the 2015. During Martha's employment XXX was also not aware if there were reports submitted to the Kentucky Board of Nursing	Details about Martha's employment in the Highlands and her

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	in terms of any issue. XXX was however aware that Martha Brooks was terminated from Highlands Regional Medical Center. She added that on the day of the incident (March 2, 2015), there was a complaint from the patient and also from the public relations. Later that afternoon the patient advocate had notified her on that day afternoon. She had known that the issue was with the administration of the promethazine only in the afternoon after the patient left the facility. Event though being in the administration department, XXX does consider herself as a nurse also. She agreed that as a nurse the patient's safety was important first. The patient has the rights to be advised of the adverse patient outcomes when they come to that hospital. When an error occurs regarding the patient's treatment within the facility, the patient does have a right to know the potential harm that had occurred.	termination
32:01 – 35:25	XXX mentioned that Geneva had already left the facility, by the time she had reviewed the medical chart of her health condition. She commented that all the charts had telephone numbers of the patients in them, but she did not specifically look into the one that belonged to Geneva. As a nurse she commented that Promethazine was a high-alert medication and there were ill effects that could occur with it. Prior to her reviewing Ms. Jude's chart she knew that the patient had a complaint and that the patient advocate went to take her complaints. Ms. Jude was in emergency room and XXX was in the second floor on the day of incident. XXX explained that she was not directly involved Ms. Jude's care. She knew that there was a complaint and the patient advocate had gone to talk to her about the complaint. She was notified by Susan Ellis that she had gotten a call from Donnie Pennington that there was a patient complaint and she was just only communicating to her, thereby XXX would be aware in the case. Susan mentioned that she had informed the patient advocate to handle the complaint. At that time Susan did not inform or discuss anything about the promethazine with XXX. Susan had informed XXX that she had notified Maxanna Bennett the public relations patient advocate to take care of the problem.	The information of the complaint of Ms. Jude XXX received on the day of incident from Susan
36:01 – 39:25	In March 2015, XXX was the director of nursing operation and she received a call from the vice president Susan Ellis about a complaint by a patient regarding a nurse and she had notified the patient advocate to check on the complaint. XXX personally did not question or ask in detail about the complaint. On the day of the incident after she was informed, she neither went to the ER to check on the patient nor she commincated to Donnie Pennington about the case. She did not do so as she was not informed or there was no indication that there was any danger or any issue that required the involvement of her at that time. She did neither call unit shift supervisor to check on the complaint as there was no indication for her to do so. XXX commented that Mr. Pinson was off on the day of incident and she had	The discussion of complaint with Susan and XXX. Her necessary actions after she had known about the complaint

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	known this from the records she reviewed for the deposition. She also reviewed some policies and procedures about the high alert medications. She reviewed Martha's documentation, the clinical note that was prepared by her on the day of incident. XXX was shown a copy of the printout of the Pyxis machine regarding the medications removed by Martha.	
40:01 – 43:25	The print out of Pyxis Machine, XXX reviewed it only the day before the deposition and the clinical note by Martha was reviewed on the afternoon of the day of incident. She mentioned that after the review of the Martha's note, she felt that it was the adverse effect of promethazine to have a burning effect after the administration. She did not do anything after the review of the record as she felt that it was common to have burning and pain with the administration of that medication. She added that in the note, the patient was yet under the care of the provider. The provider encouraged the patient to stay back for further monitoring and cold compress was applied for the patient. As a part of her role, it was not her duty to call Ms. Jude and enquire about her conditions. The corresponding medical provider would have managed her care and had given her instructions. Even though she had the authority to the call and check on the patient, she felt that the patient was being managed appropriately by the provider. She did not have the authority to manage her care.	The print out of Pyxis Machine and the clinical note of Martha about the incident
44:01 – 47:25	XXX was not aware if there were any calls to Mr. Pinson regarding this incident. XXX did not see any documentation where it was mentioned that anyone advised her of the potential outcome or injury that may have occurred as a result of the medication administered. She neither spoke to Rich Pinson nor to Donnie Pennington on the day of the incident. Mr. Pinson had spoken to her in her office the next day. He mentioned he was going to investigate and talk to Ms. Brooks collect the details and planned a coaching for her. The falsification of a medical chart grounds to immediate termination at Highlands Regional. XXX mentioned that it was one of the nurses' duties to be truthful and honest when providing patient care. She had the access to the ER charts and the in-house patient charts. She had the DBA access and commented that any nurse had the ability to edit their notes or make changes in the notes. However there was a trial that would show that they made that modification. When someone made an edit or a change in medical chart the metadata would read as modified	The discussion of the incident with Rich Pinson and the action he was going to take against Ms. Brooks The editing ability of the clinical notes by the nurses.
48:01 – 51:25	XXX mentioned that she was not aware who else had the administrative access into patient's medical record other than her at the Highlands Hospital. When one was accessing the patient's chart they have to go through the Cerner system to access the chart as there was no other way to access it. XXX did not know what maintain encounter in the metadata of patient's medical chart meant. XXX did not personally interview Martha Brooks and it was the sole responsibility of Rich Pinson. The day after the incident Rich came in person to her office and told that he was going to investigate and do a coaching with her. XXX added that Rich was going to get more details of the incident and he	XXX's level of involvement in the investigation of Martha Brooks

