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**COURT OF APPEALS, DIVISION III
OF THE STATE OF WASHINGTON**

COURT OF APPEALS
DIVISION III
STATE OF WASHINGTON
By _____

**PAMELA CLONINGER, individually, and as Personal
Representative of the ESTATE OF GLEN CLONINGER; BROOKE
CLONINGER, individually; BLAKE CLONINGER, individually;
BRITTNEY CLONINGER, individually,**

Appellants,

v.

**KIM CHEN, D.O and JANE DOE CHEN, husband and wife;
ANESTHESIA ASSOCIATES OF SPOKANE, P.S.; and
DEACONESS MEDICAL CENTER,**

Respondents.

BRIEF OF APPELLANTS

STEPHEN HASKELL LAW OFFICES, PLLC
Stephen Haskell, WSBA#7832
222 N. Wall St., Ste. 402
Spokane, WA 99201
(509) 443-9909
(509) 455-5114 fax

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I. ISSUES PERTAINING TO ASSIGNMENTS OF ERROR.

- a. Whether Deaconess' loss of critical medical data regarding the decedent's declining physical status prior to his catastrophic event required a jury instruction setting forth a rebuttable presumption the evidence was adverse to the Defendant who failed to preserve or produce it;
- b. Whether the Spoliation Doctrine applies to medical data the Defendant hospital failed to preserve absent direct evidence of bad faith, but in breach of separate duty to retain the evidence; and
- c. Whether a rebuttable presumption concerning an adverse conclusion to be drawn from evidence lost or destroyed applies to a defendant who negligently fails to secure such evidence.

II. STATEMENT OF THE CASE

A. Overview.

Glen Cloninger was a well-known Spokane architect and real estate developer who died at Deaconess Hospital December 5, 2010, the result of hypoxic brain damage following extubation from general anesthetic. At trial, Plaintiffs alleged Mr. Cloninger's postoperative brain

damage was caused by failure of the Defendant anesthesiologist, Dr. Kim Chen, to properly manage the patient's airway beginning at the time of extubation, resulting in what is known as a "lost airway," leading to cardiopulmonary collapse.

The anesthesia monitor, owned by Deaconess and utilized by Dr. Chen, was capable of retaining two hours of clinical data on an internal memory for later review. This information included Mr. Cloninger's pertinent vital signs at the time of extubation, through his cardiopulmonary collapse and code response.¹ The data would have provided critical evidence regarding the patient's airway status and medical management at the time of events in issue.² Instead it was erased post-surgically. Deaconess Hospital acknowledges the monitor was recycled shortly following the patient's catastrophic event, the data erased, despite a written hospital policy requiring immediate investigation of a so-called "Sentinel Event," including Mr. Cloninger's event.

This appeal is premised on Plaintiffs' contention the hospital's failure to preserve critical medical documentation was a negligent breach of duty, a form of spoliation. As a remedy, the Plaintiffs requested an

1 Testimony of Alan Lipschultz, Clinical Engineer, CP 349-350.

2 Lipschultz testimony, *Id.*

appropriate jury instruction addressing the rebuttable presumption of lost evidence given the destruction of critical data by the hospital. The proposed instruction read:

If Deaconess Medical Center failed to produce evidence which was under their control and reasonably available to them and not reasonably available to plaintiff, then you may infer that the evidence was unfavorable to the defendant who could have produced it and did not.”³

The trial court declined to provide the above instruction, believing there must be evidence of bad faith or wrongful intent as a basis for instructing the jury on a spoliation-related issue.⁴ The Plaintiffs in this appeal assert a separate, negligent breach of duty to preserve evidence satisfies the culpability requirement.

B. Pertinent Background.

Mr. Cloninger was admitted to Deaconess Medical Center December 1, 2010 for an elective procedure known as “lithotripsy,” utilizing a sonic wave designed to fragment a kidney stone, permitting the patient to “pass” the stone at a later time when reduced to a sand-like substance. Lithotripsy is a minimally-invasive procedure, the patient typically discharged home within several hours. Because of technical

³ Plaintiffs’ Proposed Instruction “A”; CP 574-576.

⁴ RP 540.

positioning issues, the patient requires a general anesthetic to minimize movement for the brief period of time therapy is administered.

Mr. Cloninger was evaluated by Dr. Chen preoperatively. In later drafted addenda,⁵ the physician variously noted the patient was obese and suffered from sleep apnea. Dr. Chen also later charted attempts to intubate the patient three separate times before he was able to establish an adequate airway⁶ prior to surgery. Testimony at trial established all of these factors contributed to a clinically-defined “difficult airway,”⁷ posing a greater risk for anesthetic-related complications post surgically, requiring the physician anticipate a correspondingly “difficult extubation” after encountering a difficult intubation.⁸ Issues associated with difficult intubation and extubation generally fall within the field of airway management and represent a fundamental part of an anesthesiologist’s surgical practice.⁹

5 See Exhibits P4, P5 and P6.

6 *Id.*

7 See testimony of Drs. Cooper, RP 25-26, and Caplan, RP 717.

8 See testimony of Drs. Cooper, RP 30, Hagberg, RP 359-360, and Caplan, RP 723-724; Testimony of Dr. Kim Chen, RP 494.

9 See BENUMOF & HAGBERG, AIRWAY MANAGEMENT (2nd ed. 2007). This textbook is an authoritative treatise on the topic, a fact acknowledged by all parties. At trial one of the co-authors, Dr. Jonathan Benumof, testified on behalf of the Defendants; the other co-author, Dr. Carin Hagberg, testified on behalf of the Plaintiffs. These two

The surgical procedure was uneventful. Per nursing notations from the hospital's Intraoperative Record, (Ex. 1, p. 25), surgery concluded at 0922. At 0925, the nursing record states:

Upon extubation became combative, spasm. CPR started at 0937. . . (*Id.*) (Emphasis added.)

Based on this nursing note, part of the small volume of documentation from the immediate postoperative period not purged, 12 minutes elapsed between the patient's extubation and initiation of a code response, 0925-0937. It was this critical time frame which was the focus of Plaintiffs' criticism concerning Dr. Chen's airway management.

At trial, the nurse who made the "12-minute entry" essentially recanted her note, testifying "it seemed like much less."¹⁰ Dr. Chen also challenged the accuracy of the nursing entry, testifying it was "only minutes" between extubation and reintubation, claiming he was appropriately managing the patient's airway in this short, intervening time frame.¹¹

Had the anesthesia monitor's data been retained, it would have

acknowledged experts disagreed on the propriety of Dr. Chen's airway management based on the available record.

10 Testimony of Deborah Hayes, RN, RP 311, 339.

11 Testimony of Dr. Kim Chen, RP 498, 502, 506, 518-519.

included critical data addressing the patient's clinical status,¹² and likely addressed whether the time between extubation and reintubation was 12 minutes as originally charted, or only "2 or 3 minutes" as Nurse Hayes and Dr. Chen later testified.

There is no dispute Mr. Cloninger's condition deteriorated following extubation. This was the reason a code was called when a pulse was lost and the patient reintubated. Whether Dr. Chen's response was timely was a cornerstone of the Plaintiffs' liability argument. Plaintiffs' testimony established the standard of care required Mr. Cloninger be reintubated much earlier, after his oxygenation levels were decreasing and his heart slowed to a bradycardic rate.¹³ The Plaintiffs' standard of care testimony established the patient should have been reintubated before the development of pulseless electrical activity (PEA) and his cardiopulmonary arrest.¹⁴ Instead, a code was not called and reintubation not accomplished until after the patient arrested, despite Dr. Chen's original charting to the contrary.¹⁵ Finally, testimony established the vital

12 Dr. Richard Cooper testimony, RP35-36.

13 See testimony of Drs. Cooper, RP 51-53, and Hagberg, RP 388-389.

14 *Id.*

15 See Progress Note of Dr. Kim Chen, Ex. P1, p. 44; transcribed version, Ex. D103.

signs associated with these concepts were routinely tracked by the anesthesia monitor, the patient's declining vital signs at any given time between extubation and code available for review had the monitor's data been preserved.¹⁶

As further indication of the monitor's importance, one of the anesthesiology experts called by the Defendants, Dr. Benumof, testified these events could not happen as originally charted by nursing staff over a 12-minute time frame because the anesthesia monitor had an alarm function. Dr. Benumof testified the "bong" noise allegedly generated by the monitor's alarm was "so irritating" it could not have been ignored.¹⁷ According to Dr. Benumof, it would have been "too obvious" to ignore the patient's declining status over a 12-minute time frame with a functioning alarm's intrusion.¹⁸

The activation of an alarm was not an event Dr. Chen, nursing staff, or any other individual present in the operating room noted in any testimony, yet activation of the monitor's alarm system was another feature of the monitor's ability to retain data, and potentially could have

¹⁶ See testimony of Alan Lipschultz, CP 363.

¹⁷ See testimony of Dr. Jonathan Benumof, RP 674-676; 694-695.

¹⁸ *Id.* at RP 676.

refuted Dr. Benumof's testimony on this topic had the monitor data been preserved.¹⁹

The parties agree Mr. Cloninger's code was called at 0937.²⁰ There is no criticism of any health care provider's actions once the code was initiated.²¹ The code extended until 1120, or one hour and fifty-five minutes after Mr. Cloninger was initially extubated.²² At the time the patient was removed from the anesthesia monitor, a transfer monitor was used to take the patient to ICU, where he remained over the next four days until his death. At the time the original anesthesia monitor was removed, it was capable of retaining two hours of data,²³ meaning the entirety of the clinical data beginning before 0925, the time the patient was extubated, and throughout the code, remained accessible in the monitor's hard drive.

The Plaintiffs' testimony established the anesthesia monitor had a

19 See testimony of Alan Lipschultz, CP 354 and 360.

20 *Id.* See Ex. P1, p. 25, Intraoperative Note and Code Sheet, Ex. P1, p. 151.

21 There was confusion regarding who reintubated Mr. Cloninger and whether it was before or after the code. Dr. Chen's initial note claimed he had reintubated the patient prior to the code. His Addendums acknowledge it was another anesthesiologist, Dr. King, who reintubated Mr. Cloninger after Dr. King had been called to assist in the code response.

22 See Ex. P1, p. 151.

23 Testimony of Alan Lipschultz, CP 349-350.

nonvolatile memory.²⁴ No affirmative act was needed in the midst of a medical crisis to preserve the data. All that was required was to leave the monitor powered down after utilizing the transfer monitor to ICU, the data later retrievable at any time by clinical engineering staff or others at the hospital using a simple memory stick.²⁵ Instead this monitor data was recycled and erased within a short time following Mr. Cloninger's transfer to ICU.²⁶ With the recycling and erasure of the monitor data went much of the critical evidence in this case, irreplaceable from any other source. Included were the patient's real time vital signs from the point of extubation to the time of his cardiopulmonary collapse, institution of a code and reintubation. The significance of this lost data cannot be overstated. Also lost was any notation confirming the presence or absence

²⁴ *Id.* at CP 348 and 364-365.

²⁵ *Id.*

²⁶ While the individual responsible for erasing the monitor has never been positively identified, it appears to have been Colleen Dugger, a custodial technician employed by the hospital, whose job was to clean the operating room and prepare it for the next patient. This meant recycling the anesthesia monitor, which was Ms. Dugger's usual practice, absent instructions to leave the monitor offline. Ms. Dugger was not called as a witness by either party at trial. The Plaintiffs do not allege Ms. Dugger engaged in any conscious act of bad faith when erasing this data. Instead, the Plaintiffs claim this employee should have been instructed by Dr. Chen or one of several nursing staff and supervisors involved in the patient's care and code response to simply leave the machine powered down. Plaintiffs allege this failure to instruct was not an "innocent" loss of data. Further, the Plaintiffs' clinical engineer, Alan Lipschultz, testified it would be 'strange' to erase pre-set data points, inferring it did not occur simply by recycling the monitor. Lipschultz at CP 377.

of an alarm activation, a critical point to at least one of the defense experts,²⁷ who utilized the absence of evidence to leverage the Defendants' argument.

It was clear to medical personnel involved Mr. Cloninger suffered a serious or catastrophic event at the time of his transfer to ICU.²⁸ Mr. Cloninger remained in ICU for four days, a cooling protocol utilized, the slim hope he might recover from his anoxic insult. Medical testing confirmed the patient was in a permanent vegetative state, requiring life support, and the family made the difficult decision to terminate these measures December 5, 2010. Mr. Cloninger died shortly thereafter.

C. Deaconess' Sentinel Event Policy / Duty to Preserve Evidence.

Plaintiffs claim Deaconess Hospital breached a separate duty to preserve monitor data. This breach of duty is based on the hospital's Sentinel Event Policy. (Ex. P9, pp. 555-563.)

All hospitals accredited by the JCAH (The Joint Commission), including Deaconess, are required to have a policy addressing so-called sentinel events. At the time of Mr. Cloninger's event, the Deaconess

²⁷ Testimony of Dr. Jonathan Benumof, fn 17.

²⁸ See testimony of Deborah Hayes, RN, RP 317-318.

policy stated:²⁹

A. Sentinel Event is an unexpected occurrence involving death or serious physical or psychological injury or risk thereof. . . . Such events are called ‘sentinel’ because they signal the need for immediate investigation and response. (Emphasis added.)

. . . The following have been identified by the accrediting body, the Joint Commission (TJC) as sentinel events:

. . .

11. An event that has resulted in an unanticipated death or permanent loss of function *not related* to the natural course of the patient’s illness or underlying conditions. (Emphasis per policy.)

Testimony at trial established nursing staff was aware of the hospital’s Sentinel Event Policy, and acknowledged Mr. Cloninger suffered a potentially life-threatening injury following the code.³⁰ Ultimately it was agreed Mr. Cloninger experienced a sentinel event as that term is used in the Deaconess policy.³¹ The only disagreement was technically when the sentinel event occurred: according to Plaintiffs’ hospital expert, this was at least a potential sentinel event at the time it occurred and medical staff should have recognized it as such, taking

29 Exhibit P9, p. 556.

30 See testimony of Deborah Hayes, RN, RP 317-318.

31 See testimony of Greg Repetti, Deaconess Administrator, RP 228.

appropriate measures to preserve the evidence because of the hospital's policy requiring "immediate investigation and response."³² According to Plaintiffs' clinical engineer, the data should have been timely preserved, the decision regarding a sentinel event occurring later. By contrast, the hospital's testimony asserted a sentinel event did not occur until reported to administration; only at that point did the duty for "immediate investigation and response" arise; Deaconess had no duty to preserve time-sensitive evidence prior to administration's declaration of a sentinel event.³³

The Plaintiffs argued there was a temporal, fundamental and logical inconsistency between a sentinel event policy requiring "immediate investigation and response" and the hospital's argument the event did not occur until reported through administrative channels, and only then was a "delayed immediacy" requirement triggered. Regardless, this is not an issue to be resolved either by this Court or the trial court. Instead, this was a factual issue for the jury to determine when a sentinel event occurred in connection with a proper spoliation instruction – at the time it happened,

32 See testimony of Dennis Coleman, RP 255-256; testimony of Alan Lipschultz, CP 369, established immediately after the code, the sensitive data should be saved, the fact of a Sentinel Event determined later.

33 See testimony of Greg Repetti, RP 228, 238.

whether the data should have been preserved pending a formal determination of a sentinel event, or whether the event was not sentinel until reported to administration?

Of note, the hospital's Sentinel Event Policy required a "Root Cause Analysis" (RCA), meaning Mr. Cloninger's event was at some point investigated by Deaconess and an RCA report submitted to the State of Washington Department of Health.³⁴ It is conceded this Root Cause Analysis was a Quality Assurance document, exempt from discovery for purposes of this litigation,³⁵ and Deaconess did not reference the RCA report at trial or allude to the contents of the report. No testimony has ever established whether Deaconess attempted to determine the monitor's programmed retention capability or what evidence this monitor might have provided if not erased.

In summary, Plaintiffs' evidence established Deaconess Hospital had in place a Sentinel Event Policy at the time of Mr. Cloninger's catastrophic decline, requiring immediate investigation of the cause. While it was a factual issue when the policy's investigatory requirements were activated, Plaintiffs established a *prima facie* claim the hospital had a

34 RCW 70.56. *et seq.*

35 RCW 4.24. *et seq.*, RCW 70.41.200.

duty, per administrative policy, to timely investigate this incident, including preservation of critical monitoring data. This duty to attempt to preserve evidence should have been enough to support the Plaintiffs' proposed spoliation instruction.

D. Dr. Chen's Response to Loss of Data.

At trial, the court ruled Dr. Chen was the ostensible agent of Deaconess Hospital and so instructed the jury.³⁶ Any wrongful act by Dr. Chen was imputed to Deaconess Hospital as a matter of law based on this instruction.

Plaintiffs believe both Dr. Chen and the hospital not only disposed of critical evidence having a direct bearing on the outcome of the case, but significantly leveraged this absence of evidence, creating a differing medical record beyond verification through any objective data the monitor's documentation would have provided. These events significantly hampered the Plaintiffs' testimony addressing standard of care,³⁷ and enhanced the Defendants' position, creating a differing record following erasure of the monitor data.

On the evening of this event, approximately 10-12 hours after it

³⁶ See Court's Instructions to Jury, No. 7, CP 536.

³⁷ Hagberg testimony, RP 412-413.

occurred, Dr. Chen wrote a brief Progress Note.³⁸ The note was incomplete, failed to address major issues of airway management or Mr. Cloninger's airway risk factors, contained only minimal reference to the patient's vital signs, and made critical misstatements, including a claim it was Dr. Chen who reintubated the patient prior to the code, when in fact it was another physician, Dr. James King, who reintubated the patient after the code was ongoing. In short, it is unlikely Dr. Chen could have successfully defended his treatment of Mr. Cloninger on the basis of his Progress Note.

Perhaps for this reason, Dr. Chen was not content to conclude his charting with this postoperative Progress Note. Instead, the evidence established a prolonged, concerted effort by Dr. Chen to reconstruct the record in the absence of any real time clinical data. Beginning December 3, 2010, just two days following Mr. Cloninger's catastrophic event, Dr. Chen began preparation of an addendum to the record, the details of which are contained in an audit trail³⁹ ultimately produced by Deaconess Hospital and addressed through testimony of Dr. Steven Henkind, an electronic

38 See Exhibit P1, p. 44; transcribed note, D103.

39 Plaintiffs' Ex. 3, pp. 410-513. Appendix A is the Audit Trail, over 100 pages in length, detailing each editorial change to Dr. Chen's dictated Addendum. Appellant does not necessarily suggest the court review each page of the Audit Trail in detail, but submits the sheer volume of editorial changes is significant.

medical records expert. Dr. Henkind's unrebutted testimony established the following:⁴⁰

1. Between December 3 and December 10, 2010 (five days after Mr. Cloninger died), Dr. Chen spent in excess of 200 hours editing a lengthy addendum;
2. The original Addendum was nine pages in length; Dr. Chen printed the document on 37 separate occasions, but the hospital could only produce three of these printed versions; two are nine pages in length, a third is slightly in excess of seven pages; the final addendum, signed December 21, 2010, is back to nine pages in length; it is unknown what happened to the remaining printed addendums;
3. Dr. Chen made approximately 200 editorial changes to the document from first draft to the final electronically-signed document; many of these changes were relatively minor; only "about 30" substantive changes were edited in or out of the record by Dr. Chen;⁴¹
4. The Addendum contains scores of changing vital signs

40 Testimony of Dr. Steven Henkind, RP 177 - 202.

41 Henkind testimony, RP 193.

surrounding the patient's extubation, leading up to reintubation. Dr. Chen claims he was able to recall these multiple vital signs from memory.⁴² Each editorial change made by Dr. Chen made the vital signs "better," and none of the changes reflected any deterioration in vital signs;⁴³

5. All of the changes made by Dr. Chen, particularly the patient's modified vital signs, would have been subject to verification one way or the other had the data been retained.

The net product of Dr. Chen's efforts was a heavily-edited Addendum, written in such a way it was challenging to ascribe a cause to Mr. Cloninger's decline or determine the time frame over which his decline occurred. The end-product permitted the Defendants to speculate Mr. Cloninger's death was attributable to underlying cardiac disease, despite no testimony from Mr. Cloninger's treating physicians to that effect. This absence of critical data, combined with a slanted Addendum by Dr. Chen, required Plaintiffs' experts "piece together" the remaining evidence, concluding Mr. Cloninger's death was the result of improper airway management. In many ways, this prevented Plaintiffs from

⁴² *Id.* at RP 211-212.

⁴³ *Id.*

offering more specific testimony in the absence of clinical correlation.⁴⁴ These circumstances were fundamentally inequitable and required an appropriate jury instruction addressing spoliation of the monitor's evidence.

E. Deaconess Response to Loss of Data.

If the trial court had given Plaintiffs' proposed instruction regarding the presumption related to missing evidence within the hospital's control, it is assumed Deaconess would have argued the loss of evidence, if any, was innocent, the presumption overcome, or would not have been retrievable in the first place. These determinations must await Plaintiffs' request for a new trial, armed with an appropriate instruction addressing spoliation of evidence. When a new trial takes place, any conclusion whether Deaconess would overcome the presumption would be a factual issue for the jury's determination, not decided as a matter of law. Meanwhile, there were multiple developments during the original trial calling into question the hospital's presumptive arguments.

The only expert witness familiar with the anesthesia monitor's retention capability was Alan Lipschultz, a clinical engineer called by the Plaintiffs. Mr. Lipschultz testified the monitor was capable of retaining

⁴⁴ Testimony of Dr. Hagberg, RP 412-413.

two hours of data as previously stated.⁴⁵ He further acknowledged the factory default setting would not retain data, and the monitor must be programmed by the end-user to take advantage of such functions,⁴⁶ but once accomplished it would be ‘strange’ to overwrite the function, which did not occur merely by clearing the monitor’s data. Whether this monitor was so programmed was never definitively established, but the evidence would make it likely. Ultimately, Mr. Lipschultz testified the extent of data retrievable from this monitor was unknown absent any attempt to retrieve the information, and at least no effort to do so was disclosed by the Defendant.⁴⁷ But the evidence would imply the Defendant most likely did try at some point to access the retention function of the anesthesia monitor, given the circumstances.

During trial, the Deaconess corporate representative, Greg Repetti, testified Deaconess disposed of the hospital’s anesthesia monitors at some point after this event, replacing the equipment with updated, more technologically advanced monitoring equipment. This testimony strongly inferred the monitor’s retention function could not be verified because the

45 Lipschultz testimony, CP 349-350.

46 Testimony of Alan Lipschultz, CP 351.

47 *Id.* at CP 384-385.

monitors had been disposed of.⁴⁸ In the interim, Deaconess was required by their Sentinel Event Policy to prepare a Root Cause Analysis (RCA)⁴⁹ and submit their findings to the appropriate licensing authority. While the contents of this investigative report are privileged by statute,⁵⁰ and were never offered or disclosed by Deaconess in the context of this litigation, it seems reasonable the monitor's retention function would be ascertained as part of this process.

Related, Deaconess submitted a color photograph at trial labeled "Photo of Operation Room Monitor" (Ex. D106) (Appendix B).⁵¹ This photograph was represented as demonstrating *the* monitor as it would have appeared at the time of Mr. Cloninger's event. The photograph is undated, and it is unknown when it was taken relative to the event. While one explanation may simply be the wording of the Hospital's Exhibit was imprecise, intended to portray a replica monitor, it raises a legitimate question whether this was *the* monitor involved in Mr. Cloninger's event as represented, and if so, whether the retention capabilities were

48 Testimony of Greg Repetti, RP 226, 235.

49 Deaconess Sentinel Event Policy, Ex. P9.

50 See fn 35, *Id.*

51 See Appendix B, a color photograph admitted by the Defendant, including the anesthesia monitor.

ascertained prior to disposing of the actual monitor if it was available for forensic purposes as well as preparation of the Hospital's required Root Cause Analysis.

The only other anesthesiologist called as a witness at trial associated with Dr. Chen's practice group, Anesthesia Associates of Spokane, a co-Defendant, was Dr. James King. Dr. King participated in the code and was the physician who reintubated Mr. Cloninger. Dr. King testified he utilized the retention capabilities of the anesthesia monitor on prior occasions⁵² and accessed data when he felt it appropriate. At the least, this testimony established Dr. Chen's group programmed a monitor on a prior occasion, retaining the type of clinical data the Plaintiffs requested in this case.

Finally, retention of monitor data by anesthesiologists was not an unusual practice. At trial, board-certified anesthesiologists called to testify on behalf of both parties acknowledged they retained data for later access and review when an unusual or adverse event occurred involving a patient.⁵³ Only a single witness, Dr. Jonathan Benumof, who claimed the alarm's monitor function prevented improper care, testified he never had

⁵² Testimony of Dr. James King, RP 119-120.

⁵³ Testimony of Dr. Richard Cooper, RP 35-36; testimony of Dr. Robert Caplan, RP 743.

occasion to retain or access data following an adverse event.⁵⁴

III. ARGUMENT

A. Standard of Review.

As recently noted by this Court, failure to give a particular jury instruction is reviewed for abuse of discretion. *Fergen v. Sestero*, 174 Wn. App. 393, 298 P.3d 782 (2013). If a party's theory lacks substantial evidence, a trial court should not instruct the jury on it. (*Id.*) Evidence supporting a party's theory must rise above speculation and conjecture. (*Id.*)

This Court's review of the stated legal issues should be *de novo*. While there is some added case law holding a trial court's decision regarding whether to give a proposed instruction is untenable if based on an incorrect legal standard, and falls within the 'abuse of discretion standard,' these are not the circumstances before this Court. *See, In Re Marriage of Littlefield*, 133 Wn.2d 39, 46-47, 940 P.2d 1362 (1997). In this case, it is more accurate to recognize applicable legal principles addressing a jury instruction in the context of spoliated evidence have not been fully clarified, particularly as the law relates to a party's alleged bad

⁵⁴ At the same time, Dr. Benumof also acknowledged he had never prepared an extensive Addendum such as prepared by Dr. Chen, RP 697. So did Dr. Caplan, RP 742.

faith in failing to preserve evidence, as opposed to the defendant's negligent breach of duty to preserve the same evidence. *See, Henderson v. Tyrrell*, 80 Wn. App. 592, 910 P.2d 522 (1996), discussed *infra*.

Henderson, decided by this Court, is the “leading authority”⁵⁵ addressing spoliation of evidence in the state of Washington. This case presents the appropriate opportunity to clarify the rule of law stated in *Henderson* as it relates to spoliation of evidence. Therefore, the applicable standard of review should be *de novo*.

B. The *Henderson v. Tyrrell* Rule.

The decision in *Henderson v. Tyrrell* has been characterized as the “leading modern case” addressing the appropriate jury instruction in the context of alleged spoliation of evidence, including other scholarly observations. *See*, 5A KARL B. TEGLAND, WASHINGTON PRACTICE : EVIDENCE LAW AND PRACTICE , § 402.6, fn. 14 (5th ed. 2007). Professor Tegland states:

. . . The term spoliation is usually intended as a term of art, referring to the legal conclusion that a party's destruction of evidence was in bad faith or under other circumstances such that admissibility and the other negative consequences discussed in this section should follow. No bad faith, and thus no spoliation, will be found if the party had no duty to preserve the evidence in the first place.

⁵⁵ TEGLAND, WASHINGTON PRACTICE, *infra*.

A leading legal commentator recognizes the interplay between bad faith destruction of evidence, technically spoliation, and a related but negligent breach of duty to preserve evidence. Thus, if spoliation is the intentional or bad faith loss of evidence, negligent failure to preserve evidence as a separate breach of duty must be a closely-aligned legal cousin. This case presents the opportunity for this Court to articulate the negligent destruction of evidence as the legal equivalent of spoliation, at least when the negligence stems from a separate breach of duty to preserve evidence.

A review of this Court's decision in *Henderson v. Tyrrell* is appropriate given the precedential value accorded the decision. *Henderson* originally involved conflicting claims by the parties concerning who was driving a vehicle owned by Mr. Tyrrell at the time of an accident, resulting in serious injury to Mr. Tyrrell, and only minor injury to Mr. Henderson. A bifurcated liability trial was held on this disputed issue, the jury concluding Mr. Henderson was driving Mr. Tyrrell's vehicle when the accident occurred. The case was then scheduled for the damage portion of trial.

In the time frame leading up to the damage trial, Mr. Tyrrell arranged to have the wrecked car disposed of, having retained it for two

years. At trial, the defendant requested either a dismissal or appropriate spoliation instruction as a sanction for loss of the vehicular evidence.

The *Henderson* court provided a thorough overview of the Spoliation Doctrine, noting “the focus of recent debate is on the appropriate remedy rather than on what acts constitute spoliation. . . .”⁵⁶

The court further stated:

The judicial response to the problem in other jurisdictions seems to reflect an understanding that the term encompasses a broad range of acts, and the severity of a particular act (in terms of the relevance or importance of the missing evidence or the culpability of the actor) determines the appropriate remedy. (*Parentheses by the court.*)

Following a brief overview of the term “spoliation” as “the intentional destruction of evidence,” the court noted “a more recent development is the application of a rebuttable presumption, shifting the burden of proof to a party who destroys, alters or loses important evidence” (citing *Sweet v. Sisters of Providence*, 895 P.2d 484, 490-91 (Al. 1995) discussed *infra*).

Henderson further noted “few Washington cases” had addressed the problem, citing *Pier 67, Inc. v. King County*, 89 Wn.2d 379, 573 P.2d 2 (1977) as the “most prominent.” Quoting from *Pier 67* at pages 384-85,

⁵⁶ *Id.* at p. 605.

the *Henderson* court stated:

We have previously held on several occasions that where relevant evidence which would properly be a part of the case is within the control of a party whose interests it would naturally be to produce it and he fails to do so, without satisfactory explanation, the only inference which the finder of fact may draw is that such evidence would be unfavorable to him. . . . (Citations omitted.)

Again citing *Sweet v. Sisters of Providence*, discussed *infra*, the court adopted a two-pronged test as prelude to a spoliation instruction: (1) the potential importance or relevance of the missing evidence; and (2) the culpability or fault of the adverse party.

Henderson noted whether missing evidence is important or relevant depends on the particular circumstances of the case, and each case is uniquely dependent upon the facts. As a further guideline, the court stated at page 607:

. . . Another important consideration is whether the loss or destruction of the evidence has resulted in an investigative advantage for one party over another, or whether the adverse party was afforded an adequate opportunity to examine the evidence. . . . (Citations omitted.)

In contrast to the present case, the “investigative value of Mr. Tyrrell’s car was not clear.” (*Id.*) The court further noted, “Both parties had the opportunity to retain experts to inspect the car during the two years after the accident.” This squandered investigative opportunity, available to

the defendant for two years in the *Henderson* case, was not available here, the monitor data erased shortly following Mr. Cloninger's transfer to the Intensive Care Unit.

In addition to addressing the importance of the evidence, together with opportunity for access, *Henderson* addressed the culpability element, noting the potential for overlap between an act of bad faith and a separate, negligent breach of legal duty, the focus of this appeal. The court stated at page 610:

Another important consideration is whether the actor violated a duty to preserve the evidence. . . . Several decisions from other jurisdictions were based at least in part on the fact that the *loss or destruction of medical records* violated legal or hospital requirements. *Carr v. St. Paul Fire and Marine Ins. Co.*, 384 F. Supp. 821, 831 (W.D. Ark. 1974); *Delaughter*, 601 S.2d 818 (Miss. 1992), also discussed *infra*. (Emphasis added.)

Finally, *Henderson* reviewed an instruction similar in wording to the Plaintiffs' proposed instruction regarding the rebuttable, unfavorable inference to be drawn from lost evidence. The court noted the well-established law cited earlier that "A party is entitled to have its theory of the case set forth in jury instructions, but the trial court has considerable discretion in determining whether instructions are necessary," together with the proposition "An instruction is required only if there is substantial evidence to support it." (*Id.* at p. 612.) Ultimately, this appellate court

concluded the defendant's proposed instruction, similar to the Plaintiffs' instruction in this case, was not supported under the circumstances based on the court's reasonable assumption Mr. Henderson had not intentionally destroyed evidence two years after the fact when the evidence had been equally available to both parties, and "the real culprit was the passage of time."⁵⁷ These circumstances do not exist in the present case, the real culprit not the passage of time, but instead the hospital's breach of duty.

C. Washington Law Subsequent to *Henderson v. Tyrrell*.

Numerous Washington decisions follow the basic rules set forth in *Henderson v. Tyrrell*, though a majority of the appellate decisions remain unpublished. The basic rules repeated appear to be: (1) spoliation remains the intentional destruction of evidence in which a rebuttable presumption shifts the burden of proof; (2) the trial court has considerable discretion in specifying the consequences of spoliation; and (3) violation of a separate duty to preserve the evidence is the functional equivalent of bad faith or other culpability when applying the Spoliation Doctrine.

In *Marshall v. Bally's Pacwest, Inc.*, 94 Wn. App. 372, 972 P.2d 475 (1999), the court cited *Henderson* with approval, stating at pages 381-382:

⁵⁷ *Id.* at p. 611.

In deciding whether to apply a rebuttable presumption in spoliation cases, two factors control ‘(1) the potential importance or relevance of the missing evidence; and (2) the culpability or fault of the adverse party.’ . . . In weighing the importance of the evidence, the court considers whether the adverse party was afforded an adequate opportunity to examine it. . . . Culpability turns on whether the party acted in bad faith or whether there is an innocent explanation for the destruction.

Marshall declined to approve a spoliation instruction based on the fact that the missing evidence had been available to the opposing party for four years following the incident in question. Again, this is in marked contrast to the circumstances of the present case. More recent Washington decisions appear to more expressly accept a party’s separate breach of duty as the functional equivalent of culpability.

In *Homeworks Construction, Inc. v. Wells, et al.*, 133 Wn. App. 892, 138 P.3d 654 (2006), the court cited *Henderson* with approval, noting it to be the “leading case on spoliation,” but also noting “Washington case law on spoliation is sparse.” *Id.* at p. 898. *Homeworks* noted the *Henderson* court adopted Alaska’s approach in *Sweet v. Sisters of Providence, supra*:

Under this test, the trial court weighs (1) the potential importance or relevance of the missing evidence; and (2) the culpability or fault of the adverse party (citing *Henderson*). After weighing these two general factors, the trial court uses its discretion to craft an appropriate sanction. (*Henderson* citation omitted.)

Homeworks noted, as the Plaintiffs urge in this case, a party may be responsible for spoliation even without a finding of bad faith. Citing *Henderson*, together with 5A KARL B. TEGLAND, WASHINGTON PRACTICE, *supra*, the court stated at page 658:

. . . The *Henderson* opinion suggests that spoliation encompasses a broad range of acts beyond those that are purely intentional or done in bad faith. . . . It is possible, therefore, that a party may be responsible for spoliation without a finding of bad faith. But even under this theory, the party must do more than disregard the importance of the evidence; the party must also have a duty to preserve the evidence. *A party's actions are 'improper' and constitute spoliation where the party has a duty to preserve the evidence in the first place.* (Citations omitted.) (Emphasis added.)

The above framework was recently repeated in *Tavai v. Walmart Stores, Inc.*, 176 Wn. App. 122, 307 P.3d 811 (2013), where the court again stated:

In deciding whether to apply a spoliation inference, this court has used two general factors: (1) the potential importance or relevance of the missing evidence and (2) the culpability or fault of the adverse party. (Citing *Henderson*.) Whether the missing evidence is important or relevant depends on the particular circumstances of the case. . . . In weighing the importance of the evidence, we consider whether the adverse party was given an adequate opportunity to examine it. . . . As for culpability, we examine whether the party acted in bad faith or conscious disregard of the importance of the evidence *or* whether there was some innocent explanation for the destruction. . . . *Another important factor is whether the party violated a duty to preserve the evidence.* . . . (Citing *Henderson*.)

(Emphasis added.)

Based on this review of Washington case law, at least three factors repeatedly enunciated by our courts include: (1), the missing evidence must have been of potential importance to the case; (2) the adverse party (in this case the plaintiff) must not have consciously forsaken an opportunity to otherwise examine the evidence; and (3) in the absence of actual bad faith or other intentional conduct, equivalent culpability is found where the offending party violated a separate duty to preserve the evidence.

Given the facts of this case, there is no credible argument the potential monitor data would not have been significant evidence, and the court did not indicate otherwise. Further, it was acknowledged the evidence was destroyed a short time after Mr. Cloninger's event occurred, and there was never any reasonable opportunity for the Plaintiffs to evaluate the evidence.

Had the trial court's choice to decline a spoliation instruction been based solely on the above two factors, the court's ruling might have been reviewable for abuse of discretion. However, the trial court's ruling specifically addressed the third factor of culpability, concluding there must

be an element of bad faith to constitute culpability,⁵⁸ declining to substitute a separate breach of duty in its stead.

In this case Deaconess Hospital breached a separate duty to “immediately investigate” a Sentinel Event defined under Hospital policy. This breach of separate duty was sufficient to satisfy the culpability requirement and required the court give the Plaintiffs’ proposed spoliation instruction.

D. Breach of Duty Re: Medical Data.

Given the distinct nature of medical evidence in civil litigation, a rule has developed abrogating the necessity for a separate finding of bad faith in cases involving lost or altered medical records, instead analyzing the health care provider’s breach of duty in failing to preserve such evidence. This trend was expressly noted in 5A KARL B. TEGLAND, WASHINGTON PRACTICE : EVIDENCE LAW AND PRACTICE (5th ed. 2007), *supra*, in which the author stated at page 286-287:

Some jurisdictions have made it easier to arrive at a finding of spoliation by easing, or even eliminating, the traditional requirement of proof that the evidence was destroyed in bad faith.

This movement seems to have begun in cases involving destroyed or altered medical records. The movement may

58 RP 540.

be spreading to other sorts of cases. *Washington's appellate courts have not yet stated directly that they will follow this trend, but it would not be surprising if they chose to do so.* (Italics added.)

This Court should do precisely what Professor Tegland suggests, and what this Court's decision in *Henderson v. Tyrrell* infers: a separate breach of duty to preserve medical documentation is the equivalent of culpability, meriting a spoliation instruction. In fact, *Henderson* cited two decisions standing for this proposition: *Delaughter v. Lawrence County Hospital*, 601 S.2d 818 (Miss. 1992); and *Sweet v. Sisters of Providence*, 895 P. 2d 484 (Al. 1995).

Delaughter v. Lawrence County Hospital was a wrongful death claim in which the decedent deteriorated during her short hospitalization, later transferred to another care facility. Following her death approximately one month later, the plaintiff's representatives attempted to obtain her hospitalization records. It was established the bulk of medical records had been lost, a portion reconstructed from documentation in separate departments of the hospital. On the one hand, *Delaughter* represents more egregious circumstances than presented in this case given the fact virtually the entirety of the record was allegedly lost. On the other hand, reconstruction of the record is a strikingly similar event to the reconstructed, heavily-edited addendum prepared by Dr. Chen.

Delaughter reversed the trial court's refusal to give a related spoliation instruction, similar to the instruction proposed by the Plaintiffs in this case, transferring the burden of proof to the Defendant hospital to explain a lost portion of records. The court stated:

The issue concerns what the jury was entitled to hear and what instruction should have been given regarding the reconstructed medical records. The jury was entitled to be told the original hospital record would not be produced in court, as that was a relevant fact. The hospital had the duty to give an adequate explanation for the absence of the original hospital record. Therefore, the jury was entitled to be told why the original hospital record was missing, also a relevant fact. (*Id.* at p. 621.)

Somewhat tongue-in-cheek, the court noted there could be a potential but unlikely innocent reason for loss of records:

. . . As with any other evidence, the explanation for the original record's absence may be fully satisfying either that it was lost through no fault of the hospital, that the hospital deliberately destroyed it, or as in most cases, somewhere in between, thereby making it a jury issue. *For example, where the evidence is positive that the hospital been destroyed by fire, such circumstance would adequately account for the loss of the original medical record. . . .* (Emphasis added.)

On the other hand, where the evidence is positive that the hospital deliberately destroyed the original medical record or where a record required by law to be kept is *unavailable due to negligence* an inference arises that the record contained information unfavorable to the hospital, and the

jury should be so instructed.⁵⁹ (Emphasis added.)

Delaughter disapproved shifting the entire burden of proof to include the causation issue, but left it to the parties and to the court to craft an appropriate instruction at retrial. The court stated:

In sum, we find that the hospital chart was not fully reconstructed. We further find that the trial court erred in failing to place the burden of proof on the hospital to show that the chart was not lost or destroyed by the hospital. In addition, we find that the trial court erred in failing to give an instruction on the spoliation issue. We recognize that *Delaughter* did not submit a proper instruction on this issue; however, based upon the record now before us, we cannot say that the error was harmless.⁶⁰

The concurrence, joined by three of the justices from the Mississippi Supreme Court, not known as a bastion of liberalism, was more strident in criticizing the hospital's failure to preserve the record. The opinion also highlights the evidentiary equivalence between an intentional act of bad faith and negligent breach of duty. The concurrence stated:

I disagree with the majority in at least three respects. First, the majority wrongly concludes that the Spoliation Rule comes into play only when a hospital 'deliberately' destroys a record. *Both intentional and negligent loss of medical records can constitute spoliation.* . . . (Citations omitted.)

⁵⁹ *Id.* at pp. 821-822.

⁶⁰ *Id.* at p. 823.

...

In other words the very act of spoliation can haunt the hospital's case even after the hospital introduces evidence to show that the records would not have been particularly helpful to the plaintiff. Since the presumption of unfavorability operates 'indefinitely though strongly' against the hospital's entire case and is not solely confined to the specific issue of what information the records contained, the jury is thus still free [to] draw a general inference of unfavorability from the act of spoliation regarding what the hospital's rebuttal evidence shows concerning the content or effect of the missing records.⁶¹

The second case noted by *Henderson* was *Sweet v. Sisters of Providence*, 895 P.2d 484 (Al. 1995) and appears to have been a foundation for the enunciated burden of proof involving spoliation cases in Washington via the *Henderson v. Tyrrell* rule.

Sweet involved a claim by the parents of a brain damaged infant against a hospital which failed to preserve certain portions of the record including narrative nursing notes, medication sheet, a graphic record and nursing care flow sheet, though the vast majority of the record remained intact. Similar to the present case, the Sweet's claimed missing records precluded them succeeding on their medical negligence claims, but unlike this case, the Plaintiffs claimed they were entitled to a conclusive presumption of negligence. The trial court instructed the jury regarding

⁶¹ *Id.* at pp. 826-827.

negligent spoliation of evidence, similar to the instruction proposed by Plaintiffs in this case, but disagreed the presumption attributable to spoliation was a conclusive one.

The *Sweet* decision included a thorough review of negligent spoliation, particularly in the context of medical records, stating:

. . . It is for this very reason that a number of courts in other jurisdictions have created a rebuttable presumption shifting the burden of persuasion to a health care provider who negligently alters or loses medical records relevant to a malpractice claim. . . . (Citations omitted.)⁶²

Sweet extensively relied on the approach of the Florida Supreme Court in the case of *Public Health Trust v. Valcin*, 507 S.2d 596 (Fla. 1987). As in *Sweet*, and to a large extent in the present case, the plaintiffs in *Valcin* argued the absence of medical documentation significantly hindered the ability to satisfy their burden of proof when requesting a spoliation instruction, essentially shifting the burden of proof regarding the missing evidence, in effect creating a rebuttable presumption. The *Valcin* court noted the presumption created by burden shifting is rebuttable, but is not a “vanishing presumption.”⁶³ This acknowledgment there is no “vanishing presumption” is a critical concept, as it requires a jury’s

⁶² *Id.* at p. 491.

⁶³ Pp. 600-601.

determination regardless of the offending party's explanation for lost evidence. The court's observation in this regard is applicable to the reconstructed addendum by Dr. Chen, *Valcin* noting:

If the plaintiff is in fact sufficiently 'hindered' by the absence of an operative note, odds are that the defendant's production of some evidence of nonnegligence will not place the plaintiff in a better position. Testimony based on the selective recollections of a surgeon and his staff would be considered 'substantial' enough to 'burst the bubble,' thus keeping the presumption from the jury. Plaintiff could rarely prove negligence by a preponderance of the evidence when the presumption has given him nothing more than the self-serving testimony of the defendant.

...

When evidence rebutting such a presumption is introduced, the presumption does not automatically disappear. It is not overcome until the trier of fact believes that the presumed fact has been overcome by whatever degree of persuasion is required by the substantive law of the case. Rebuttable presumptions which shift the burden of proof are 'expressions of social policy,' rather than mere procedural devices employed to 'facilitate the determination of the particular action.'⁶⁴

Unrelated, *Sweet* addressed the intentional spoliation of evidence as a potentially separate cause of action. The Plaintiffs in this action do not assert intentional spoliation and did not propose a separate claim related to the lost monitor evidence. Nonetheless, *Sweet* makes it clear the

64 *Id.* at pp. 600-601.

rebuttable presumption associated with negligent spoliation of evidence is not a “vanishing presumption,” and regardless of the Defendants’ argument or evidence, the spoliation issue should be submitted to a jury.

Addressing the specific circumstances of this case, and the presumptive argument by Deaconess Hospital a custodial employee’s erasure of the monitor data may have been innocent, or the data not otherwise available, does not overcome the spoliation presumption. The so-called ‘innocence element,’ in terms of failure to direct a custodial employee to retain evidence yielded the same result as an affirmative act of bad faith (i.e., instructing the employee to erase the data). As a practical matter, there was no real difference between the employee’s act of omission and an affirmative act by the defendant of commission, a reality the Defendant hospital and its agents arguably recognized. At the least, this was a question of fact for a jury’s determination.