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	certainly had the opportunity to change the plan if he chose to. There were a multiple meeting with Rich on the same day, but all of them were not formal nor were they documented. XXX explained that she did not keep any documentation of such an incident, as it was the duty of the respective managers to do so. There was no requirement in her job description that she had to maintain a formal record of every advice or every encounter that she had with someone in she might render advice.	
52:01 – 55:25	She continued that if she was personally involved in the investigation, then she would document the incident. The patient safety committee met once in every month. XXX was not aware if there was any occurrence report completed by anyone in regards to the incident of Geneva Jude and medication error that occurred on March 2, 2015. On the request of Cheryl Blair, she did check to find out if there was any such report created on such incident. She had known that the incident involved a medication error when she had met Rich Pinson after the incident day. So based on policies and procedures at Highlands Regional Medical Center, there should have been an occurrence report created. XXX repeated that as a director she was only the collector of the occurrence reports and it was not her duty to monitor whether such reports were created and documented after every incident. She added that when Rich had come to her office and discussed about the Ms. Jude's incident she was in the understanding that the report was created already. She had neither had asked Rich if the report was completed.	
56:01 – 59:25	The patient safety committee they would not have addressed one single nurse's performance. They would address aggregate data that has been collected over time and trends that have been identified and issues. If in an incident, harm was done to the patient then it would have been addressed in the patient safety committee. However in this incident Ms. Jude was administered Phenergan and the adverse effect of this drug was burning effect which the patient suffered, therefore they did not address this as an issue. XXX explained that they cannot determine the outcome of the adverse effect of every medication that has been administered to each patient in the hospital. They usually are not known that the patient would have suffered the adverse effect of the medicine until there has been a lawsuit. Therefore it was her testimony that Highlands Regional had no knowledge regarding the outcome pertaining to Geneva Jude until the receipt of the lawsuit. XXX had not seen the photographs of the Ms. Jude's hand and neither she was aware that Ms. Jude had to undergo several amputations following her ER visit at Highlands Regional Medical Center on March 2, 2015. There was a request for documents from the risk management coordinator there by XXX had known that there was a lawsuit signed for this case.	The justification for why this incident was not addressed in the patient safety committee
60:01 – 63:25	XXX mentioned that as a part of the investigation, they would continue to track and trend to see if there were any other such issues. However in this incident, it	The occurrence report of Ms. Jude

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	was determined that the information was there on the how to correctly administer the medicine in the medication order. XXX had addressed the point that no occurrence report was made even though the policies and procedures required an occurrence report to be completed. She did not address the medication error that occurred on March 2nd 2015 to the pharmacy and therapeutics committee. She added that the adverse effects of the drugs which would create severe harm to the patients should be addressed to the FDA, by the director of the pharmacy and it was his duty to make such reports. However XXX was unaware if there was any such report created for the Ms. Jude's case. XXX had not reviewed any of the Ms. Jude's prior medical records and neither had she requested any report to be generated pertaining to Ms. Jude.	and the issue reported to the FDA regarding the adverse effect of the drug
64:01 – 67:10	XXX was not involved in the termination of Martha Brooks. XXX had known that there was a progression she let go and there were some other errors. She could not specifically recall what medication errors were or the occurrences that might have led to it. She had seen the timeline only the day before the deposition. She was not aware if those medication errors were reported by the hospital to the Kentucky Board of the Nursing. XXX justified that it was only an error done by Martha by not being complaint to the mediation order in terms to administer the medication. Martha did not have any willful intent to harm the patient, thereby it to be considered as a violation from the standard of practice. When Rich met XXX in person after the incident day, he did not discuss anything about the Martha's job performance prior to this event. However Rich Pinson was yet employed at the Highlands. The deposition concluded at 12:52pm	XXX's justification for Martha's error and violation from the standard of practice