E. Proposed Rule Re: Negligent Spoliation of Evidence.

In Mr. Cloninger’s case, there were multiple reasons why an instruction regarding the rebuttable presumption associated with negligent spoliation of evidence would have been appropriate: the hospital’s Sentinel Event Policy, with the associated requirement of immediate investigation, required preservation of critical medical evidence; it was a

standard practice to retain this type of data when an adverse event occurred, testified to by multiple anesthesia experts called by the parties in this case; it was also a practice utilized in the past by Dr. Chen's partner, Dr. James King; perhaps most egregious, Defendant Chen leveraged the loss of data by creating a highly-edited addendum, adding another layer of evidence; finally, one of the defense experts, Dr. Jonathan Benumof, attempted to utilize the absence of data to the Defendants' advantage, claiming the alarm function, also a part of the recorded data, would have prevented Mr. Cloninger's health care providers from delaying interventive action.

Based on the circumstances noted above, together with the weight of legal authority beginning with *Henderson v. Tyrrell*, Plaintiffs assert this Court should recognize a rule concerning negligent spoliation of medical evidence as follows: when evidence is shown to be material and not otherwise available to an opponent, a party who negligently fails to preserve evidence in violation of a duty to do so is subject to a rebuttable inference the evidence was unfavorable; whether evidence introduced rebutting the inference sufficiently overcomes the presumption is a question of fact to be resolved by a jury.

IV. CONCLUSION

The trial court should have instructed the jury pursuant to the Plaintiffs' proposed instruction addressing the rebuttable, adverse presumption associated with lost evidence. The trial court's failure to do so merits reversal and a new trial.

Respectfully submitted this 19 day of December, 2013.

STEPHEN HASKELL LAW OFFICES, PLLC

By 
Stephen Haskell, WSBA#7832
Counsel for Appellants

PROOF OF SERVICE

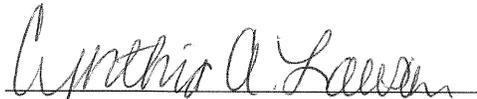
I, the undersigned, certify that on the 19th day of December, 2013, I caused a true and correct copy of the foregoing to be forwarded, with all required charges prepaid, by the method(s) indicated below, to the following persons:

Counsel for Respondent Dr. Chen/Anesthesia Associates:
Mary H. Spillane
Williams Kastner & Gibbs
601 Union St., Ste. 4100
Seattle, WA 98101-2380

- Next Day Air
- U.S. Mail
- Facsimile
- Email:
mspillane@williamskastner.com

Counsel for Respondent Deaconess:
Brian Rekofke
Matthew Daley
Witherspoon – Kelley, P.S.
422 W. Riverside, Ste. 1100
Spokane, WA 99201

- Hand Delivery
- U.S. Mail
- Facsimile: (509) 458-2728
- Email:
BTR@witherspoonkelley.com
MWD@witherspoonkelley.com


Cynthia A. Lawson

APPENDIX A

RUN DATE: 10/05/12
RUN TIME: 1001
IN USER: DLC7

Rockwood Health System MIS *LIVE*
USER LOOKUP FUNCTION

PAGE 1

ENLT	NAME/OFFICE	PHONE	TITLE
BDB15	Baughman, Brenda D DEC PERFORMANCE IMPROVE	DMC 473-7001 1010.871040	RN CASE REVIEWER
CJF1	Fontaine, Carol J	509 232-8375 2590.845951	IRM SYSTEMS ANALYST 4 - PCI
CLJ	Johnson, Carol L DEC INFECTION CONTROL	7063 DMC 1010.871070	INFECTION CONTROL SECRETARY
CSL6	Long, Cindy Susan DEC PT CARE OPERATIONS	DMC 473-7036 1010.873050	ADMINISTRATIVE SUPERVISOR
CXB56	Berryman, Charlotte DEC PERFORMANCE IMPROVE	7383 1010.871040	EHS CLINICAL RISK MANAGER
DEC2	Christiansen, Darlene DEC MEDICAL RECORDS	DMC 7492 1010.869000	RECORDS COORDINATOR
DLC7	Cook, Debbie L DEC MEDICAL RECORDS	DMC 2036 1010.869000	CLERICAL SUPERVISOR
DMC20	Caudill, Doreen M DEC MEDICAL RECORDS	1010.869000	HEALTH INFORMATION ANALYST
DRG4	Gillingham, Dorothy R	489-7504	Heart Cl NW - RN
ERP	Peller, Ellen R DEC CICU	7267 1010.601200	DMC REGISTERED NURSE
HJS4	Shepherd, Hollie J	838-7711 HCNW	Scheduler/HCNW
HMB4	Elghannam, Hesham M SPC P&CC-ELGHANNAM	474-3237 1560.727443	IMRS PHYSICIAN SPECIALIST
JJP1	Petrik, Jennifer J DEC PT CARE OPERATIONS	473-7258 1010.873050	DMC ASSISTANT CNO
JKH6	Hong, Jean K DEC PHARMACY	7333 1010.717000	PHARMACIST - DAY-EVENING
KDC2	Chen, Kim D		PHYSICIAN
KLC17	Cheney, Kathy L DEC MEDICAL RECORDS	2356 1010.869000	DMC HEALTH INFORMATION ANALYST
MLM62	Monson, Michele L	489-7504 HCNW	HEART CLINIC NW/Scheduler/Recp
MMB33	Brown, Malina M	483-6449 SU	Spokane Urology/FILE CLERK

RUN DATE: 10/05/12
RUN TIME: 1001
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Rockwood Health System MIS *LIVE*
USER LOOKUP FUNCTION

PAGE 2

INID	NAME/OFFICE	PHONE	TITLE
MOH	Henneberry, Michael O	747-3147	Spokane Urology/MD
MSF1	Fleming, Monita S DEC PHARMACY	5479 1010.717000	DMC PHARMACIST - DAY-EVENING
PPH	Hopp, Pamela P DEC ICU	7223 1010.601000	DMC HEALTH UNIT COORDINATOR
RKT2	Turner, Ryanne K	747-3147	Spokane Urology/Referral Coord
SJAB	Alexander, Susan J MD	455-8820	Spokane Cardiology/MD
TLH25	Higgins, Terri L SPC P&CC-OH	2647 1560.727414	BILLING SPEC PRACTICE MGMT
TLH71	Horn, Tina L	483-6449 SU	SPOKANE UROLOGY/BKCP
TLL8	Lucas, Tina L	747-3147	Spokane Urology/Surg Sched

000411

RUN DATE: 10/05/12
RUN TIME: 0957
USER: DLC7

Rockwood Health System MIS *LIVE*
USER LOOKUP FUNCTION

PAGE 1

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	INTERF INTERFACE	IRM	

RUN DATE: 09/24/12
RUN TIME: 1045
RUN USER: DLC7

DEACONESS ORDER ENTRY *** LIVE ***
REPORT'S AUDIT TRAIL

PAGE 1

DEPARTMENT: DTRAN
REPORT: 1204-0012 PROG NGHE
PATIENT: DX3769908 CLONINGER, GLEN A

DATE: 12/04/10
TIME: 0223
USER: interface
EVENT: report initialized

DATE: 12/04/10
TIME: 0223
USER: interface
EVENT: report printed on PATP

DATE: 12/04/10
TIME: 0550
USER: CSL6
EVENT: Draft report viewed in PCI

DATE: 12/04/10
TIME: 0909
USER: PPH
EVENT: Draft report viewed in PCI

DATE: 12/04/10
TIME: 1009
USER: HME4
EVENT: Draft report viewed in PCI

DATE: 12/04/10
TIME: 1046
USER: PPH
EVENT: Draft report viewed in PCI

DATE: 12/04/10
TIME: 1109
USER: PPH
EVENT: Draft report viewed in PCI

DATE: 12/04/10
TIME: 1117
USER: PPH
EVENT: Draft report viewed in PCI

DATE: 12/04/10
TIME: 1117
USER: PPH
EVENT: Draft report viewed in PCI

DATE: 12/04/10
TIME: 1657
USER: DMC20
EVENT: report viewed on D-MRPC25.1

DATE: 12/04/10
TIME: 1716

000413

RUN DATE: 09/24/12
RUN TIME: 1045
RUN USER: DLC7

DEACONESS ORDER ENTRY *** LIVE ***
REPORT'S AUDIT TRAIL

PAGE 2

DEPARTMENT: DTRAN
REPORT: 1204-0012 PRG NOTE
PATIENT: DX3769908 CLONINGER, GLEN A

USER: DMC20
EVENT: report viewed on D-MRPC25.2

DATE: 12/05/10
TIME: 1347
USER: JKH6
EVENT: Draft report viewed in PCI

DATE: 12/05/10
TIME: 2131
USER: JJPL
EVENT: Draft report viewed in PCI

DATE: 12/05/10
TIME: 2132
USER: JJPL
EVENT: Draft report printed in PCI

DATE: 12/06/10
TIME: 0548
USER: CSL6
EVENT: Draft report viewed in PCI

DATE: 12/06/10
TIME: 0900
USER: HJS4
EVENT: Draft report viewed in PCI

DATE: 12/06/10
TIME: 0934
USER: ERP
EVENT: Draft report viewed in PCI

DATE: 12/06/10
TIME: 1017
USER: DEC2
EVENT: report viewed on D-MRPC016.2

DATE: 12/06/10
TIME: 1018
USER: DEC2
EVENT: report viewed on D-MRPC016.2

DATE: 12/06/10
TIME: 1018
USER: DEC2
EVENT: report printed on D-MRLJ009

DATE: 12/06/10
TIME: 1024
USER: CJF1
EVENT: 'dictated by' data edited

RUN DATE: 09/24/12
RUN TIME: 1045
RUN USER: DLC7

DEACONESS ORDER ENTRY *** LIVE ***
REPORT'S AUDIT TRAIL

PAGE 3

DEPARTMENT: DTPAN
REPORT: 1204-0012 PROG NOTE
PATIENT: DX3769908 CHONINGER, GLEN A

ORIGINAL:
dictated by: CHEKI
date dictated: 12/03/10
time dictated:

EDITED:
dictated by: CHEKI
date dictated: 12/03/10
time dictated: 1200

DATE: 12/06/10
TIME: 1029
USER: KDC2
EVENT: Draft report viewed in PCI

DATE: 12/06/10
TIME: 1114
USER: KDC2
EVENT: Draft report viewed in PCI

DATE: 12/06/10
TIME: 1118
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)

ORIGINAL:
very personable and pleasant 66-year-old active male and he is here for a right ureteral stone extracorporeal shock wave lithotripsy today, which will be preceded by a cystoscopy, ureteroscopy and stent placement.

EDITED:
very personable and pleasant 66-year-old active male here for cystoscopy, ureteroscopy and stent placement followed by extracorporeal shock wave lithotripsy.

DATE: 12/06/10
TIME: 1123
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)

ORIGINAL:
other than a baby aspirin daily. He denied prescribed medications or doctor

EDITED:
other than a baby aspirin daily. He denied noncompliance with prescribed medications or doctor

DATE: 12/06/10
TIME: 1123
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)

ORIGINAL:
history. He denied any cardiovascular history or pulmonary history. He did

000415

RUN DATE: 09/24/12
RUN TIME: 1045
RUN USER: DLC7

DEACONESS ORDER ENTRY *** LIVE ***
REPORT'S AUDIT TRAIL

PAGE 4

DEPARTMENT: DTRAN
REPORT: 1204-0012 PROG NOTE
PATIENT: DX3768908 CLONINGER, GLEN A

EDITED:
history. He denied any cardiovascular history or pulmonary history but did admit to snoring a little when asked about any history of Obstructive sleep apnea.
He did

DATE: 12/06/10
TIME: 1124
USER: KDC2
EVENT: Draft report viewed in PCI

DATE: 12/06/10
TIME: 1124
USER: KDC2
EVENT: Draft report viewed in PCI

DATE: 12/06/10
TIME: 1154
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)
ORIGINAL:
Preop EKG showed EKG with normal sinus rhythm with a rate of 60 beats per
EDITED:
Preop EKG showed EKG with normal sinus rhythm with a rate of 68 beats per

DATE: 12/06/10
TIME: 1154
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)
ORIGINAL:
PHYSICAL EXAMINATION: HEENT: The patient had the following dental work:
EDITED:
PHYSICAL EXAMINATION: Obese 66 year old male in no acute distress. Hieght: 5'9" Wieght: 104 KG (230 LBS)
HEENT: The patient had the following dental work:

DATE: 12/06/10
TIME: 1154
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)
ORIGINAL:
approximately 60 beats per minute. There was no murmur, gallops or rubs
EDITED:

000415

RUN DATE: 09/24/12
RUN TIME: 1045
RUN USER: DLC7

DEACONESS ORDER ENTRY *** LIVE ***
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DEPARTMENT: DTRAN
REPORT: 1204-0012 PRGG NOTE
PATIENT: DX3769908 CLONINGER, GLEN A

approximately 60 beats per minute. There were no murmurs, gallops or rubs

DATE: 12/06/10
TIME: 1154
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)
ORIGINAL:
anesthesia for his procedure. We discussed the reasons why this would not be a good idea for him. This would not be the best anesthetic for him to have for the following reasons:

EDITED:
anesthesia for his procedure. We discussed that for reasons related to his obesity and history of untreated Gastroesophageal reflux disease by themselves required a general endotracheal anesthetic be done for the procedure to safely proceed.
Other factors also discussed were patient positioning for the two distinct parts of the procedure that would negatively impact his ability to ventilate adequately on his own. And the potential for a lengthy procedure for which it was important to the success of

DATE: 12/06/10
TIME: 1155
USER: KDC2
EVENT: Draft report viewed in PCI

DATE: 12/06/10
TIME: 1214
USER: MLM62
EVENT: Draft report viewed in PCI

DATE: 12/06/10
TIME: 1217
USER: MLM62
EVENT: Draft report viewed in PCI

DATE: 12/06/10
TIME: 1257
USER: TLL8
EVENT: Draft report viewed in PCI

000417

RUN DATE: 09/24/12

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RUN TIME: 1045

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RUN USER: DLC7

DEPARTMENT: DTRAN

REPORT: 1204-0012 PROG NOTE

PATIENT: DX3769908 CLONINGER, GLEN A

DATE: 12/06/10

TIME: 1312

USER: KDC2

EVENT: section 3 of report edited through PREVIEW (PCI)

ORIGINAL:

very personable and pleasant 66-year-old active male here for cystoscopy, ureteroscopy and stent placement followed by extracorporeal shock wave lithotripsy.

EDITED:

very personable and pleasant 66-year-old active male here for cystoscopy, ureteroscopy and stent placement followed by extracorporeal shock wave lithotripsy.

DATE: 12/06/10

TIME: 1312

USER: KDC2

EVENT: ~~section 3 of report edited through PREVIEW (PCI)~~

ORIGINAL:

medications or doctor visits. His health system survey showed negative for all medical problems, so he was specifically asked system by system if he had had any past medical history. He denied any cardiovascular history or pulmonary history but did admit to snoring a little when asked about any history of Obstructive sleep apnea.

He did

admit to some occasional acid reflux for which he does not take medications.

He denied any endocrine problems, history of hepatorenal difficulties or neurologic deficits.

EDITED:

medications or doctor visits. His health system survey showed negative for all medical problems, he was therefore specifically asked system by system if he had had any past medical history. He denied any cardiovascular history or pulmonary history but did admit to snoring a little when asked about any history of Obstructive sleep apnea. He did admit to some occasional acid reflux for which he does not take medications. He denied any endocrine problems, history of hepatorenal difficulties or neurologic deficits.

DATE: 12/06/10

TIME: 1312

USER: KDC2

EVENT: section 3 of report edited through PREVIEW (PCI)

ORIGINAL:

PHYSICAL EXAMINATION: Obese 66 year old male in no acute distress. Height:

5'9" Weight: 104 KG (230 LBS)

HEENT: The patient had the following dental work:

000418

RUN DATE: 09/24/12
RUN TIME: 1045
RUN USER: DLC7

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DEPARTMENT: DTRAM
REPORT: 1204-0012 PRG NOTE
PATIENT: DX3769908 CLONINGER, GLEN A

EDITED:
PHYSICAL EXAMINATION:
Obese 66 year old male in no acute distress. Height: 5'9" Weight: 104 KG (230 LBS)
HEENT: The patient had the following dental work:

DATE: 12/06/10
TIME: 1312
USER: KDC2

EVENT: section 3 of report edited through PREVIEW (PCI)

ORIGINAL:

ANESTHETIC PLAN/DISCUSSION: The patient inquired about having sedation anesthesia for his procedure. We discussed that for reasons related to his obesity and history of untreated Gastroesophageal reflux disease by themselves required a general endotracheal anesthetic be done for the procedure to safely proceed.

Other factors also discussed were patient positioning for the two distinct parts of the procedure that would negatively impact his ability to ventilate adequately on his own. And the potential for a lengthy procedure for which it was important to the success of

1. We discussed that while oftentimes patients can just have sedation anesthesia for lithotripsy or cystoscopy, that in his case this would not be a prudent course of action and the reason for this was discussed as relating to his obesity and the potential for him experiencing airway obstruction as his sedation levels were increased to make him comfortable for the procedure. It was explained to him that his feet would be up in stirrups and that that would place further pressure on his enlarged abdomen, that would then place further pressure on his diaphragm and increase the work of breathing for him. I let him know that as levels of sedation increased that his respiratory efforts would likely become weaker and he would have difficulty taking adequate breaths to stay properly oxygenated. We also talked about how his airway was different than an average weight/normal weight patient and that he is at increased risk for obstruction, and with his obese body habitus, that he likely already experiences obstructive sleep apnea while he sleeps. Also discussed was that the lithotripsy procedure itself is quite stimulating and uncomfortable, and he likely had quite a large stone and this procedure could be quite long, requiring ever increasing amounts of sedation that he would not be able to safely tolerate. We discussed that a general anesthetic would be the safest anesthetic for him _____ as he does have a history of acid reflux. Because his airway would be secured by an endotracheal tube at the beginning of the case rather sometime during the case when his sedation became sufficient enough to cause him to obstruct and not ventilate properly. The patient agreed that this was the best plan of action and we then discussed some other risks associated with an endotracheal tube such as postoperative sore throat and possibility of a hoarse voice for a short period time. We also discussed that during the procedure he would be given medications to make him comfortable for when he awakens from surgery and also medication

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RUN USER: DLC7

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DEPARTMENT: DTRAN
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PATIENT: DX3769908 CLONINGER, GLEN A

to prevent postoperative nausea and vomiting. I also made him aware that someone would be with him at all times postoperatively so that if he should experience any discomfort or nausea that he could simply let us know and we would try something different for him to make him comfortable.

EDITED:

ANESTHETIC PLAN/DISCUSSION:

The patient inquired about having sedation anesthesia for his procedure. We discussed that for reasons related to his obesity (70 extra pounds) and history of untreated Gastroesophageal Reflux Disease by themselves required a general endotracheal anesthetic be done for the procedure to safely proceed. Other factors also discussed were patient positioning for the two distinct parts of the procedure that would each negatively impact his ability to ventilate adequately on his own. And finally the potential for a lengthy procedure for which success depended on the patient's ability to hold still. We discussed that while often times patients can just have sedation anesthesia for lithotripsy or cystoscopy, that in his case this would not be a prudent course of action and the reason for this was discussed as relating to his obesity and the potential for him experiencing airway obstruction as his sedation levels were increased to keep him comfortable and still for the procedure. It was explained to him that his feet would be up in stirrups and that that would place further pressure on his enlarged abdomen, that would then place further pressure on his diaphragm and increase the work of breathing for him. I let him know that as levels of sedation increased that his respiratory efforts would likely become weaker and he would have difficulty taking adequate breaths to stay properly oxygenated.

The patient agreed that this was the best plan of action and we then discussed some other risks associated with an endotracheal tube such as postoperative sore throat and possibility of a hoarse voice for a short period time. The patient asked about risks of not waking up from anesthesia. The patient was informed that cardiac arrest and death are uncommon events but do rarely occur. More likely for him we discussed was the unlikely potential for a prolonged wake up period requiring some additional time on the ventilator. It was also discussed that during the procedure he would be given medications to make him comfortable for when he awakens from surgery and also medication to prevent postoperative nausea and vomiting. I also made him aware that someone would be with him at all times postoperatively so that if he should experience any discomfort or nausea he could simply let us know and we would take the necessary measures to make him comfortable.

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RUN USER: DLC7

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DEPARTMENT: DTRAN
REPORT: 1204-0012 PROC NOTE
PATIENT: DXE769908 CLONINGER, GLEN A

DATE: 12/06/10
TIME: 1312
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)

ORIGINAL:
anesthesia, he was given 150 mcg of fentanyl, 0.1 of glycopyrrolate to aid in keeping his airway dry, followed by continued preoxygenation for 2-3 minutes, with the patient instructed to take large tidal volumes. Following proper preoxygenation with stable vital signs, blood pressure 142/92 and a heart rate of about 68 and a sat of 98% on 100% O2, 100 mg of lidocaine and 200 mg of propofol were slowly administered, followed by 50 mg of rocuronium.

EDITED:
anesthesia, he was given 150 mcg of fentanyl, 0.1mg of glycopyrrolate followed by continued preoxygenation for 2-3 minutes, with the patient instructed to take large breaths. Tidal volumes were 700-1000ml and end tidal CO2=32-34. Following proper preoxygenation with stable vital signs, blood pressure 142/92 and a heart rate of 68 bpm and a sat of 99% on 100% O2, 100 mg of lidocaine and 200 mg of propofol were administered, followed by 50 mg of rocuronium.

After the patient was asleep, an oral airway was placed and the patient was bag masked ventilated without difficulty, after which a MAC 3 blade was used to attempt to visualize the vocal cords. The first 2 attempts were brief and only revealed the tip of the epiglottis. Sats remained at 99% and the patient was bag mask ventilated without difficulty for another 30 seconds. A Bougie was placed through an 8.0 endotracheal tube and the MAC 3 blade was used once again. The patient was successfully intubated with the 8.0 endotracheal tube. The endotracheal tube cuff was inflated and ET tube attached to the anesthesia circuit followed by verification of positive end tidal CO2=34 and positive bilateral breath sounds being equal. Sats remained at 99% with a end tidal CO2=34 and a HR=68. The endotracheal tube was secured at 21 cm at the teeth and oral airway placed back in the patients mouth.

DATE: 12/06/10
TIME: 1312
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)

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RUN DATE: 09/24/12
RUN TIME: 1045
RUN USER: DLC7

DEACONESS ORDER ENTRY *** LIVE ***
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DEPARTMENT: DITRAN
REPORT: 1204-0012 PROG NOTE
PATIENT: DX3769908 CHONINGER, GLEN A

ORIGINAL:

After the patient was asleep, a 70 mm oral airway was placed and the patient was bag masked ventilated, after which a MAC 3 blade was used to attempt to visualize the vocal cords. The first 2 attempts were brief and only revealed the tip of the epiglottis, so the patient was bag mask ventilated for another 30 seconds and a Bougie was placed through an 8.0 endotracheal tube and the MAC 3 blade was used once again a third time and the patient was successfully intubated with the 8.0 endotracheal tube. The endotracheal tube cuff was inflated and attached to the anesthesia circuit followed by verification of positive end tidal CO2 and positive bilateral breath sounds being equal. The tube was secured at 21 cm at the teeth.

EDITED:

DATE: 12/06/10
TIME: 1312
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)

ORIGINAL:

The patient's blood pressure rose to the 180s/102 briefly and his blood pressure rapidly came back down to the normal range following the ramping up of his anesthetic levels. His heart rate rose from the high 60s into the mid to high 70s, and briefly after a few minutes of anesthesia touched 90 and then over the next few minutes (10-15 minutes) then dropped back down to roughly his baseline in the mid to high 60s, and remained in the 58-64 range for the remainder of the procedure itself.

EDITED:

The patient's blood pressure rose to 182/102 briefly following intubation. Fentanyl 100mcg was given. A follow up blood pressure two minutes later following initial ramp up of anesthetic levels equalled 140/80 with a HR=80. Heart rate rose briefly following intubation from the high 60s into the mid to high 70s, and briefly after a few minutes of anesthesia touched 90 and then

000422

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RUN TIME: 1045
RUN USER: DLC7

DEACONESS ORDER ENTRY *** LIVE ***
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DEPARTMENT: BTRAN
REPORT: 1204-0012 PROG NOTE
PATIENT: DX3769908 CLONTINGER, GLEN A

over the next few minutes (10-15 minutes) dropped back down to roughly his baseline in the mid 60s, and remained in the 58-64 range for the remainder of the procedure.

Following induction of anesthesia and securing of the endotracheal tube, the patient was moved down to the end of the lithotripsy table and his legs placed in the stirrups so that the cystoscopy and ureteroscopy could be performed. This part of the procedure progressed uneventfully with vital signs remaining stable.

DATE: 12/06/10
TIME: 1312
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)

ORIGINAL:
Following induction of anesthesia and securing of the airway and endotracheal tube, the patient was moved down to the end of the lithotripsy table and his legs placed in the stirrups so that the cystoscopy and ureteroscopy could be performed. This was done uneventfully and his hemodynamics were stable through this portion of the procedure.

EDITED:

DATE: 12/06/10
TIME: 1312
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)

ORIGINAL:
was utilized to cradle the face and the anesthesia circuit was reconnected and bilateral breath sounds were once again verified, as was positive end tidal CO2. Vital signs were stable through this process of turning the patient to the prone position. Lithotripsy then proceeded uneventfully. The patient's heart rate remained in the 58-64 range. There were 3 separate attempts to raise his heart rate slightly to reduce the time of lithotripsy and improve the effectiveness of the procedure, and this was done by administering, as is commonly and customarily done, 100 mcg of atropine. However, no heart rate change was observed with administration of atropine 100 mcg on 3 separate occasions, therefore, further attempts at increasing heart rate using atropine was abandoned, and the procedure continued uninterrupted with the heart rate remaining in the 58-64 range.

EDITED:
was utilized to cradle the patients face and the anesthesia circuit was reconnected and

000423

RUN DATE: 09/24/12
RUN TIME: 1045
RUN USER: DLC7

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DEPARTMENT: DTRAN
REPORT: 1204-0012 PROC NOTE
PATIENT: DX3769908 CLONINGER, GLEN A

bilateral breath sounds were once again verified, as was positive end tidal CO2. Vital signs were stable through this process of turning the patient to the prone position. Lithotripsy then proceeded uneventfully. The patient's heart rate remained in the 58-64 range. There were 3 separate attempts to raise his heart rate slightly to reduce the time of lithotripsy and improve the effectiveness of the procedure, and this was done by administering, as is commonly and customarily done, 100 mcg of atropine. However, no heart rate change was observed with administration of atropine 100 mcg on 3 separate occasions, therefore, further attempts at increasing heart rate using atropine was abandoned, and the procedure continued uninterrupted with the heart rate remaining in the 58-64 range.

DATE: 12/06/10
TIME: 1327
USER: TLH25
EVENT: Draft report viewed in PCI

DATE: 12/06/10
TIME: 1351
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)

ORIGINAL:

patient was bag mask ventilated without difficulty for another 30 seconds. A bougie was placed through an 8.0 endotracheal tube and the MAC 3 blade was used once again. The patient was successfully intubated with the 8.0 endotracheal tube. The endotracheal tube cuff was inflated and ET tube attached to the anesthesia circuit followed by verification of positive end tidal CO2=34 and positive bilateral breath sounds being equal. Sats remained at 99% with a end tidal CO2=34 and a HR=68. The endotracheal tube was secured at 21 cm at the teeth and oral airway placed back in the patients mouth.

EDITED:

patient was bag mask ventilated without difficulty for another 30 seconds. The Glide Scope was requested. A Bougie was placed through an 8.0 endotracheal tube and the MAC 3 blade was used once again. The patient was successfully intubated with the 8.0 endotracheal tube. The endotracheal tube cuff was inflated and ET tube attached to the anesthesia circuit followed by verification of positive end tidal CO2=34 and positive bilateral breath sounds being equal. Sats remained at 99% with a end tidal CO2=34 and a HR=68. The endotracheal tube was secured at 21 cm at the teeth and oral airway placed back in the patients mouth. The Glide Scope arrived and remained in the room.

DATE: 12/06/10
TIME: 1351
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)

ORIGINAL:

Following cystoscopy, the patient was returned to the head of the bed and then turned to the prone position with full monitoring in place. A prone pillow was utilized to cradle the patients face and the anesthesia circuit was reconnected and

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RUN DATE: 09/24/12
RUN TIME: 1045
RUN USER: DLC7

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DEPARTMENT: DTRAN
REPORT: 1204-0012 BRGG NOTE
PATIENT: DX3769908 CHONENGER, GLEN A

bilateral breath sounds were once again verified, as was positive end tidal CO2. Vital signs were stable through this process of turning the patient to the prone position. Lithotripsy then proceeded uneventfully. The patient's heart rate remained in the 58-64 range. There were 3 separate attempts to raise his heart rate slightly to reduce the time of lithotripsy and improve the effectiveness of the procedure, and this was done by administering, as is commonly and customarily done, 100 mcg of atropine. However, no heart rate change was observed with administration of atropine 100 mcg on 3 separate occasions, therefore, further attempts at increasing heart rate using atropine was abandoned, and the procedure continued uninterrupted with the heart rate remaining in the 58-64 range.

EDITED:

Following cystoscopy, the patient was returned to the head of the bed. A prone pillow placed on the patients face, the anesthesia circuite briefly disconnected and the patient then turned to the prone position with all monitors remaining in place. The anesthesia circuit was reconnected and bilateral breath sounds were once again verified, as was positive end tidal CO2. Vital signs were stable through this process of turning the patient to the prone position. The patients face was checked regularly to verify proper pillow positioning and eye clearance.

Lithotripsy proceeded uneventfully. The patient's heart rate remained in the 58-64 range. There were 3 attempts to raise the patients heart rate slightly to reduce the time of lithotripsy and this was done by administering 100 mcg of atropine. However, no heart rate change was ever abserved and further attempts at increasing heart rate for the proceedure using atropine was abandoned. Near the end of Lithotrypsy the patients train of four was verified. Neostigmine 2mg with .4mg of glycopyrolate was administered as a precautionary measure to minimize the chance of any residual paralytic effect. The procedure continued uninterrupted with the heart rate remaining in the 58-64 range for the duration of Lithitrypsy.

DATE: 12/06/10
TIME: 1351
USER: KDC2

EVENT: section 3 of report edited through PREVIEW (PCI)
ORIGINAL:

The end of lithotripsy concluded the procedure at approximately 09:22, after which the patient was then prepared to turn from the prone position to the supine position. The anesthesia circuit was disconnected from the endotracheal tube temporarily, while the remaining monitors, blood pressure cuff, EKG and pulse oximeter remained in place. The patient was turned to the supine position without difficulty and the anesthesia circuit was then reconnected to the endotracheal tube followed by verification of positive end tidal CO2 and positive bilateral breath sounds.

EDITED:

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RUN USER: DLC7

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DEPARTMENT: DTRAN
REPORT: 1204-0012 PROG NOTE
PATIENT: DK3769908 CLONINGER, GLEN A

DATE: 12/06/10
TIME: 1351
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)
ORIGINAL:

supine position. The anesthesia circuit was disconnected from the endotracheal tube temporarily, while the remaining monitors, blood pressure cuff, EKG and pulse oximeter remained in place. The patient was turned to the supine position without difficulty and the anesthesia circuit was then reconnected to the endotracheal tube followed by verification of positive end tidal CO2 and positive bilateral breath sounds.

EDITED:

supine position. The anesthesia circuit was disconnected from the endotracheal tube temporarily, while the monitors, blood pressure cuff, EKG and pulse oximeter remained in place. The patient was turned to the supine position without difficulty and the anesthesia circuit then reconnected to the endotracheal tube followed by verification of positive end tidal CO2 and positive bilateral breath sounds.

DATE: 12/06/10
TIME: 1351
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)
ORIGINAL:

breaths per minute. For this emergence phase of the anesthetic that lasted approximately 6-7 minutes, the ventilator respiratory rate was decreased from

EDITED:

breaths per minute. End tidal CO2 had remained at 34-36 for the duration of the procedure.
ventilator respiratory rate was decreased from

DATE: 12/06/10
TIME: 1351
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)
ORIGINAL:

encourage spontaneous ventilations. After approximately 5 minutes of

EDITED:

encourage spontaneous ventilations. After approximately 4 minutes of

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RUN USER: DLC7

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PATIENT: DX3769908 CLONINGER, GLEN A

DATE: 12/06/10
TIME: 1351
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)

ORIGINAL:

3-4 minutes, the patient began to gradually resume spontaneous ventilations of ever increasing frequency and depth. Respirations of ever increasing frequency and tidal volume. As emergence proceeded, the patient became gradually more and more restless, requiring 3 nursing staff to restrain him. This was done so that the endotracheal tube would not be prematurely dislodged from the trachea and also to prevent the patient from injuring himself. Sats at that time remained at 98%, respiratory rate was 8-12, tidal volumes remained inadequate at about 275 to 400, and heart rate continued below 60 at roughly 56-58, and the blood pressure by cuff was 97/53. The nurses and I verbally continued to reassure the patient, that everything was going well,

EDITED:

2 minutes, the patient began to gradually resume spontaneous ventilations of ever increasing frequency and depth. As emergence proceeded, the patient became gradually more and more restless, requiring 3 nursing staff to restrain him. This was done so that the endotracheal tube would not be prematurely dislodged from the trachea and also to prevent the patient from injuring himself. The patient was verbally reassured that surgery was over and he needed to remain still and take deep breaths. Sats at that time remained at 98%, respiratory rate was assisted 8-12, tidal volumes remained inadequate at about 275 to 400 unassisted, and heart rate continued below 60 at roughly 56-58, and the blood pressure by cuff was 97/53. The nurses and I verbally continued to reassure the patient, that everything was going well,

DATE: 12/06/10
TIME: 1355
USER: MSF1
EVENT: Draft report viewed in PCI

DATE: 12/06/10
TIME: 1401
USER: MSF1
EVENT: Draft report viewed in PCI

DATE: 12/06/10
TIME: 1430
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)

ORIGINAL:

ventilator respiratory rate was decreased from 10 to 8, and the tidal volumes were left at approximately 700 mL. This decrease in respiratory rate was to help increase end tidal CO2 levels and encourage spontaneous ventilations. After approximately 4 minutes of

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RUN TIME: 1045
RUN USER: DLC7

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PATIENT: DX3769908 CLONINGER, GLEN A

continued mechanical ventilation, the anesthesia machine was placed on bag ventilation and ventilations were supported manually by bag, and over the next 2 minutes, the patient began to gradually resume spontaneous ventilations of ever increasing frequency and depth.

EDITED:

Ventilator respiratory rate was decreased from 10 to 8, and tidal volumes remained at 700-750mls. End tidal CO2 levels rose into the low 40s over two minutes and the anesthesia machine placed on bag and the patients ventilations assisted for another 3 minutes.

DATE: 12/06/10
TIME: 1430
USER: KDC2

EVENT: section 3 of report edited through PREVIEW (PCI)

ORIGINAL:

that surgery was over and he needed to remain still and take deep breaths. Sats at that time remained at 98%, respiratory rate was assisted 8-12, tidal volumes remained inadequate at about 275 to 400 unassisted, and heart rate continued below 60 at roughly 56-58, and the blood pressure by cuff was 97/53. The nurses and I verbally continued to reassure the patient, that everything was going well, that he was just waking up from surgery and to lay still so that he would not hurt himself or pull his endotracheal tube out prematurely. This went on for approximately 2 more minutes, until the patient started demonstrating a stable pattern of respirations and tidal volumes where we were comfortable with faithfully extubating him. So just prior to extubation, sats remained at 98%, his tidal volumes were now 750 to 1150 and his rate was 14-18 and we felt confident that he had returned to spontaneous respirations adequate for extubation.

EDITED:

that surgery was over and he needed to remain still and take deep breaths. Sats at that time remained at 98%. Respiratory rate was assisted 8-12, tidal volumes remained inadequate at about 275mls to 400mls unassisted, and heart rate continued below 60 at roughly 56-58, blood pressure by cuff was 97/53. The nurses and I verbally continued to reassure the patient, that everything was going well, that he was just waking up from surgery and to lay still so that he would not hurt himself or pull his endotracheal tube out prematurely. This went on for approximately 2 more minutes, at which point the patient started demonstrating a stable pattern of respirations and tidal volumes with good sats and acceptable CO2. The patients tidal volumes were now 750 to 1150 with a rate of 18-24, Sats=98%, end tidal CO2=44-46, HR=58 and BP=97/53. About 75 mls of clear yellow fluid was suctioned from the patients stomach and the oral cavity suctioned and cleared of any secretions after which the patient was extubated.

DATE: 12/06/10

000428

RUN DATE: 09/24/12
RUN TIME: 1045
RUN USER: DLC7

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DEPARTMENT: DTRAN
REPORT: 1204-0012 PROG NOTE
PATIENT: EX3769908 CLONINGER, GLEN A

TIME: 1430
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)
ORIGINAL:

At this point, the patient was very difficult to restrain. We had 4 OR staff members, at least 3 of which were nurses, and myself at the head of bed trying to protect the patient from hurting himself and we were cognizant of the fact that removing the endotracheal tube may well calm him down, and now that he met extubation criteria we proceeded to suction the patient orally and extubate the patient in the hopes that we would have some calming occur. This, however, did not occur and if anything he was at least as restless and relatively combative as he was prior to the extubation. We tried to maintain contact with all our monitors and were largely successful since we had so much help in the room at that point. I was at the head of the bed, of course, managing the airway. At this point, airway management was simply trying to maintain oxygen mask from the anesthesia circuit on the patient, and he was breathing into it. He was fogging the mask. He was breathing adequately. We saw tidal volumes of 750-900 and the anesthesia bag was visibly collapsing and inflating as he breathed through the circuit. This lasted for approximately 30 seconds to 1 minute, at which time the patient had an apparent laryngospasm requiring positive pressure ventilation. This was difficult to achieve because the patient was still squirming in his bed, but we still had 4 OR staff members restraining the patient, and I was successful in maintaining some positive pressure ventilation and that broke the laryngospasm. At that time, his sats had dipped into the 68-78 region, but then quickly returned up to up to 88 and then 94%. His heart rate at that time was 48 to roughly 52, and we had another blood pressure that was 97/53. Positive pressure was then reduced and the patient was ventilating adequately for approximately 30 seconds with tidal volumes of 750-850. He was still restless, sats were as stated, and then he suddenly laryngospasmed once again. Positive pressure was increased, however, this time the laryngospasm did not break and he had a rapid desaturation from the low/mid 90s into the 70s and 60s.

EDITED:

The oxygen mask was placed on the patient and he continued to breath adequately throught he mask for about 20-30 seconds with tidal volumes of 550mls to 900mls. was requesting the oxygen mask be remaove from his face and reaching to remove it. He was fogging the mask. He was breathing adequately. We saw tidal volumes of 750-900 and the anesthesia bag was visibly collapsing and inflating as he breathed through the circuit. This lasted for approximately 30 seconds to 1 minute, at which time the patient had an apparent laryngospasm requiring positive pressure ventilation. This was difficult to achieve because the patient was still squirming in his bad, but we still had 4 OR staff members restraining the patient, and I was successful in maintaining some positive pressure ventilation and that broke the laryngospasm. At that time, his sats had dipped into the 68-78 region, but then quickly returned up to up to 88 and then 94%. His heart rate at that time was 48 to roughly 52, and we had another blood pressure that was 97/53. Positive pressure was then reduced and the patient was ventilating adequately for approximately 30 seconds with tidal volumes of 750-850. He was still restless, sats were as stated, and then he

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RUN DATE: 09/24/12
RUN TIME: 1045
RUN USER: DLC7

DEACONESS ORDER ENTRY *** LIVE ***
REPORT'S AUDIT TRAIL

PAGE 18

DEPARTMENT: DTRAN
REPORT: E204-0012 PROC NOTE
PATIENT: DX3769908 CLONINGER, GLEN A

suddenly laryngospasmed once again. Positive pressure was increased, however, this time the laryngospasm did not break and he had a rapid desaturation from the low/mid 90s into the 70s and 60s.

DATE: 12/06/10
TIME: 1430
USER: JKH6
EVENT: Draft report viewed in PCI

DATE: 12/06/10
TIME: 1430
USER: JKH6
EVENT: Draft report viewed in PCI

DATE: 12/06/10
TIME: 1432
USER: KDC2
EVENT: Draft report viewed in PCI

DATE: 12/06/10
TIME: 1523
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)
ORIGINAL:
engaged in and he told me that he was healthy and went to the gym regularly.

EDITED:
engaged in and he told me that he was healthy and went to the gym regularly. He denied any history of shortness of breath or chest pain at any time with activity or at rest.

DATE: 12/06/10
TIME: 1523
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)
ORIGINAL:
done some years ago without anesthetic complications.

EDITED:
done some years ago without anesthetic complications. There is not a family history of any anesthetic complications that he is aware of.

UNHCSA

RUN DATE: 09/24/12
RUN TIME: 1045
RUN USER: DLC7

DEACONESS ORDER ENTRY *** LIVE ***
REPORT'S AUDIT TRAIL

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DEPARTMENT: ETRAN
REPORT: L204-0012 PROG NOTE
PATIENT: DX3769908 CLONINGER, GLEN A

DATE: 12/06/10
TIME: 1523
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)
ORIGINAL:
Preop EKG showed EKG with normal sinus rhythm with a rate of 68 beats per

EDITED:
Preop EKG showed normal sinus rhythm with a rate of 68 beats per

DATE: 12/06/10
TIME: 1523
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)
ORIGINAL:

endotracheal anesthetic be done for the procedure to safely proceed. Other factors also discussed were patient positioning for the two distinct parts of the procedure that would each negatively impact his ability to ventilate adequately on his own. And finally the potential for a lengthy procedure for which success depended on the patients ability to hold still. We discussed that while often times patients can just have sedation anesthesia for lithotripsy or cystoscopy, that in his case this would not be a prudent course of action and the reason for this was discussed as relating to his obesity and the potential for him experiencing airway obstruction as his sedation levels were increased to keep him comfortable and still for the procedure. It was explained to him that his feet would be up in stirrups and that that would place further pressure on his enlarged abdomen, that would then place further pressure on his diaphragm and increase the work of breathing for him. I let him know that as levels of sedation increased that his respiratory efforts would likely become weaker and he would have difficulty taking adequate breaths to stay properly oxygenated.

EDITED:
endotracheal anesthetic be done in order for the procedure to safely proceed. Other factors also discussed were patient positioning for the two distinct parts of the procedure that would each negatively impact his ability to ventilate adequately on his own. And finally the potential for a lengthy procedure for which success depended on the patients ability to hold still. We discussed that while often times patients can just have sedation anesthesia for lithotripsy or cystoscopy, that in his case this would not be a prudent course of action and the reason for this was discussed as relating to his obesity and the potential for him experiencing airway obstruction as his sedation levels were increased to keep him comfortable and still for the procedure. It was explained to him that his feet would be up in stirrups and that would place further pressure on his enlarged abdomen, that would then place further pressure on his diaphragm and increase the work of breathing for him. I let him know that as levels of sedation increased that his respiratory efforts would likely become weaker and he would have difficulty taking adequate breaths to stay properly oxygenated.

DATE: 12/06/10
TIME: 1523

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RUN DATE: 09/24/12
RUN TIME: 1045
RUN USER: DLC7

DEACONESS ORDER ENTRY *** LIVE ***
REPORT'S AUDIT TRAIL

PAGE 20

DEPARTMENT: DTRAN
REPORT: 1204-0012 PROG NOTE
PATIENT: DX3769908 CLONINGER, GLEN A

USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)
ORIGINAL:
informed that cardiac arhest and death are uncommon events but do rarely occur.

EDITED:
informed that cardiac arhest and death are rare events but do rarely occur.

DATE: 12/06/10
TIME: 1523
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)
ORIGINAL:
wake up period requireing some additional time on the ventilator. It was also

EDITED:
wake up period requireing some additional time on the ventilator. It was also

DATE: 12/06/10
TIME: 1523
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)
ORIGINAL:
postoperative nausea and vomiting. I also made him aware that someone would

EDITED:
postoperative nausea and vomiting. I also made him aware that someone would

DATE: 12/06/10
TIME: 1523
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)
ORIGINAL:
necessary measures to make him comfortable.

EDITED:
necessary measures to make him comfortable. The patient indicated that he
wanted to proceed and get something to eat as soon as surgery was over.

DATE: 12/06/10
TIME: 1523
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)
ORIGINAL:
take large breaths. Tidal volumes were 700-1000ml and end tidal CO2=32-34.

EDITED:
take large breaths. Tidal volumes were 700-1100ml and end tidal CO2=32-34.

DATE: 12/06/10
TIME: 1523

000432

RUN DATE: 09/24/12
RUN TIME: 1045
RUN USER: DLC7

DEACONESS ORDER ENTRY *** LIVE ***
REPORT'S AUDIT TRAIL

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DEPARTMENT: DTRAN
REPORT: 1204-0012 PROG NOTE
PATIENT: DX3769908 CLONINGER, GLEN A

USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)
ORIGINAL:

the end of Lithotripsy the patients train of four was verified. Neostigmine 2mg with .4mg of glycopyrolate was administered as a precautionary measure to minimize the chance of any residual paralytic effect. The procedure continued uninterrupted with the heart rate remaining in the 58-64 range for the duration of Lithitripsy.

EDITED:
the end of Lithotripsy the patients train of four was verified as 4/4. Neostigmine 2mg with .4mg of glycopyrolate was administered as a precautionary measure to minimize the chance of any residual paralytic effect. The procedure continued uninterrupted with the heart rate remaining in the 58-64 range for the duration of Lithitripsy.

DATE: 12/06/10
TIME: 1523
USER: KDC2

EVENT: section 3 of report edited through PREVIEW (PCI)
ORIGINAL:

Sats at that time remained at 98%. Respiratory rate was assisted 8-12, tidal volumes remained inadequate at about 275mls to 400mls unassisted, and heart rate continued below 60 at roughly 56-58, blood pressure by cuff was 97/53. The nurses and I verbally continued to reassure the patient, that everything was going well, that he was just waking up from surgery and to lay still so that he would not hurt himself or pull his endotracheal tube out prematurely. This went on for approximately 2 more minutes, at which point the patient started demonstrating a stable pattern of respirations and tidal volumes with good sats and acceptable CO2. The patients tidal volumes were now 750 to 1150 with a rate of 18-24, Sats=98%, end tidal CO2=44-46, HR=58 and BP=97/53. About 75 mls of clear yellow fluid was suctioned from the patients stomach and the oral cavity suctioned and cleared of any secretions after which the patient was extubated.

The oxygen mask was placed on the patient and he continued to breath adequately throught he mask for about 20-30 seconds with tidal volumes of 550mls to 900mls. was requesting the oxygen mask be remaove from his face and reaching to remove it. He was fogging the mask. He was breathing adequately. We saw tidal volumes of 750-900 and the anesthesia bag was visibly collapsing and inflating as he breathed through the circuit. This lasted for approximately 30 seconds to 1 minute, at which time the patient had an apparent laryngospasm requiring positive pressure ventilation. This was difficult to achieve because the patient was still squirming in his bad, but we still had 4 OR staff members restraining the patient, and I was successful in maintaining some positive pressure ventilation and that broke the laryngospasm. At that time, his sats had dipped into the 68-78 region, but then quickly returned up to up to 88 and then 94%. His heart rate at that time was 48 to roughly 52, and we had another blood pressure that was 97/53. Positive pressure was then reduced and the patient was ventilating adequately for approximately 30 seconds with tidal

000433

RUN DATE: 09/24/12
RUN TIME: 1045
RUN USER: DLC7

DEACONESS ORDER ENTRY *** LIVE ***
REPORT'S AUDIT TRAIL

PAGE 22

DEPARTMENT: DTRAN
REPORT: 1204-0012 PROG NOTE
PATIENT: DX3769908 CLONINGER, GLEN A

volumes of 750-850. He was still restless, sats were as stated, and then he suddenly laryngospasmed once again. Positive pressure was increased, however, this time the laryngospasm did not break and he had a rapid desaturation from the low/mid 90s into the 70s and 60s.

EDITED:

Sats at that time remained at 98%. Respiratory rate was assisted at 8-12, tidal volumes remained inadequate at about 275mls to 400mls unassisted, and heart rate continued below 60 at roughly 56-58, blood pressure by cuff was 97/53. The nurses and I verbally continued to reassure the patient, that everything was going well, that he was just waking up from surgery and to lay still so that he would not hurt himself or pull his endotracheal tube out prematurely. This went on for approximately 2 more minutes, at which point the patient started demonstrating a stable pattern of respirations and tidal volumes with good sats and acceptable CO2. The patients tidal volumes were now 750 to 1150 with a rate of 18-24, Sats=98%, end tidal CO2=38-42, HR=48 and BP=97/53. About 75 mls of clear yellow fluid was suctioned from the patients stomach and the oral cavity suctioned and cleared of any secretions after which the patient was extubated.

DATE: 12/06/10
TIME: 1523
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)
ORIGINAL:

000434

RUN DATE: 09/24/12
RUN TIME: 1045
RUN USER: DLC7

DEACONESS ORDER ENTRY *** LIVE ***
REPORT'S AUDIT TRAIL

PAGE 23

DEPARTMENT: DTRAN
REPORT: 1204-0012 PRG NOTE
PATIENT: BX3769908 CLONINGER, GLEN A

EDITED:

The anesthesia machine oxygen mask was placed on the patient and he continued to breath adequately throught the mask for about 20-30 seconds with RR=18-22, tidal volumes of 550mls to 900mls, Sats=97%, ETCO2=42-44, HR=48. The patient then began requesting the oxygen mask be removed from his face and he was reaching to remove it. He was fogging the mask. Tidal volumes of 500-900 and the anesthesia bag was visibly collapsing and inflating as he breathed through the circuit. This lasted for approximately 20 seconds, with a RR=18-24, Sats=92-94%. The patient then experienced laryngospasm requiring positive pressure ventilation that broke the laryngospasm. At that time, his sats had dipped into the 68-78 region, but then quickly returned up to up to 88 and then 94%. His heart rate at that time was 48. Positive pressure was then reduced and the patient was ventilating adequately for approximately 30 seconds with tidal volumes of 750-850. He suddenly laryngospasmed once again. Positive pressure was increased, however, this time the laryngospasm did not break and he had a rapid desaturation from the low/mid 90s into the 70s and 60s.

DATE: 12/06/10
TIME: 1523
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)

ORIGINAL:

rate of decline of his saturations and noticing that his heart rate now was in the low 40s, I immediately elected to reintubate the patient and rapidly administered 100 mg of succinylcholine and 100 mg of propofol. At this point, the oral airway that was previously in the patient's mouth while we were trying to apply positive pressure ventilation to break the laryngospasm had been spit out, so that was replaced. Positive pressure bag mask ventilation was then attempted once again. This proved to be difficult. Bradycardia was worsening and we had rate in the mid to high 30s and the sat was dropping into the low 60s, and 53% was seen. I elected to attempt intubation at this point since ventilations were difficult. I instrumented the airway quickly with the MAC 3 blade. I had a poor view. Dr. King by this moment in time was standing next to me with the Glide Scope in his hand. He stepped in and instrumented the airway with the Glide Scope and was successful at placing an 8.0 mm endotracheal tube into the trachea. Dr. King achieved intubation of the trachea very rapidly with the Glide Scope, taking only a few seconds, and an 8.0 mm endotracheal tube was placed. The cuff was inflated. Bilateral breath sounds were verified as was end tidal CO2. End tidal CO2 was found to be in

000435

RUN DATE: 09/24/12
RUN TIME: 1045
RUN USER: DLC7

DEACONESS ORDER ENTRY *** LIVE ***
REPORT'S AUDIT TRAIL

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DEPARTMENT: DTRAN
REPORT: 1204-0012 PROG NOTE
PATIENT: DX3769908 CLONINGER, GLEN A

the low 20s. Heart rate remained in the mid 30s and we had sats of 53

EDITED:

rate of decline of his saturations and heart rate now in the low 40s, I immediately elected to reintubate the patient and rapidly administered 100 mg of succinylcholine and 100 mg of propofol. Positive pressure bag mask ventilation was then done once again with oral air way in place. Bradycardia was worsening and we had rate in the mid to high 30s and the sat was dropping into the 60s. No pulse was found and CPR was initiated. Dr. King by this moment in time was standing next to me with the Glide Scope in his hand. He stepped in and instrumented the airway with the Glide Scope and was successful at placing an 8.0 mm endotracheal tube into the trachea. Dr. King achieved intubation of the trachea very rapidly with the Glide Scope, taking only a few seconds, and an 8.0 mm endotracheal tube was placed. The cuff was inflated. Bilateral breath sounds were verified as was end tidal CO2. End tidal CO2 was found to be in the low 20s. Heart rate remained in the mid 30s and we had sats of 53

DATE: 12/06/10
TIME: 1531
USER: KDC2

EVENT: section 3 of report edited through PREVIEW (PCI)

ORIGINAL:

dipped into the 68-78 region, but then quickly returned up to up to 88 and then

EDITED:

dipped into the 68-78 region, but then quickly returned to 88 and then

DATE: 12/06/10
TIME: 1531
USER: KDC2

EVENT: section 3 of report edited through PREVIEW (PCI)

ORIGINAL:

tidal volumes of 750-850. He suddenly laryngospasmed once again. Positive pressure was increased, however, this time the laryngospasm did not break and he had a rapid desaturation from the low/mid 90s into the 70s and 60s.

000436

RUN DATE: 09/24/12
RUN TIME: 1045
RUN USER: DLC7

DEACONESS ORDER ENTRY *** LIVE ***
REPORT'S AUDIT TRAIL

PAGE 25

DEPARTMENT: DIFRAN
REPORT: 1204-0012 PROC NOTE
PATIENT: DX3769908 CLONINGER, GLEN A

EDITED:

tidal volumes of 750-850. He suddenly laryngospasmed once again. Dr. King was called to assist. Positive pressure was increased, however, this time the laryngospasm did not break. The patients heart rate suddenly dropped to 34 and he had a rapid desaturation from 92% into the 70s and 60s. I immediately elected to reintubate the patient and rapidly administered 100 mg of succinylcholine and 100 mg of propofol. Positive pressure bag mask ventilation was then done once again with oral air way in place. Bradycardia was worsening and we had rate in the mid to high 30s and the sat was dropping into the 60s. No pulse was found and CPR was initiated. Dr. King by this moment in time was standing next to me with the Glide Scope in his hand. He stepped in and instrumented the airway with the Glide Scope and was successful at placing an 8.0 mm endotracheal tube into the trachea. Dr. King achieved intubation of the trachea very rapidly with the Glide Scope, taking only a few seconds, and an 8.0 mm endotracheal tube was placed. The cuff was inflated. Bilateral breath sounds were verified as was end tidal CO2. End tidal CO2 was found to be in the low 20s. Heart rate remained in the mid 30s and we had sats of 53 percent.

DATE: 12/06/10
TIME: 1531
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)
ORIGINAL:

At this point because of the second laryngospasm and especially due to the rate of decline of his saturations and heart rate now in the low 40s, I immediately elected to reintubate the patient and rapidly administered 100 mg of succinylcholine and 100 mg of propofol. Positive pressure bag mask ventilation was then done once again with oral air way in place. Bradycardia was worsening and we had rate in the mid to high 30s and the sat was dropping into the 60s. No pulse was found and CPR was initiated. Dr. King by this moment in time was standing next to me with the Glide Scope in his hand. He stepped in and instrumented the airway with the Glide Scope and was successful at placing an 8.0 mm endotracheal tube into the trachea. Dr. King achieved intubation of the trachea very rapidly with the Glide Scope, taking only a few seconds, and an 8.0 mm endotracheal tube was placed. The cuff was inflated. Bilateral breath sounds were verified as was end tidal CO2. End tidal CO2 was found to be in the low 20s. Heart rate remained in the mid 30s and we had sats of 53 percent.

EDITED:

000437

RUN DATE: 09/24/12
RUN TIME: 1045
RUN USER: DLC7

DEACONESS ORDER ENTRY *** LIVE ***
REPORT'S AUDIT TRAIL

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DEPARTMENT: DTRAN
REPORT: 1204-0012 PROG NOTE
PATIENT: DX3769908 CLONINGER, GLEN A

DATE: 12/06/10
TIME: 1554
USER: KDC2

EVENT: section 3 of report edited through PREVIEW (PCI)

ORIGINAL:

to breath adequately throught the mask for about 20-30 seconds with RR=18-22,

EDITED:

to breath adequately throught the mask for about 20 seconds with RR=18-22,

DATE: 12/06/10
TIME: 1554
USER: KDC2

EVENT: section 3 of report edited through PREVIEW (PCI)

ORIGINAL:

reaching to remove it. He was fogging the mask. Tidal volumes of 500-900 and the anesthesia bag was visibly collapsing and inflating as he breathed through the circuit. This lasted for approximately 20 seconds, with a RR=18-24, Sats=92-94%. The patient then experienced laryngospasm requiring positive pressure ventilation that broke the laryngospasm. At that time, his sats had dipped into the 68-78 region, but then quickly returned to 88 and then 94%. His heart rate at that time was 48. Positive pressure was then reduced and the patient was ventilating adequately for approximately 30 seconds with tidal volumes of 750-850. He suddenly laryngospasmed once again. Dr. King was called to assist. Positive pressure was increased, however, this time the laryngospasm did not break. The patients heart rate suddenly dropped to 34 and he had a rapid desaturation from 92% into the 70s and 60s. I immediately elected to reintubate the patient and rapidly administered 100 mg of succinylcholine and 100 mg of propofol. Positive pressure bag mask ventilation was then done once again with oral air way in place. Bradycardia was worsening and we had rate in the mid to high 30s and the sat was dropping into the 60s. No pulse was found and CPR was initiated. Dr. King by this moment in time was standing next to me with the Glide Scope in his hand. He stepped in and instrumented the airway with the Glide Scope and was successful at placing an 8.0 mm endotracheal tube into the trachea. Dr. King achieved intubation of the trachea very rapidly with the Glide Scope, taking only a few seconds, and an 8.0 mm endotracheal tube was placed. The cuff was inflated. Bilateral breath sounds were verified as was end tidal CO2. End tidal CO2 was

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RUN DATE: 09/24/12
RUN TIME: 1045
RUN USER: DLC7

DEACONESS ORDER ENTRY *** LIVE ***
REPORT'S AUDIT TRAIL

PAGE 27

DEPARTMENT: DERAN
REPORT: 1204-0012 PROG NOTE
PATIENT: DX3769908 CLONINGER, GLEN A

found to be in the low 20s. Heart rate remained in the mid 30s and we had sats
of 53
percent.

EDITED:
reaching to remove it. The patient then began to obstruct and an oral airway
was placed and jaw thrust applied with continued 100% oxygen.

DATE: 12/06/10
TIME: 1554
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)
ORIGINAL:

000439

RUN DATE: 09/24/12
RUN TIME: 1045
RUN USER: DLC7

DEACONESS ORDER ENTRY *** LIVE ***
REPORT'S AUDIT TRAIL

PAGE 28

DEPARTMENT: DITRAN
REPORT: 1204-0012 PROG NOTE
PATIENT: DX2769908 CLONINGER, GLEN A

EDITED:

The patient then experienced laryngospasm requiring positive pressure ventilation. The laryngospasm was successfully over about 20 second time frame. At that time, his sats had dipped to 78-82% region, but then quickly returned to 88 and then 94%. His heart rate at that time was 48. Positive pressure was then reduced and the patient was ventilating adequately for approximately 30 seconds with , Sats=tidal volumes of 750-850. He suddenly laryngospasmed once again. Dr. King was called to assist. Positive pressure was increased, however, this time the laryngospasm did not break. The patients heart rate suddenly dropped to 34 and he had a rapid desaturation from 92% into the 70s and 60s. I immediately elected to emergently reintubate the patient and rapidly administered 100 mg of succinylcholine and 100 mg of propofol. Positive pressure bag mask ventilation was done without difficulty with oral air way in place. Dr. King by this moment in time was standing next to me with the Glide Scope in his hand. He stepped in and instrumented the airway with the Glide Scope and was successful at placing an 8.0 mm endotracheal tube into the trachea. Dr. King achieved intubation of the trachea very rapidly with the Glide Scope, taking only a few seconds, and an 8.0 mm endotracheal tube was placed. The cuff was inflated. Bilateral breath sounds were verified as was end tidal CO2. End tidal CO2 was found to be in the low 20s. Heart rate remained in the mid 30s and we had sats of 53 percent.

DATE: 12/06/10
TIME: 1632
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)

ORIGINAL:

ventilation. The laryngospasm was successfully over about 20 second time frame. At that time, his sats had dipped to 78-82% region, but then quickly returned to 88 and then 94%. His heart rate at that time was 48. Positive pressure was then reduced and the patient was ventilating adequately for approximately 30 seconds with , Sats=tidal volumes of 750-850. He suddenly laryngospasmed once again. Dr. King was called to assist. Positive pressure was increased, however, this time the laryngospasm did not break. The patients heart rate suddenly dropped to 34 and he had a rapid desaturation from 92% into the 70s and 60s. I immediately elected to emergently reintubate the patient and rapidly administered 100 mg of succinylcholine and 100 mg of propofol. Positive pressure bag mask ventilation was done without difficulty with oral air way in place. Dr. King by this moment in time was standing next to me with the Glide Scope in his hand. He stepped in and instrumented the airway with the Glide Scope and was successful at placing an 8.0 mm endotracheal tube into the trachea. Dr. King achieved intubation of the trachea very rapidly with the

000440

RUN DATE: 09/24/12
RUN TIME: 1045
RUN USER: DLC7

DEACONESS ORDER ENTRY *** LIVE ***
REPORT'S AUDIT TRAIL

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DEPARTMENT: DITRAN
REPORT: 1204-0012 PROG NOTE
PATIENT: DX3769908 CLONINGER, GLEN A

Glide Scope, taking only a few seconds, and an 8.0 mm endotracheal tube was placed. The cuff was inflated. Bilateral breath sounds were verified as was end tidal CO2. End tidal CO2 was found to be in the low 20s. Heart rate remained in the mid 30s and we had sats of 53 percent.

EDITED:

The laryngospasm was successfully treated over about a 20 second time frame. At that time, his sats had dipped to 78-82% region, but then quickly returned to 88% and then 94%. His heart rate at that time was 48. Positive pressure was then reduced and the patient was ventilating adequately for approximately 1 minute with, Sats=92% tidal volumes of 750-850. He then suddenly began to laryngospasm once again. Dr. King was called to assist. Positive pressure bag/mask ventilation was instituted however, this time the laryngospasm was not successfully relieved. The patients heart rate suddenly dropped to 34 and he had a rapid desaturation from 92% into the 70s and 60s. I immediately elected to emergently reintubate the patient and rapidly administered 200 mg of succinylcholine, 100 mg of propofol, epinephrine 500mcg and atropine 400mcg. A pulse was searched for and not found. Pulseless electrical activity was obvious. EKG showed bradycardia at 32 bpm then 24bpm. The remaining 500mcg of epinephrine was then administered and flushed through the IV tubing immediately followed by another 1mg of epinephrine. CPR was immediately started and the Code cart brought to the room. IV fluids were running wide open. Positive pressure bag mask ventilation was done without difficulty with oral air way in place. Dr. King by this moment in time was standing next to me with the Glide Scope in his hand. Sats had risen with CPR and bag/mask ventilation to 97%. I took the Glide Scope and immediately upon instrumenting the airway knew a larger blade was need. Dr. King had the larger blade in his hand and immediately instrumented the airway and easily intubated the patient with a 8.0mm endotracheal tube. Cuff was inflated, positive ETCO2=24 then rising to 48-50 and back down into the high 20s with continued CPR. Bilateral breath sounds were verified. The ET tube was secured at 21cm at the teeth.

DATE: 12/06/10
TIME: 1636
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)
ORIGINAL:
was secured at 21cm at the teeth.

EDITED:
was secured at 21cm at the teeth. Ventilator was set at 20bpm with TV=850-900.

DATE: 12/06/10
TIME: 1636

000441

RUN DATE: 09/24/12
RUN TIME: 1045
RUN USER: DLC7

DEACONESS ORDER ENTRY *** LIVE ***
REPORT'S AUDIT TRAIL

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DEPARTMENT: DTRAN
REPORT: 1204-0012 PRGG NOTE
PATIENT: DX3769908 CLONINGER, GLEN A

USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)
ORIGINAL:

During this rapidly occurring set of events, atropine 0.4 mg had been administered and two 500 mcg boluses of epinephrine had simultaneously been given and flushed through the IV. With ongoing chest compressions, we saw sats rise rather quite quickly into the 60s, 70s and we saw sats briefly in the 80s, as high as 89% for 30 seconds or so. Sats then trailed off into the mid to high 70s and fluctuated up into the 80s and 90s with ongoing chest compressions.

EDITED:

DATE: 12/06/10
TIME: 1859
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)
ORIGINAL:

perioperative period. It was a privilege to have met the patient on the morning of 12/01/2010 in the preoperative area prior to his surgery. He is a very personable and pleasant 66-year-old active male here for cystoscopy, ureteroscopy and stent placement followed by extracorporeal shock wave lithotripsy.

EDITED:
perioperative period. I meet the patient on the morning of 12/01/2010 in the preoperative area prior to his surgery. He was a very personable and pleasant 66-year-old male here for cystoscopy, ureteroscopy and stent placement followed by extracorporeal shock wave lithotripsy.

DATE: 12/06/10
TIME: 1859
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)
ORIGINAL:

medications or doctor visits. His health system survey showed negative for all medical problems, he was therefore specifically asked system by system if he

EDITED:
medications or doctor visits. His health system survey was negative for all medical problems, he was therefore specifically asked system by system if he

DATE: 12/06/10
TIME: 1859

000442

RUN DATE: 09/24/12
RUN TIME: 1045
RUN USER: DLC7

DEACONESS ORDER ENTRY *** LIVE ***
REPORT'S AUDIT TRAIL

PAGE 31

DEPARTMENT: DTRAN
REPORT: 1204-0012 PROG NOTE
PATIENT: DX3769908 CLONINGER, GLEN A

USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)
ORIGINAL:

More likely for him we discussed was the unlikely potential for a prolonged wake up period requiring some additional time on the ventilator. It was also discussed that during the procedure he would be given medications to make him comfortable for when he awakens from surgery and also medication to prevent postoperative nausea and vomiting. I also made him aware that someone would be with him at all times postoperatively so that if he should experience any discomfort or nausea he could simply let us know and we would take the necessary measures to make him comfortable. The patient indicated that he wanted to proceed and get something to eat as soon as surgery was over.

EDITED:

we also discussed the unlikely potential for post operative ventilation on a ventilator. It was also discussed that during the procedure he would be given medications to make him comfortable for when he awakens from surgery and also medication to prevent postoperative nausea and vomiting. I also made him aware that someone would be with him at all times postoperatively so that if he should experience any discomfort or nausea he could simply let us know and we would take the necessary measures to make him comfortable. The patient indicated that he wanted to proceed and get something to eat as soon as surgery was over.

DATE: 12/06/10
TIME: 1859
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)
ORIGINAL:

Following proper preoxygenation with stable vital signs, blood pressure 142/92 and a heart rate of 68 bpm and a sat of 99% on 100% O2, 100 mg of lidocaine and

EDITED:

Following preoxygenation with stable vital signs, blood pressure 142/92 and a heart rate of 68 bpm and a sat of 99% on 100% O2, 100 mg of lidocaine and

DATE: 12/06/10
TIME: 1859
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)
ORIGINAL:

After the patient was asleep, an oral airway was placed and the patient was bag masked ventilated without difficulty, after which a MAC 3 blade was used to attempt to visualize the vocal cords. The first 2 attempts were brief and only revealed the tip of the epiglottis. Sats remained at 99% and the patient was bag mask ventilated without difficulty for another 30 seconds. The Glide Scope was requested. A Bougie was placed through an 8.0 endotracheal tube and the MAC 3 blade was used once again. The patient was successfully intubated with the 8.0 endotracheal tube. The endotracheal tube cuff was inflated and ET tube attached to the anesthesia circuit followed by

EDITED:

000443

RUN DATE: 09/24/12
RUN TIME: 1045
RUN USER: DLC7

DEACONESS ORDER ENTRY *** LIVE ***
REPORT'S AUDIT TRAIL

PAGE 32

DEPARTMENT: DTRAN
REPORT: 1204-0012 PROG NOTE
PATIENT: DXS769908 CLONINGER, GLEN A

After the patient was asleep, with circoid pressure, an oral airway was placed and the patient was bag masked ventilated without difficulty, after which a MAC 3 blade was used to attempt to visualize the vocal cords. The first 2 attempts were brief and only revealed the tip of the epiglottis. Sats remained at 99% and the patient was bag mask ventilated without difficulty for another 30 seconds. The Glide Scope was requested. A Bougie was placed through an 8.0 endotracheal tube and the MAC 3 blade was used once again. The patient was successfully intubated with the 8.0 endotracheal tube. The endotracheal tube cuff was inflated and ET tube attached to the anesthesia circuit followed by

DATE: 12/06/10
TIME: 1859
USER: KDC2

EVENT: section 3 of report edited through PREVIEW (PCI)
ORIGINAL:

positioning and eye clearance.
Lithotripsy proceeded uneventfully. The patient's heart rate remained in the

EDITED:
positioning, eye clearance and neck alignment.
Lithotripsy proceeded uneventfully. The patient's heart rate remained in the

DATE: 12/06/10
TIME: 1859
USER: KDC2

EVENT: section 3 of report edited through PREVIEW (PCI)
ORIGINAL:

for approximately 1 minute with, Sats=92% tidal volumes of 750-850. He then suddenly began to laryngospasm once again. Dr. King was called to assist. Positive pressure bag/mask ventilation was instituted however, this time the laryngospasm was not successfully relieved. The patients heart rate suddenly dropped to 34 and he had a rapid desaturation from 92% into the 70s and 60s. I immediately elected to emergently reintubate the patient and rapidly administered 200 mg of succinylcholine, 100 mg of propofol, epinephrine 500mcg and atropine 400mcg. A pulse was searched for and not found. Pulseless electrical activity was obvious. EKG showed bradycardia at 32 bpm then 24bpm. The remaining 500mcg of epinephrine was then administered and flushed through the IV tubing immediately followed by another 1mg of epinephrine. CPR was immediately started and the Code cart brought to the room. IV fluids were running wide open. Positive pressure bag mask ventilation was done without difficulty with oral air way in place. Dr. King by this moment in time was standing next to me with the Glide Scope in his hand. Sats had risen with CPR and bag/mask ventilation to 97%. I took the Glide Scope and immediately upon instrumenting the airway knew a larger blade was need. Dr. King had the larger blade in his hand and immediately instrumented the airway and easily intubated the patient with a 8.0mm endotracheal tube. Cuff was inflated, positive ETCO2=24 then rising to 48-50 and back down into the high 20s with continued CPR. Bilateral breath sounds were verified. The ET tube was secured at 21cm at the teeth. Ventilator was set at 20bpm with TV=850-900.

EDITED:
for approximately 1 minute with Sats=92% and tidal volumes of 750-850. He then

000444

RUN DATE: 09/24/12
RUN TIME: 1045
RUN USER: DLC7

DEACONESS ORDER ENTRY *** LIVE ***
REPORT'S AUDIT TRAIL

PAGE 33

DEPARTMENT: DITRAN
REPORT: 1204-0012 PROG NOTE
PATIENT: DX3769908 CLONINGER, GLEN A

began to laryngospasm once again. Dr. King was called to assist. Positive pressure bag/mask ventilation was instituted however, this time the laryngospasm was not successfully relieved in approximately 15 to 20 seconds. Noting the patients heart rate dropping to 34 and a rapid desaturation from 92% into the 70s and 60s. I prepared to emergently reintubate the patient after the administration of 200 mg of succinylcholine, 100 mg of propofol, epinephrine 500mcg and atropine 400mcg. A pulse was searched for and not found. Pulseless electrical activity was obvious. EKG showed bradycardia at 32 bpm then 24bpm. The remaining 500mcg of epinephrine was then administered and flushed through the IV tubing immediately followed by another 1mg of epinephrine. CPR was immediately started and the Code cart brought to the room. IV fluids were running wide open. Positive pressure bag mask ventilation was done without difficulty with oral air way in place. Dr. King by this moment in time was standing next to me with the Glide Scope in his hand. Sats had risen with CPR and bag/mask ventilation to 97%. CPR was suspended for 20 seconds to accomplish intubation. Rescue medications had no affect on HR as it remained in 20s and no pulse was palpable. Blood pressure cuff continued to search for a pressure.

ATE: 12/06/10
TIME: 1859
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)
ORIGINAL:

EDITED:

Dr. King handed me the Glide Scope and upon instrumenting the airway I knew a larger blade was need. Dr. King had the larger blade in his hand and instrumented the airway and easily intubated the patient with a 8.0mm endotracheal tube. The ET tube Cuff was inflated, positive ETCO2 verified, no pulse found, HR=24 and CPR resumed. Epinephrine 3mg and atropine .4 mg were given IV and flushed through. Positive ETCO2=24 then rising to 48-50 and back down into the high 20s with continued CPR. Bilateral breath sounds were verified. Initial Sat=53% with the resumption of CPR. The ET tube was secured at 21cm at the teeth. Ventilator was set at 20bpm with TV=850-900. Sats quickly rose back into the 90s and leveled of at 92-94% with ongoing CPR.

DATE: 12/06/10
TIME: 1859

000445

RUN DATE: 09/24/12
RUN TIME: 1045
RUN USER: DLC7

DEACONESS ORDER ENTRY *** LIVE ***
REPORT'S AUDIT TRAIL

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DEPARTMENT: DTRAN
REPORT: 1204-0012 PROC NOTE
PATIENT: DX3769908 CLONINGER, GLEN A

USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)
ORIGINAL:

EDITED:

The Cardiovascular tech was called to the room to assist Dr. King with arterial line placement and perform arterial blood gas analysis. Ultrasound was brought to the room to assist in arterial line placement. The defibrillator pads were placed as was the pacer pad. Both left wrist and left groin were steriley prepped.

CPR was suspended and no pulse was found HR=28. CPR was resumed and 5mg epinephrine and atropine .4mg was flushed through the IV. No cuff pressure was obtainable and Sats rose back into the 92-95% range and ETCO2=48-55. I placed a right internal jugular double lumen central venous catheter without difficulty utilizing sterile technique. IV fluids were attached to both lumens and run wide open.

CPR was briefly suspended for arterial line placement which was achieved very quickly by Dr. King. Arterial line placement was verified by positive draw back and a sample collected for analysis. Arterial BP was not registering. No pulsatile wave form was seen. Heart rate was 24 with P-waves absent. Vasopressin 40U IV was then given throught the right IJ central line as was all susequent medications. CPR resumed, more CPR staff assisted and CPR traded off every 1-2 minutes. Upon resumption of CPR

000446

RUN DATE: 09/24/12

DEACONESS ORDER ENTRY *** LIVE ***

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RUN TIME: 1045

REPORT'S AUDIT TRAIL

RUN USER: DLC7

DEPARTMENT: DTRAN

REPORT: 1204-0012 PROG NOTE

PATIENT: DM3769908 CLONINGER, GLEN A

DATE: 12/06/10

TIME: 1953

USER: KDC2

EVENT: section 3 of report edited through PREVIEW (PCI)

ORIGINAL:

pulsatile wave form was seen. Heart rate was 24 with P-waves absent. Vasopressin 40U IV was then given through the right IJ central line as was all subsequent medications. CPR resumed, more CPR staff assisted and CPR traded off every 1-2 minutes. Upon resumption of CPR

EDITED:

pulsatile wave form was seen. Heart rate was 24 with P-waves absent then V-tach followed by V-fib was seen and defibrilated at 200J x 2 with resumption of a bradycardic rhythm at 17bpm. No pulse was found and CPR was resumed. Lidocaine 100mg was given through the right IJ central line followed by Vasopressin 40U, atropine .4mg IV and 1 Amp of bicarb. All subsequent medications were also given through the right IJ central line. More CPR staff were added and assisted with CPR by trading off every 1-2 minutes. The BP began to rise

DATE: 12/06/10

TIME: 1953

USER: KDC2

EVENT: section 3 of report edited through PREVIEW (PCI)

ORIGINAL:

The crash cart had already been called into the room and the nurses were placing defibrillator pads on the patient and a transcutaneous pacing pad as well. The anesthesia machine ventilator settings had been set for a rate of 20 with tidal volumes of 850. Ongoing chest skin compressions proceeded and we did not see the response that we would typically expect from administration of atropine and epinephrine. These drugs were again administered in doses of 1 mg bolus of epinephrine, immediately followed by a 2 mg bolus of epinephrine and another amp of atropine. These interventions had relatively little effect on heart rate and any blood pressure changes were transient and largely dependent on ongoing chest compressions. These blood pressures that we obtained were only seen once Dr. King had placed the ART line, which he did successfully and very quickly mind you under the circumstances. I had quickly placed a right IJ double lumen catheter and was administering medications and fluids through that as well. Transvenous pacing had been attempted early on without capture. We, therefore, resumed chest compressions immediately following failure to capture and was able to sustain blood pressures through chest compressions of anywhere from the mid to high 70s all the way up into the 90s. This characterized the resuscitation in that large doses of epinephrine were given with little effect on heart rate and blood pressure. We only had sustained blood pressures when we had effective chest compressions in progress. Following approximately 5-10 minutes of CPR, vasopressin was given 40 units IV and then in another few minutes we administered 2 ampules of bicarb just following drawing our first blood gas. Our first blood gas

000447

RUN DATE: 09/24/12
RUN TIME: 1045
RUN USER: DLC7

DEACONESS ORDER ENTRY *** LIVE ***
REPORT'S AUDIT TRAIL

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DEPARTMENT: DTRAN
REPORT: 1204-0012 PROG NOTE
PATIENT: DX3769908 CLONINGER, GLEN A

indicated that we had had some success, really quite good success with our chest compressions.

EDITED:

DATE: 12/06/10
TIME: 1953
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)

ORIGINAL:

The 09:58 ABG values are as follows: pH 7.3, pCO2 22.8, pO2 360, bicarb 11, base excess -13 with a sat of 99%. Hemoglobin 15 and hematocrit 45. K was met as the potassium was 4.5, sodium 143, calcium was normal, as was the glucose. I had the cath lab called to have sent over the transvenous pacing equipment since our transcutaneous pacing was not effective. I also had the Cath Lab called and put on alert that we may need to bring the patient over to the Cath Lab for evaluation. Also, the cardiologist on call was contacted, Dr. Huber, and asked to come to the OR to help evaluate this patient. A 12-lead EKG was ordered and TEE technician was called to come to the OR.

EDITED:

000448

RUN DATE: 09/24/12
RUN TIME: 1045
RUN USER: DLC7

DEACONESS ORDER ENTRY *** LIVE ***
REPORT'S AUDIT TRAIL

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DEPARTMENT: DTRAN
REPORT: 1204-0012 PROC NOTE
PATIENT: DXB769908 CLONINGER, GLEN A

DATE: 12/06/10
TIME: 1953
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)
ORIGINAL:

EDITED:

The 09:58 ABG values which were drawn upon arterial line placement are as follows: pH 7.3, pCO2 22.8, pO2 360, bicarb.11, base excess -13 with a sat of 99%. Hemoglobin 15 and hematocrit 45. K was met as the potassium was 4.5, sodium 143, calcium 1.5, glucose 138. I had the cath lab called to have sent over the transvenous pacing equipment since our transcutaneous pacing was not effective. I also had the Cath Lab called and put on alert that we may need to bring the patient over to the Cath Lab for evaluation. Also, the cardiologist on call was contacted, Dr. Huber, and asked to come to the OR to help evaluate this patient. A 12-lead EKG was ordered and TEE technician was called to come to the OR.

DATE: 12/06/10
TIME: 1953
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)
ORIGINAL:

Finally at approximately 10:50 in the morning, the patient developed independently sustainable heart rate and blood pressures that continued to steadily improved from that time forward. Those initial pressures were in the high 80s and low 90s systolically, with heart rates hovering around 50 and then rapidly over the ensuing few minutes climbing into the mid 50s and up into the 60 range. The drips continued, including amiodarone at one mcg per minute and epinephrine at 50 mcg per minute and dopamine at 20 mcg per kilo per minute. Dr. Huber arrived just following the arrival of the echo tech, and I placed the echo probe and the exam was done and those findings can be found in the medical record in further detail, but there were no focal segmental defects. The heart was globally depressed, however, but by the time we were ready to leave the operating room, the ejection fraction had improved from roughly 15-20% to 40%. The EKG showed no acute changes and no evidence

000449

RUN DATE: 09/24/12
RUN TIME: 1045
RUN USER: DLC7

DEACONESS ORDER ENTRY *** LIVE ***
REPORT'S AUDIT TRAIL

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DEPARTMENT: DTRAN
REPORT: 1204-0012 PROG NOTE
PATIENT: DX3769908 CLONINGER, GLEN A

of injury. There was obviously a bradycardic rhythm and there was a junctional rhythm with nonspecific ST and T-wave changes.

EDITED:

Finally, at approximately 10:50 in the morning, the patient developed a sustainable heart rate and blood pressure that continued to steadily improved from that time forward. Those initial pressures were in the high 80s and low 90s systolically, with heart rates hovering around 50 and then rapidly over the ensuing few minutes climbing into the mid 50s and up into the 60 range. The drips continued, including amiodarone at one mcg per minute and epinephrine at 50 mcg per minute and dopamine at 20 mcg per kilo per minute. Dr. Huber arrived just following the arrival of the echo tech, and I placed the echo probe and the exam was done and those findings can be found in the medical record in further detail, but there were no focal segmental defects. The heart was globally depressed, however, but by the time we were ready to leave the operating room, the ejection fraction had improved from roughly 15-20% to 40%. The EKG showed no acute changes and no evidence of injury. There was obviously a bradycardic rhythm and there was a junctional rhythm with nonspecific ST and T-wave changes.

By 11:15, the patient appeared stable enough to proceed to the ICU. At that time blood pressures were in the 140s range/mid 40s-50s with heart rates in the 60s, end tidal CO2 was 28, sats were 96-97% with a respiratory rate on the anesthesia ventilator of 20. Tidal volumes were maintained in the 850-900 range. Upon leaving the OR, the patients vital signs were essentially unchanged and we proceeded to the ICU without any difficulty. We maintained continuation of all previously established drips and monitoring and proceeded with the patient on 100% O2. Upon arrival, report was given to the ICU staff and vital signs were as follows: Blood pressures 127/66, heart rate was 73-76, sat was 96% on FIO2 of 100% with a respiratory rate of 18 on the ventilator.

DATE: 12/06/10
TIME: 1953
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)

ORIGINAL:

By 11:15, the patient appeared stable enough to proceed to the ICU. At that time blood pressures were in the 140s range/mid 40s-50s with heart rates in the 60s, end tidal CO2 was 28, sats were 96-97% with a respiratory rate on the anesthesia ventilator of 20. Tidal volumes were maintained in the 850-900 range. At _____, the vital signs were essentially the same and we

000450

RUN DATE: 09/24/12
RUN TIME: 1045
RUN USER: DLC7

DEACONESS ORDER ENTRY *** LIVE ***
REPORT'S AUDIT TRAIL

PAGE 39

DEPARTMENT: DTRAN
REPORT: 1204-0012 PROG NOTE
PATIENT: DX3769908 CLONINGER, GLEN A

proceeded to the ICU without any difficulty. We maintained continuation of all previously established drips and monitoring and proceeded with the patient on 100% O2. Upon arrival, report was given to the ICU staff and vital signs were as follows: Blood pressures 127/66, heart rate was 73-76, sat was 96% on FIO2 of 100% with a respiratory rate of 18 on the ventilator.

EDITED:

DATE: 12/06/10
TIME: 1953
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)
ORIGINAL:

EDITED:

DATE: 12/06/10
TIME: 2057
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)
ORIGINAL:
CPB was suspended and no pulse was found HR=28. CPR was resumed and 5mg

EDITED:
CPB was suspended and no pulse was found HR=28. CPR was resumed and 4mg

DATE: 12/06/10
TIME: 2057
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)
ORIGINAL:
were added and assisted with CPR by trading off every 1-2 minutes. The BP began to rise.

000451

RUN DATE: 09/24/12
RUN TIME: 1045
RUN USER: DLC7

DEACONESS ORDER ENTRY *** LIVE ***
REPORT'S AUDIT TRAIL

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DEPARTMENT: DTRAN
REPORT: 1204-0012 PROG NOTE
PATIENT: DX3769908 CLONINGER, GLEN A

The 09:58 ABG values which were drawn upon arterial line placement are

EDITED:
were added and assisted with CPR by trading off every 1-2 minutes.

The 09:58 ABG values which were drawn upon arterial line placement are

DATE: 12/06/10
TIME: 2057
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)
ORIGINAL:

EDITED:
of 99%. Hemoglobin 15 and hematocrit 45. Potassium was 4.5, sodium 143,
calcium 1.5, glucose 138.

DATE: 12/06/10
TIME: 2057
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)
ORIGINAL:

The 09:58 ABG values which were drawn upon arterial line placement are as follows: pH 7.3, pCO2 22.8, pO2 360, bicarb 11, base excess -13 with a sat of 99%. Hemoglobin 15 and hematocrit 45. K was met as the potassium was 4.5, sodium 143, calcium 1.5, glucose 138. I had the cath lab called to have sent over the transvenous pacing equipment since our transcutaneous pacing was not effective. I also had the Cath Lab called and put on alert that we may need to bring the patient over to the Cath Lab for evaluation. Also, the cardiologist on call was contacted, Dr. Huber, and asked to come to the OR to help evaluate this patient. A 12-lead EKG was ordered and TEE technician was called to come to the OR.

EDITED:
Medications were rapidly being consumed so another drug tray was ordered to the room. Now with an arterial line in place and CPR resumed following the run of V-tach/V-fib defibrillation sequence, CPR could be optimized and blood pressures now were initially seen 68/22 and soon rose to 90-93/28-34. High concentration epinephrine from pharmacy was ordered. ETCO2=20-30, Sats increased from initial post defibrillation values of 62% into the 92-96% range over about 2 minutes. Pressures drifted down into the 70s. Epinephrine 2mg x 3, Calcium Chloride 1 g and 2 Amps of Bicarb were administered. With on-going CPR, pressures increased to 110-112/38-40 then to 135/48 for several minutes. Sats=97% with ETCO2=58-78. ETCO2 decreased into the 40s, Sats=97% and CPR was

000452

RUN DATE: 09/24/12
RUN TIME: 1045
RUN USER: DLC7

DEACONESS ORDER ENTRY *** LIVE ***
REPORT'S AUDIT TRAIL

PAGE 41

DEPARTMENT: DTRAN
REPORT: 1204-0612 PROG NOTE
PATIENT: DX3769908 CLONINGER, GLEN A

suspended to check for rate, rythm and pulse. HR=32 arterial blood pressure 42/12. V-tach then V-fib was seen and required defibrillation x 2 at 200J for return of a brady rythm 24 and no BP. CPR resumed and

DATE: 12/06/10
TIME: 2057
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)
ORIGINAL:

On 2 separate occasions swelling when we stopped chest compressions to check for return of heart rate and blood pressure, we saw 2 episodes of V-tach and V-fib. They were very short. We defibrillated them on each occasion with 200 joules x2 with return to the bradycardic rhythm that we had seen throughout the rest of the resuscitation. We also attempted transcutaneous pacing once again at higher levels since the transvenous pacing equipment had not arrived yet. I also had called for isoproterenol as a pharmacologic route to pacing this patient out of the bradycardia. Dopamine arrived prior to isoproterenol arrival. I began drawing up dopamine into 20 mL syringe and then administering 2-3 mL of dopamine directly into the right IJ central line. The nurses during the code had set up 3 drips for me. We had administered amiodarone 300 mg early on in the code and had started that drip. We had also started an epinephrine drip at 50 mcg per minute, and now we had a dopamine drip going and I was also bolusing by syringe.

EDITED:

DATE: 12/06/10
TIME: 2057
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)
ORIGINAL:

000453

RUN DATE: 09/24/12
RUN TIME: 1045
RUN USER: DLC7

DEACONESS ORDER ENTRY *** LIVE ***
REPORT'S AUDIT TRAIL

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DEPARTMENT: DTRAN
REPORT: 1204-0012 PROG NOTE
PATIENT: DXS769908 CLONINGER, GLEN A

EDITED:

Transvenous pacing equipment was requested from the Cath Lab since transcutaneous pacing was not effective. I also had the Cath Lab called and put on alert that we may need to bring the patient over to the Cath Lab for evaluation. Also, the cardiologist on call was contacted, Dr. Huber, and asked to come to the OR to help evaluate this patient. A 12-lead EKG was ordered and TEE technician was called to come to the OR.

On 2 separate occasions swelling when we stopped chest compressions to check for return of heart rate and blood pressure, we saw 2 episodes of V-tach and V-fib. They were very short. We defibrillated them on each occasion with 200 joules x2 with return to the bradycardic rhythm that we had seen throughout the rest of the resuscitation. We also attempted transcutaneous pacing once again at higher levels since the transvenous pacing equipment had not arrived yet. I also had called for isoproterenol as a pharmacologic route to pacing this patient out of the bradycardia. Dopamine arrived prior to isoproterenol arrival. I began drawing up dopamine into 20 mL syringe and then administering 2-3 mL of dopamine directly into the right IJ central line. The nurses during the code had set up 3 drips for me. We had administered amiodarone 300 mg early on in the code and had started that drip. We had also started an epinephrine drip at 50 mcg per minute, and now we had a dopamine drip going and I was also bolusing by syringe.

DATE: 12/06/10
TIME: 2114
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)
ORIGINAL:

pressures increased to 110-112/38-40 then to 135/48 for several minutes. Sats=97% with ETCO2=58-78. ETCO2 decreased into the 40s, Sats=97% and CPR was suspended to check for rate, rhythm and pulse. HR=32 arterial blood pressure 42/12. V-tach then V-fib was seen and required defibrillation x 2 at 200J for return of a brady rhythm 24 and no BP. CPR resumed and

000454

RUN DATE: 09/24/12
RUN TIME: 1045
RUN USER: DLC7

DEACONESS ORDER ENTRY *** LIVE ***
REPORT'S AUDIT TRAIL

PAGE 43

DEPARTMENT: DTRAN
REPORT: E204-0012 PROC NOTE
PATIENT: DXS769908 CLONINGER, GLEN A

EDITED:

pressures increased to 110-112/38-40 for several minutes then to the 135/45 range for 10 minutes. Blood pressures rose as high as 170/100 for about 45 seconds. Sats remained 94-97% while pressures above 90 were being generated and ET_{CO2} slowly decreased from an eventual high of 78 down into the 42-44 range. CPR was suspended to check for rate, rythm and pulse. HR=32 and arterial blood pressure fell from CPR levels of 135/45 to 42/12. Transcutaneous pacing failed and V-tach then V-fib was seen requiring defibrillation x 2 at 200J for return of a brady rythm of 24bpm and no BP. Transvenous pacing equipment was requested from the Cath Lab since transcutaneous pacing was not effective. I also had the Cath Lab called and put on alert that we may need to bring the patient over to the Cath Lab for evaluation. Also, the cardiologist on call was contacted, Dr. Huber, and asked to come to the OR to help evaluate this patient. A 12- lead EKG was ordered and TEE technician was called to come to the OR.

DATE: 12/06/10
TIME: 2114
USER: KDC2

EVENT: section 3 of report edited through PREVIEW (PCI)
ORIGINAL:

Transvenous pacing equipment was requested from the Cath Lab since transcutaneous pacing was not effective. I also had the Cath Lab called and put on alert that we may need to bring the patient over to the Cath Lab for evaluation. Also, the cardiologist on call was contacted, Dr. Huber, and asked to come to the OR to help evaluate this patient. A 12- lead EKG was ordered and TEE technician was called to come to the OR.

EDITED:

DATE: 12/06/10
TIME: 2115

000455

RUN DATE: 09/24/12
RUN TIME: 1045
RUN USER: DLC7

DEACONESS ORDER ENTRY *** LIVE ***
REPORT'S AUDIT TRAIL

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DEPARTMENT: DTRAN
REPORT: 1204-0012 PROG NOTE
PATIENT: DX2769908 CLONINGER, GLEN A

USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)
ORIGINAL:
requested from the Cath Lab since transcutaneous pacing was not effective. I
also had the Cath Lab called and put on alert that we may need to bring the

EDITED:
requested from the Cath Lab.
he Cath Lab called and put on alert that we may need to bring the

DATE: 12/06/10
TIME: 2141
USER: MSF1
EVENT: Draft report viewed in PCI

DATE: 12/06/10
TIME: 2141
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)
ORIGINAL:
Chloride 1 g and 2 Amps of Bicarb were administered. With on-going CPR,

EDITED:
Chloride 1g and 2 Amps of Bicarb were administered. With on-going CPR,

DATE: 12/06/10
TIME: 2141
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)
ORIGINAL:
return of a brady rythm of 24bpm and no BP. Transvenous pacing equipment was
requested from the Cath Lab.
he Cath Lab called and put on alert that we may need to bring the
patient over to the Cath Lab for evaluation. Also, the cardiologist on call
was contacted, Dr. Huber, and asked to come to the OR to help evaluate this
patient. A 12- lead EKG was ordered and TEE technician was called to come to
the OR.

EDITED:
return of a brady rythm of 24bpm and no BP. CPR resumed, lidocaine 100mg was
given and blood pressures increased into the 94-97/28-40 range, Sats soon
increased to 94-97% and ETCO2=60 initially and then declining to 28-32.
Asystole was never seen during the conduct of CPR.

DATE: 12/06/10
TIME: 2141
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)
ORIGINAL:

000456

RUN DATE: 09/24/12
RUN TIME: 1045
RUN USER: DLC7

DEACONESS ORDER ENTRY *** LIVE ***
REPORT'S AUDIT TRAIL

PAGE 45

DEPARTMENT: DTRAN
REPORT: 1204-0012 PROG NOTE
PATIENT: DX3769908 CLONINGER, GLEN A

On 2 separate occasions swelling when we stopped chest compressions to check for return of heart rate and blood pressure, we saw 2 episodes of V-tach and V-fib. They were very short. We defibrillated them on each occasion with 200 joules x2 with return to the bradycardic rhythm that we had seen throughout the rest of the resuscitation. We also attempted transcutaneous pacing once again at higher levels since the transvenous pacing equipment had not arrived yet. I also had called for isoproterenol as a pharmacologic route to pacing this patient out of the bradycardia. Dopamine arrived prior to isoproterenol arrival. I began drawing up dopamine into 20 mL syringe and then administering 2-3 mL of dopamine directly into the right IJ central line. The nurses during the code had set up 3 drips for me. We had administered amiodarone 300 mg early on in the code and had started that drip. We had also started an epinephrine drip at 50 mcg per minute, and now we had a dopamine drip going and I was also bolusing by syringe.

EDITED:

Transvenous pacing equipment was requested from the Cath Lab. Isuprel and dopamine drips were ordered. The Cath Lab was called and alerted that we may need to bring the patient over for evaluation. Also, the cardiologist on call, Dr. Huber was asked to come to the OR to help evaluate this patient. A 12-lead EKG was ordered and TEE technician was called to come to the OR.

DATE: 12/06/10
TIME: 2141
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)
ORIGINAL:

EDITED:

Dopamine arrived prior to isoproterenol arrival. Dopamine was drawn up into a 20 mL syringe and then administered 2-3 mL at a time directly into the right IJ central line. Three medication drips were now running. Amiodarone at 1mg/min, epinephrine 50mcg/min and dopamine 20mcg/min.

DATE: 12/06/10
TIME: 2145
USER: MSF1

000457

RUN DATE: 09/24/12
RUN TIME: 1045
RUN USER: DLC7

DEACONESS ORDER ENTRY *** LIVE ***
REPORT'S AUDIT TRAIL

PAGE 46

DEPARTMENT: DTRAN
REPORT: 1204-0012 PROG NOTE
PATIENT: DX3769908 GLOWINGER, GLEN A

EVENT: Draft report viewed in PCI

DATE: 12/06/10
TIME: 2200
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)

ORIGINAL:

anesthetic record is a record that is extremely densely packed with information in a small area and it is often difficult to describe everything that you wish to describe accurately in such a tiny space, so this is why I am adding the addendum to the anesthetic record.

EDITED:

anesthetic record is a record that is extremely densely packed with information in a small area and it is often difficult to describe everything that you wish to describe accurately in such a tiny space, so this is why I am adding the addendum to the anesthetic record.

DATE: 12/06/10
TIME: 2200
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)

ORIGINAL:

Approximately 73 minutes into CPR, the patient developed a heart rate and blood pressure that was independent of chest compressions. Prior to this time, we were successful in maintaining episodically pressures as mentioned earlier from mid 70s all the way up into the 90s, and even up into the 131-140 range systolically with chest compressions and, of course, large doses of epinephrine.

Finally, at approximately 10:50 in the morning, the patient developed a sustainable heart rate and blood pressure that continued to steadily improved.

EDITED:

Approximately 73 minutes into CPR at approximately 10:50, the patient developed a sustainable heart rate and blood pressure that continued to steadily improved.

DATE: 12/06/10
TIME: 2200
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)

ORIGINAL:

90s systolically, with heart rates hovering around 50 and then rapidly over the ensuing few minutes climbing into the mid 50s and up into the 60 range. The drips continued, including amiodarone at one mcg per minute and epinephrine at

000458

RUN DATE: 09/24/12
RUN TIME: 1045
RUN USER: DLC7

DEACONESS ORDER ENTRY *** LIVE ***
REPORT'S AUDIT TRAIL

PAGE 47

DEPARTMENT: DTRAN
REPORT: 1204-0012 PRG NOTE
PATIENT: DX3769908 CLONINGER, GLEN A

50 mcg per minute and dopamine at 20 mcg per kilo per minute. Dr. Huber arrived just following the arrival of the echo tech, and I placed the echo probe and the exam was done and those findings can be found in the medical record in further detail, but there were no focal segmental defects. The heart was globally depressed, however, but by the time we were ready to leave the operating room, the ejection fraction had improved from roughly 15-20% to 40%. The EKG showed no acute changes and no evidence of injury. There was obviously a bradycardic rhythm and there was a junctional rhythm with nonspecific ST and T-wave changes.

EDITED:

90s systolically, with heart rates 48-54. Both progressively increased over the following 20 minutes with HR=60-65 and BP=140-150/42-44.

The drips continued, including amiodarone at one mcg per minute and epinephrine at 50 mcg per minute and dopamine at 20 mcg per kilo per minute. Dr. Huber arrived just following the arrival of the Echo Tech, the echo probe was placed and the exam was performed. The findings can be found in the medical record in further detail, but there were no focal segmental defects, both atria were equally enlarged with no significant valvular abnormalities. The heart was globally depressed, however, but by the time we were ready to leave the operating room, the ejection fraction had improved from roughly 15-20% to 40%. The EKG showed no acute changes and no evidence of injury. There was obviously a bradycardic rhythm and there was a junctional rhythm with nonspecific ST and T-wave changes.

DATE: 12/06/10
TIME: 2214
USER: KDC2

EVENT: section 3 of report edited through PREVIEW (PCI)

ORIGINAL:

IJ central line. Three medication drips were now running. Amiodarone at 1mg/min, epinephrine 50mcg/min and dopamine 20mcg/min.

EDITED:

IJ central line. Bicarb 2 amps IV were given over 5 minutes. Three medication drips were now running. Amiodarone at 1mg/min, epinephrine 50mcg/min and dopamine 20mcg/min.

DATE: 12/06/10
TIME: 2214
USER: KDC2

EVENT: section 3 of report edited through PREVIEW (PCI)

ORIGINAL:

The dopamine drip had been set at 20 mcg per kilo per minute and other meds as well throughout this resuscitation had continued to be administered, specifically epinephrine in 1-3 mg increments. At one point we gave 6 mg of epinephrine as a bolus. Total bicarb amps not reflected on the anesthetic record were 6; the record only shows 4. There is another inconsistency in the

000459'

RUN DATE: 09/24/12
RUN TIME: 1045
RUN USER: DLC7

DEACONESS ORDER ENTRY *** LIVE ***
REPORT'S AUDIT TRAIL

PAGE 48

DEPARTMENT: DTRAN
REPORT: 1204-0012 PROG NOTE
PATIENT: DX3769908 CLONINGER, GLEN A

written record in my anesthesia CPR events note. I wrote a page and a half note and the inconsistency is in the arrival sequence of Dr. King. My note actually talks about him arriving and starting the A-line and femoral central line, when in fact he arrived and did place the 8-0 endotracheal tube and then placed the ART line and central line. Also, it should be noted that the anesthetic record is a record that is extremely densely packed with information in a small area and it is often difficult to describe everything that you wish to describe accurately in such a tiny space, so this is why I am adding the addendum to the anesthetic record.

EDITED:

Total bicarb amps not reflected on the anesthetic record were 6; the record only shows 4. There is another inconsistency in the written record in my anesthesia CPR events note. I wrote a page and a half note and the inconsistency is in the arrival sequence of Dr. King. My note actually talks about him arriving and starting the A-line and femoral central line, when in fact he arrived and did place the 8-0 endotracheal tube and then placed the ART line and central line. Also, it should be noted that the anesthetic record is a record that is extremely densely packed with information in a small area and it is often difficult to describe everything that you wish to describe accurately in such a tiny space, so this is why I am adding the addendum to the anesthetic record.

DATE: 12/06/10
TIME: 2214
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)
ORIGINAL:

The drips continued, including amiodarone at one mcg per minute and epinephrine at 50 mcg per minute and dopamine at 20 mcg per kilo per minute. Dr. Huber arrived just following the arrival of the Echo Tech, the echo probe was placed and the exam was performed. The findings can be found in the medical record in further detail, but there were no focal segmental defects, both atria were equally enlarged with no significant valvular abnormalities. The heart was globally depressed, however, but by the time we were ready to leave the operating room, the ejection fraction had improved from roughly 15-20% to 40%. The EKG showed no acute changes and no evidence of injury. There was obviously a bradycardic rhythm and there was a junctional rhythm with nonspecific ST and T-wave changes.

EDITED:

The drips continued, including amiodarone at one mcg per minute, epinephrine at 50 mcg per minute and dopamine at 20 mcg per kilo per minute. Dr. Huber arrived just following the arrival of the Echo Tech, the echo probe was placed and the exam was performed. The findings can be found in the medical record in further detail, but there were no focal segmental defects, both atria were equally enlarged with no significant valvular abnormalities. The heart was globally depressed, however, but by the time we were ready to leave the operating room, the ejection fraction had improved from roughly 15-20% to 40%.

000460

RUN DATE: 09/24/12
RUN TIME: 1045
RUN USER: DLC7

DEACONESS ORDER ENTRY *** LIVE ***
REPORT'S AUDIT TRAIL

PAGE 49

DEPARTMENT: DITAN
REPORT: 1204-0012 PROC NOTE
PATIENT: DX8769908 CLONINGER, GLEN A

The EKG showed no acute changes and no evidence of injury. There was obviously a bradycardic rhythm and there was a junctional rhythm with nonspecific ST and T-wave changes.

DATE: 12/06/10
TIME: 2214
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)
ORIGINAL:

Later in the day I met with the family, specifically the wife, 1 of the daughters and significant other of the daughter and discussed in detail the events of the day and answered any questions. I also left them with my contact information and let them know that they could contact me at any time day or night should they have any questions that they would like answered.

EDITED:

Later in the day I met with the family, specifically the patients wife, one of the daughters and her significant other and discussed in detail the events of the day and answered any questions. I left them with my contact information and let them know that they could contact me at any time day or night should they have any questions they would like answered. I also let them know I would be available in the ICU for any questions every morning and evening.

DATE: 12/06/10
TIME: 2214
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)
ORIGINAL:

EDITED:

DATE: 12/06/10
TIME: 2217
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)
ORIGINAL:

line and central line. Also, it should be noted that the anesthetic record is a record that is extremely densely packed with information in a small area and it is often difficult to describe everything that you wish to describe accurately in such a tiny space, so this is why I am adding the addendum to the anesthetic record.

EDITED:

line and central line.

000461

RUN DATE: 09/24/12
RUN TIME: 1045
RUN USER: DLC7

DEACONESS ORDER ENTRY *** LIVE ***
REPORT'S AUDIT TRAIL

PAGE 50

DEPARTMENT: BTRAN
REPORT: 1204-0012 PROC NOTE
PATIENT: DX3769908 CLONINGER, GLEN A

DATE: 12/06/10
TIME: 2219
USER: KDC2
EVENT: report printed on D-MRLJ1

DATE: 12/06/10
TIME: 2220
USER: KDC2
EVENT: report printed on D-MRLJ1

DATE: 12/06/10
TIME: 2221
USER: KDC2
EVENT: report printed on D-MRLJ1

DATE: 12/07/10
TIME: 0715
USER: KLC17
EVENT: report printed on D-MRLJ8

DATE: 12/07/10
TIME: 1328
USER: KDC2
EVENT: Draft report viewed in PCI

DATE: 12/07/10
TIME: 1414
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)
ORIGINAL:
informed that cardiac arrest and death are rare events but do rarely occur.
we also discussed the unlikely potential for post operative ventilation on a
EDITED:
informed that cardiac arrest and death are rare events but do rarely occur.
We also discussed the unlikely potential for post operative ventilation on a

DATE: 12/07/10
TIME: 1414
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)
ORIGINAL:
at increasing heart rate for the procedure using atropine was abandoned. Near
EDITED:
at increasing heart rate for the procedure was abandoned. Near

DATE: 12/07/10
TIME: 1414
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)
ORIGINAL:

000462

RUN DATE: 09/24/12
RUN TIME: 1045
RUN USER: DLC7

DEACONESS ORDER ENTRY *** LIVE ***
REPORT'S AUDIT TRAIL

PAGE 51

DEPARTMENT: DTRAN
REPORT: 1204-0012 PROG NOTE
PATIENT: DX3769908 CLONINGER, GLEN A

Sats at that time remained at 98%. Respiratory rate was assisted at 8-12, tidal volumes remained inadequate at about 275mls to 400mls unassisted, and heart rate continued below 60 at roughly 56-58, blood pressure by cuff was 97/53. The nurses and I verbally continued to reassure the patient, that everything was going well, that he was just waking up from surgery and to lay still so that he would not hurt himself or pull his endotracheal tube out prematurely. This went on for approximately 2 more minutes, at which point the patient started demonstrating a stable pattern of respirations and tidal volumes with good sats and acceptable CO2. The patients tidal volumes were now 750 to 1150 with a rate of 18-24, Sats=98%, end tidal CO2=38-42, HR=48 and BP=97/53. About 75 mls of clear yellow fluid was suctioned from the patients stomach and the oral cavity suctioned and cleared of any secretions after which the patient was extubated.

EDITED:

Sats at that time remained at 98%. Respiratory rate was assisted at 8-12bpm, spontaneous tidal volumes remained inadequate at about 275mls to 400 unassisted (TV=750-850 assisted), and heart rate continued below 60 at roughly 56-58, blood pressure by cuff was 97/53. The nurses and I verbally continued to reassure the patient, that everything was going well, that he was just waking up from surgery and to lay still so that he would not hurt himself or pull his endotracheal tube out prematurely. This went on for approximately 2 more minutes, at which point the patient started demonstrating a stable pattern of respirations and tidal volumes with good sats and acceptable CO2. The patients tidal volumes were now 750 to 1150 with a rate of 18-24, Sats=98%, end tidal CO2=38-42, HR=48 and BP=97/53. About 75 mls of clear yellow fluid was suctioned from the patients stomach and the oral cavity suctioned and cleared of any secretions after which the patient was extubated.

DATE: 12/07/10
TIME: 1414
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)
ORIGINAL:

92% into the 70s and 60s. I prepared to emergently reintubate the patient after

EDITED:

92% into the 70s and 60s. I emergently reintubate the patient after

DATE: 12/07/10
TIME: 1414
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)
ORIGINAL:

lumens and run wide open.

EDITED:

lumens and run wide open. Another liter was added to the periferal IV.

DATE: 12/07/10
TIME: 1414
USER: KDC2

000453

RUN DATE: 09/24/12
RUN TIME: 1045
RUN USER: DLC7

DEACONESS ORDER ENTRY *** LIVE ***
REPORT'S AUDIT TRAIL

PAGE 52

DEPARTMENT: DTRAN
REPORT: 1204-0012 PROG NOTE
PATIENT: DX3769908 CLONINGER, GLEN A

EVENT: section 3 of report edited through PREVIEW (PCI)

ORIGINAL:

Vasopressin 40U, atropine .4mg IV and 1 Amp of bicarb. All subsequent medications were also given through the right IJ central line. More CPR staff were added and assisted with CPR by trading off every 1-2 minutes.

EDITED:

Vasopressin 40U, atropine .4mg IV, 1 Amp of bicarb, and (2) 1mg epinephrine syringes were give. All subsequent medications were also given through the right IJ central line. More CPR staff were added and assisted with CPR by trading off every 1-2 minutes.

DATE: 12/07/10
TIME: 1414
USER: KDC2

EVENT: section 3 of report edited through PREVIEW (PCI)

ORIGINAL:

of 99%. Hemoglobin 15 and hematocrit 45. Potassium was 4.5, sodium 143,

EDITED:

of 99.6%. Hemoglobin 15 and hematocrit 45. Potassium was 4.5, sodium 143,

DATE: 12/07/10
TIME: 1414
USER: KDC2

EVENT: section 3 of report edited through PREVIEW (PCI)

ORIGINAL:

return of a brady rythm of 24bpm and no BP. CPR resumed, lidocaine 100mg was given and blood pressures increased into the 94-97/28-40 range, Sats soon increased to 94-97% and ETCO2=60 initially and then declining to 28-32. Asystole was never seen during the conduct of CPR.

EDITED:

return of a brady rythm of 24bpm and no BP. CPR resumed, lidocaine 100mg, atropine .4mg, 2mg epinephrine and 2 Amps Bicarb was given and blood pressures increased over several minutes into the 94-97/28-40 range, Sats soon increased to 94-97% and ETCO2=60 initially and then declining to 28-32.

DATE: 12/07/10
TIME: 1414
USER: KDC2

EVENT: section 3 of report edited through PREVIEW (PCI)

ORIGINAL:

EDITED:

DATE: 12/07/10
TIME: 1414
USER: KDC2

000454

RUN DATE: 09/24/12
RUN TIME: 1045
RUN USER: DLC7

DEACONESS ORDER ENTRY *** LIVE ***
REPORT'S AUDIT TRAIL

PAGE 53

DEPARTMENT: DTRAN
REPORT: 1204-0012 PROG NOTE
PATIENT: DX3769908 CLONINGER, GLEN A

EVENT: section 3 of report edited through PREVIEW (PCI)
ORIGINAL:

Dopamine arrived prior to isoproterenol arrival. Dopamine was drawn up into a 20 mL syringe and then administered 2-3 mL at a time directly into the right IJ central line. Bicarb 2 amps IV were given over 5 minutes. Three medication drips were now running. Amiodarone at 1mg/min, epinephrine 50mcg/min and dopamine 20mcg/min.

EDITED:

DATE: 12/07/10
TIME: 1414
USER: KDC2

EVENT: section 3 of report edited through PREVIEW (PCI)
ORIGINAL:

Total bicarb amps not reflected on the anesthetic record were 6; the record

EDITED:

10:23 Arterial blood gas values are pH 6.707, pCO2 130.6, pO2 110.4, bicarb 16, base excess -22.5 with a sat of 90.8% Hemoglobin 13.9 and hematocrit 41. K=4.73, sodium 147.8, calcium 1.5 and glucose 374.

Dopamine arrived prior to isoproterenol arrival. Dopamine was drawn up into a 20 mL syringe a 5ml bolus given and then administered 2-3 mL at a time directly into the right IJ central line. Bicarb 2 amps IV were given over 5 minutes. Additional epinephrine by 1mg syringe was given three more times as a response to dopamine had not been seen. An additional 2 amps of bicarb was given.

Transvenous pacing equipment was now in the OR and been prepared for placement. Three medication drips were now running. Amiodarone at 1mg/min, epinephrine 50mcg/min and dopamine 20mcg/min.

Total bicarb amps not reflected on the anesthetic record were 9-10; the record

000455

RUN DATE: 09/24/12
RUN TIME: 1045
RUN USER: DLC7

DEACONESS ORDER ENTRY *** LIVE ***
REPORT'S AUDIT TRAIL

PAGE 54

DEPARTMENT: DTRAN
REPORT: 1204-0012 PROG NOTE
PATIENT: DX3769908 CLONINGER, GLEN A

DATE: 12/07/10
TIME: 1414
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)
ORIGINAL:

Approximately 73 minutes into CPR at approximately 10:50, the patient developed a sustainable heart rate and blood pressure that continued to steadily improved from that time forward. Those initial pressures were in the high 80s and low 90s systolically, with heart rates 48-54. Both progressively increased over the following 20 minutes with HR=60-65 and BP=140-150/42-44.

EDITED:

DATE: 12/07/10
TIME: 1414
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)
ORIGINAL:

from that time forward. Those initial pressures were in the high 80s and low 90s systolically, with heart rates 48-54. Both progressively increased over the following 20 minutes with HR=60-65 and BP=140-150/42-44.

The drips continued, including amiodarone at one mcg per minute, epinephrine at 50 mcg per minute and dopamine at 20 mcg per kilo per minute. Dr. Huber arrived just following the arrival of the Echo Tech, the echo probe was placed and the exam was performed. The findings can be found in the medical record in further detail, but there were no focal segmental defects, both atria were equally enlarged with no significant valvular abnormalities. The heart was globally depressed, however, but by the time we were ready to leave the operating room, the ejection fraction had improved from roughly 15-20% to 40%. The EKG showed no acute changes and no evidence of injury. There was obviously a bradycardic rhythm and there was a junctional rhythm with nonspecific ST and T-wave changes.

EDITED:
from that time forward. The patient at this time still require 2-3 ml boluses of dopamine to maintain acceptable blood pressures. Those initial pressures were in the high 80s and low 90s systolically, with heart rates 48-54. Both progressively increased over the following 20 minutes with HR=60-65 and BP=140-150/42-44. Sats had

700466

RUN DATE: 09/24/12
RUN TIME: 1045
RUN USER: DLC7

DEACONESS ORDER ENTRY *** LIVE ***
REPORT'S AUDIT TRAIL

PAGE 55

DEPARTMENT: DTRAN
REPORT: 1204-0012 PROG NOTE
PATIENT: DX3769908 CLONINGER, GLEN A

DATE: 12/07/10
TIME: 1414
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)

ORIGINAL:

The EKG showed no acute changes and no evidence of injury. There was obviously a bradycardic rhythm and there was a junctional rhythm with nonspecific ST and T-wave changes.

EDITED:

The 12 lead EKG showed no acute changes and no evidence of injury. There was obviously a bradycardic rhythm and there was a junctional rhythm with nonspecific ST and T-wave changes.

DATE: 12/07/10
TIME: 1415
USER: KDC2
EVENT: report printed on D-MRLJ1

DATE: 12/07/10
TIME: 1430
USER: KDC2
EVENT: Draft report viewed in PCI

DATE: 12/07/10
TIME: 1450
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)

ORIGINAL:

at increasing heart rate for the procedure was abandoned. Near the end of Lithotripsy the patients train of four was verified as 4/4. Neostigmine 2mg with .4mg of glycopyrolate was administered as a precautionary measure to minimize the chance of any residual paralytic effect. The procedure continued uninterrupted with the heart rate remaining in the 58-64 range for the duration of Lithitripsy.

EDITED:

at increasing heart rate for the procedure was abandoned. Near the end of Lithotripsy the patients train of four was verified as 4/4. Neostigmine 2mg with .4mg of glycopyrolate was administered as a precautionary measure to minimize the chance of any residual paralytic effect. The procedure continued uninterrupted with the heart rate remaining in the 58-64 range for the duration of Lithitripsy.

DATE: 12/07/10

000457

RUN DATE: 09/24/12
RUN TIME: 1045
RUN USER: DLC7

DEACONESS ORDER ENTRY *** LIVE ***
REPORT'S AUDIT TRAIL

PAGE 56

DEPARTMENT: DTRAN
REPORT: 1204-0012 PROG NOTE
PATIENT: DX3769908 CLONINGER, GLEN A

TIME: 1450
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)

ORIGINAL:

92% into the 70s and 60s. I emergently reintubate the patient after the administration of 200 mg of succinylcholine, 100 mg of propofol, epinephrine 500mcg and atropine 400mcg. A pulse was searched for and not found. Pulseless electrical activity was obvious. EKG showed bradycardia at 32 bpm then 24bpm. The remaining 500mcg of epinephrine was then administered and flushed through the IV tubing immediately followed by another 1mg of epinephrine. CPR was immediately started and the Code cart brought to the room. IV fluids were running wide open. Positive pressure bag mask ventilation was done without difficulty with oral air way in place. Dr. King by this moment in time was standing next to me with the Glide Scope in his hand. Sats had risen with CPR and bag/mask ventilation to 97%. CPR was suspended for 20 seconds to accomplish intubation. Rescue medications had no affect on HR as it remained in 20s and no pulse was palpable. Blood pressure cuff continued to search for a pressure.

EDITED:

92% into the 70s and 60s. I emergently reintubate the patient after the administration of 200 mg of succinylcholine, 100 mg of propofol, epinephrine 500mcg and atropine 400mcg. A pulse was searched for and not found. Pulseless electrical activity was obvious. EKG showed bradycardia at 32 bpm then 24bpm. The remaining 500mcg of epinephrine was then administered and flushed through the IV tubing immediately followed by another 1mg of epinephrine. CPR was immediately started and the Code cart brought to the room. IV fluids were running wide open. Positive pressure bag mask ventilation was done without difficulty with oral air way in place. Dr. King by this moment in time was standing next to me with the Glide Scope in his hand. Sats had risen with CPR and bag/mask ventilation to 97%. CPR was suspended for 20 seconds to accomplish intubation. Rescue medications had no affect on HR as it remained in 20s and no pulse was palpable. Blood pressure cuff continued to search for a pressure.

DATE: 12/07/10
TIME: 1450
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)

ORIGINAL:

EDITED:

Dr. King was successful in placing a left femoral central line. Two liters of IV fluid were hung and run wide open.

DATE: 12/07/10
TIME: 1450
USER: KDC2

000468

RUN DATE: 09/24/12

DEACONESS ORDER ENTRY *** LIVE ***

PAGE 57

RUN TIME: 1045

REPORT'S AUDIT TRAIL

RUN USER: DLC7

DEPARTMENT: DTRAN

REPORT: 1204-0012 PROG NOTE

PATIENT: DXS769908 GLENTINGER, GLEN A

EVENT: section 3 of report edited through PREVIEW (PCI)

ORIGINAL:

Additional epinephrine by 1mg syringe was given three more times as a response to dopamine had not been seen. An additional 2 amps of bicarb was given.

EDITED:

CPR was stopped several times to check for rate, rythm and pulse. Interspersed between checks additional epinephrine by 1mg syringe was given three more times as well as epinephrine drawn up into syringe from the high concentration epinephrine bag. Atropine .4mg and an additional 2 amps of bicarb was given.

DATE: 12/07/10

TIME: 1450

USER: KDC2

EVENT: section 3 of report edited through PREVIEW (PCI)

ORIGINAL:

Transvenous pacing equipment was now in the OR and been prepared for placement.

EDITED:

Transvenous pacing equipment was now in the OR and was prepared for placement.

DATE: 12/07/10

TIME: 1450

USER: KDC2

EVENT: section 3 of report edited through PREVIEW (PCI)

ORIGINAL:

Approximately 73 minutes into CPR at approximately 10:50, the patient developed a sustainable heart rate and blood pressure that continued to steadily improved from that time forward. The patient at this time still require 2-3 ml boluses of dopane to maintain acceptable blood pressures. Those initial pressures were in the high 80s and low 90s systolically, with heart rates 48-54. Both progressively increased over the following 20 minutes with HR=60-65 and BP=140-150/42-44. Sats had

EDITED:

DATE: 12/07/10

TIME: 1450

USER: KDC2

EVENT: section 3 of report edited through PREVIEW (PCI)

ORIGINAL:

from that time forward. The patient at this time still require 2-3 ml boluses of dopane to maintain acceptable blood pressures. Those initial pressures were

000469

RUN DATE: 09/24/12

DEACONESS ORDER ENTRY *** LIVE ***

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RUN TIME: 1045

REPORT'S AUDIT TRAIL

RUN USER: DLC7

DEPARTMENT: DTRAN

REPORT: L204-0012 PROG NOTE

PATIENT: DK3769908 CLONINGER, GLEN A

in the high 80s and low 90s systolically, with heart rates 48-54. Both progressively increased over the following 20 minutes with HR=60-65 and BP=140-150/42-44. Sats had

EDITED:

from that time forward. The patient at this time still require 2-3 ml boluses of dopamine to maintain acceptable blood pressures. Those initial pressures were in the high 80s and low 90s systolically, with heart rates 48-54. Both progressively increased over the following 20 minutes with HR=60-65 and BP=140-150/42-44. Sats had remained 92-97% will was CPR in progress. End tidal CO2 leveled off into the 40s with occasional 50s to high 60s seen.

DATE: 12/07/10

TIME: 1450

USER: KDC2

EVENT: section 3 of report edited through PREVIEW (PCI)

ORIGINAL:

EDITED:

000470

RUN DATE: 09/24/12
RUN TIME: 1045
RUN USER: DLC7

DEACONESS ORDER ENTRY *** LIVE ***
REPORT'S AUDIT TRAIL

PAGE 59

DEPARTMENT: DTRAN
REPORT: 1204-0012 PROG NOTE
PATIENT: DX3769908 CLONINGER, GLEN A

DATE: 12/07/10
TIME: 1451
USER: KDC2
EVENT: report printed on D-MRLJ1

DATE: 12/07/10
TIME: 1512
USER: KDC2
EVENT: Draft report viewed in PCI

DATE: 12/07/10
TIME: 1515
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)
ORIGINAL:
66-year-old male here for cystoscopy, ureteroscopy and stent placement followed by extracorporeal shock wave lithotripsy.

EDITED:
morbidly 66-year-old male here for cystoscopy, ureteroscopy and stent placement followed by extracorporeal shock wave lithotripsy.

DATE: 12/07/10
TIME: 1515
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)
ORIGINAL:
Obese 66 year old male in no acute distress. Height: 5'9" Weight: 104 KG (230 LBS)

EDITED:
Morbidly obese 66 year old male in no acute distress. Height: 5'9" Weight: 104 KG (230 LBS)

DATE: 12/07/10

000471

RUN DATE: 09/24/12
RUN TIME: 1045
RUN USER: DLC7

DEACONESS ORDER ENTRY *** LIVE ***
REPORT'S AUDIT TRAIL

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DEPARTMENT: DTRAN
REPORT: 1204-0012 PROG NOTE
PATIENT: DX3769908 CLONINGER, GLEN A

TIME: 1519
USER: KDC2
EVENT: report printed on D-MRLJ1

DATE: 12/07/10
TIME: 1519
USER: KDC2
EVENT: report printed on D-MRLJ1

DATE: 12/07/10
TIME: 1519
USER: KDC2
EVENT: report printed on D-MRLJ1

DATE: 12/07/10
TIME: 1520
USER: KDC2
EVENT: report printed on D-MRLJ1

DATE: 12/07/10
TIME: 1710
USER: KDC2
EVENT: Draft report viewed in PCI

DATE: 12/07/10
TIME: 1823
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)
ORIGINAL:
morbidly 66-year-old male here for cystoscopy, ureteroscopy and stent placement followed by extracorporeal shock wave lithotripsy.

EDITED:
morbidly obese 66-year-old male here for cystoscopy, ureteroscopy and stent placement followed by extracorporeal shock wave lithotripsy.

DATE: 12/07/10
TIME: 1823
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)
ORIGINAL:
Morbidly obese 66 year old male in no acute distress. Height: 5'9" Weight: 104

EDITED:
Morbidly obese 66 year old male in no acute distress. Height: 5'9" Weight: 104

DATE: 12/07/10
TIME: 1823
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)
ORIGINAL:
I to II airway.

000472

RUN DATE: 09/24/12
RUN TIME: 1045
RUN USER: DLC7

DEACONESS ORDER ENTRY *** LIVE ***
REPORT'S AUDIT TRAIL

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DEPARTMENT: BTRAN
REPORT: 1204-0012 PRSG NOTE
PATIENT: DX3769908 CLONINGER, GLEN A

EDITED:
I airway.

DATE: 12/07/10
TIME: 1823
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)
ORIGINAL:
endotracheal anesthetic be done in order for the procedure to safely proceed.

EDITED:
endotracheal anesthetic be done in order for the procedure to safely proceed;

DATE: 12/07/10
TIME: 1823
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)
ORIGINAL:
parts of the procedure that would each negatively impact his ability to ventilate adequately on his own. And finally the potential for a lengthy procedure for which success depended on the patients ability to hold still. We discussed that while often times patients can just have sedation anesthesia

EDITED:
parts of the procedure that would each negatively impact his ability to ventilate adequately on his own; Finally the potential for a lengthy procedure, for which success depended on the patients ability to hold still. We discussed that while oftentimes patients can just have sedation anesthesia

DATE: 12/07/10
TIME: 1823
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)
ORIGINAL:
that would place further pressure on his enlarged abdomen, that would then

EDITED:
that would place further pressure on his enlarged abdomen; This would then

DATE: 12/07/10
TIME: 1823
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)
ORIGINAL:
efforts would likely become weaker and he would have difficulty taking adequate breaths to stay properly oxygenated.

EDITED:
efforts would likely become weaker, and he would have difficulty taking adequate breaths to stay properly oxygenated.

000473

RUN DATE: 09/24/12
RUN TIME: 1045
RUN USER: DLC7

DEACONESS ORDER ENTRY *** LIVE ***
REPORT'S AUDIT TRAIL

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DEPARTMENT: DIRAN
REPORT: 1204-0012 PROG NOTE
PATIENT: DX3769908 CLONINGER, GLEN A

DATE: 12/07/10
TIME: 1823
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)
ORIGINAL:

informed that cardiac arrest and death are rare events but do rarely occur. We also discussed the unlikely potential for post operative ventilation on a ventilator. It was also discussed that during the procedure he would be given medications to make him comfortable for when he awakens from surgery and also medication to prevent postoperative nausea and vomiting. I also made him aware that someone would be with him at all times postoperatively so that if he should experience any discomfort or nausea he could simply let us know and we would take the necessary measures to make him comfortable. The patient

EDITED:
informed that cardiac arrest and death are rare events but can occur. We also discussed the unlikely potential for requiring post-operative ventilation on a ventilator. It was also discussed that during the procedure he would be given medications to make him comfortable for when he awakens from surgery and also medication to prevent postoperative nausea and vomiting. I also made him aware that medical staff would be with him at all times postoperatively so that if he should experience any discomfort or nausea, he could simply let us know and we would take the necessary measures to make him comfortable. The patient

DATE: 12/07/10
TIME: 1823
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)
ORIGINAL:

After the patient was asleep, with cricoid pressure, an oral airway was placed and the patient was bag masked ventilated without difficulty, after which a MAC 3 blade was used to attempt to visualize the vocal cords. The first 2 attempts were brief and only revealed the tip of the epiglottis. Sats remained at 99% and the patient was bag mask ventilated without difficulty for another 30 seconds. The Glide Scope was requested. A Bougie was placed through an 8.0 endotracheal tube and the MAC 3 blade was used once again. The patient was successfully intubated with the 8.0 endotracheal tube. The endotracheal tube cuff was inflated and ET tube attached to the anesthesia circuit followed by verification of positive end tidal CO₂=34 and positive bilateral breath sounds being equal. Sats remained at 99% with a end tidal CO₂=34 and a HR=68. The endotracheal tube was secured at 21 cm at the teeth and oral airway placed back in the patients mouth. The Glide Scope arrived and remained in the room.

EDITED:
After the patient was asleep, with cricoid pressure applied, an oral airway was placed and the patient was bag masked ventilated without difficulty, after which a MAC 3 blade was used to attempt to visualize the vocal cords. The first 2 attempts were brief and only revealed the tip of the epiglottis. Sats remained at 99% and the patient was bag mask ventilated without difficulty for another 30 seconds. The Glide Scope was requested. A Bougie was placed through an 8.0 endotracheal tube and the MAC 3 blade was used once again. The

000474

RUN DATE: 09/24/12
RUN TIME: 1045
RUN USER: DLC7

DEACONESS ORDER ENTRY *** LIVE ***
REPORT'S AUDIT TRAIL

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DEPARTMENT: DTRAN
REPORT: 1204-0012 PROG NOTE
PATIENT: DX3769908 CLOWINGER, GLEN A

patient was successfully intubated with the 8.0 endotracheal tube. The endotracheal tube cuff was inflated and ET tube attached to the anesthesia circuit followed by verification of positive end tidal CO2=34 and positive bilateral breath sounds being equal. Sats remained at 99% with a end tidal CO2=34 and a HR=68. The endotracheal tube was secured at 21 cm at the teeth and oral airway placed back in the patients mouth. The Glide Scope arrived and remained in the room.

DATE: 12/07/10
TIME: 1823
USER: KDC2

EVENT: section 3 of report edited through PREVIEW (PCI)
ORIGINAL:

This part of the procedure progressed uneventfully with vital signs remaining

EDITED:

This part of the procedure progressed uneventfully with vital signs remaining

DATE: 12/07/10
TIME: 1823
USER: KDC2

EVENT: section 3 of report edited through PREVIEW (PCI)
ORIGINAL:

Following cystoscopy, the patient was returned to the head of the bed. A prone pillow placed on the patients face, the anesthesia circuite briefly disconnected and the patient then turned to the prone position with all monitors remaining in place. The anesthesia circuit was reconnected and bilateral breath sounds were once again verified, as was positive end tidal CO2. Vital signs were stable through this process of turning the patient to the prone position. The patients face was checked regularly to verify proper pillow positioning, eye clearance and neck alignment. Lithotripsy proceeded uneventfully. The patient's heart rate remained in the 58-64 range. There were 3 attempts to raise the patients heart rate slightly to reduce the time of lithotripsy and this was done by administering 100 mcg of atropine. However, no heart rate change was ever observed and further attempts at increasing heart rate for the procedure was abandoned. Near the end of Lithotripsy the patients train of four was verified as 4/4. Neostigmine 2mg with .4mg of glycopyrolate was administered as a precautionary measure to minimize the chance of any residual paralytic effect. The procedure continued uninterrupted with the heart rate remaining in the 58-64 range for the duration of Lithitripsy.

EDITED:

Following cystoscopy, the patient was returned to the head of the bed. A prone pillow placed on the patients face, the anesthesia circuit briefly disconnected and the patient then turned to the prone position with all monitors remaining in place. The anesthesia circuit was reconnected and bilateral breath sounds were once again verified, as was positive end tidal CO2. Vital signs were stable through this process of turning the patient to the prone position. The patients face was checked regularly to verify proper pillow positioning, eye clearance and neck alignment. Lithotripsy proceeded uneventfully. The patient's heart rate remained in the 58-64 range. There were 3 attempts to

000475

RUN DATE: 09/24/12
RUN TIME: 1045
RUN USER: DLC7

DEACONESS ORDER ENTRY *** LIVE ***
REPORT'S AUDIT TRAIL

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DEPARTMENT: DTRAN
REPORT: 1204-0012 PROG NOTE
PATIENT: DK3769908 CLONINGER, GLEN A

raise the patients heart rate slightly to reduce the time of lithotripsy and this was done by administering 100 mcg of atropine. However, no heart rate change was ever observed and further attempts at increasing heart rate for the procedure was abandoned. Near the end of Lithotripsy the patients train of four was verified as 4/4. Neostigmine 2mg with .4mg of glycopyrolate was administered as a precautionary measure to minimize the chance of any residual paralytic effect. The procedure continued uninterrupted with the heart rate remaining in the 58-64 range for the duration of lithotripsy.

DATE: 12/07/10
TIME: 1823
USER: KDC2

EVENT: section 3 of report edited through PREVIEW (PCI)

ORIGINAL:

began to laryngospasm once again. Dr. King was called to assist. Positive pressure bag/mask ventilation was instituted however, this time the laryngospasm was not successfully relieved in approximately 15 to 20 seconds. Noting the patients heart rate dropping to 34 and a rapid desaturation from 92% into the 70s and 60s. I emergently reintubate the patient after the administration of 200 mg of succinylcholine, 100 mg of propofol, epinephrine 500mcg and atropine 400mcg. A pulse was searched for and not found. Pulseless electrical activity was obvious. EKG showed bradycardia at 32 bpm then 24bpm. The remaining 500mcg of epinephrine was then administered and flushed through the IV tubing immediately followed by another 1mg of epinephrine. CPR was immediately started and the Code cart brought to the room. IV fluids were running wide open. Positive pressure bag mask ventilation was done without difficulty with oral air way in place. Dr. King by this moment in time was standing next to me with the Glide Scope in his hand. Sats had risen with CPR and bag/mask ventilation to 97%. CPR was suspended for 20 seconds to accomplish intubation. Rescue medications had no affect on HR as it remained in 20s and no pulse was palpable. Blood pressure cuff continued to search for a pressure.

EDITED:

began to laryngospasm once again. Positive pressure bag/mask ventilation was instituted however, this time the laryngospasm was not successfully relieved in approximately 15 to 20 seconds. Noting the patients heart rate dropping to 34 and a rapid desaturation from 92% into the 70s and 60s. I administered 200 mg of succinylcholine, 100 mg of propofol, epinephrine 500mcg and atropine 400mcg. Rescue medications had no effect on HR as it remained in the 20s and no pulse was palpable. Blood pressure cuff continued to search for a pressure. Pulseless electrical activity was obvious. EKG showed bradycardia at 32 bpm then 24bpm. The remaining 500mcg of epinephrine was then administered and flushed through the IV tubing immediately followed by another 1mg of epinephrine.

000476

RUN DATE: 09/24/12

DEACONESS ORDER ENTRY *** LIVE ***

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RUN TIME: 1045

REPORT'S AUDIT TRAIL

RUN USER: DLC7

DEPARTMENT: BTRAN

REPORT: 1204-0012 PROG NOTE

PATIENT: DX3769908 CLONINGER, GLEN A

DATE: 12/07/10

TIME: 1823

USER: KDC2

EVENT: section 3 of report edited through PREVIEW (PCI)

ORIGINAL:

Dr. King handed me the Glide Scope and upon instrumenting the airway I knew a larger blade was need. Dr. King had the larger blade in his hand and instrumented the airway and easily intubated the patient with a 8.0mm endotracheal tube. The ET tube Cuff was inflated, positive ETCO2 verified, no pulse found, HR=24 and CPR resumed. Epinephrine 3mg and atropine .4 mg were given IV and flushed through. Positive ETCO2=24 then rising to 48-50 and back down into the high 20s with continued CPR. Bilateral breath sounds were verified. Initial Sat=53% with the resumption of CPR. The ET tube was secured at 21cm at the teeth. Ventilator was set at 20bpm with TV=850-900. Sats quickly rose back into the 90s and leveled of at 92-94% with ongoing CPR.

EDITED:

CPR was immediately started and the Code cart brought to the room. After arrival of the Code cart, defibrillator pads were placed as was the pacer pad. Dr. King was called to the room. IV fluids were running wide open. Positive pressure bag mask ventilation was done without difficulty with oral air way in place. Sats had risen with CPR and bag/mask ventilation to 97%. I inserted the Glide Scope size 3 blade, gained a Grade III view (epiglottis only) and moved to intubate, but found a poor view which would not facilitate intubation. I removed the Glidescope Blade to resume bag mask ventilation with oral airway in place. Ventilations were successful. After three breaths, Dr. King was at my side with a ready Glide Scope Size 4 blade and rigid J-stylet 8.0mm ETT. Dr. King instrumented the airway and easily intubated the patient with an 8.0mm endotracheal tube. The ET tube cuff was inflated; ETT was secured at 23cm at the teeth; positive ETCO2 verified; bilateral breath sounds were verified; ventilator was set at 20bpm with TV=850-900; no pulse found; HR=24 and CPR resumed. Epinephrine 3mg and atropine 0.4 mg were given IV and flushed through. Positive ETCO2=24 then rising to 48-50 and back down into the high 20s with continued CPR. Sats quickly rose back into the 90s and leveled of at 92-94% with ongoing CPR.

DATE: 12/07/10

TIME: 1823

USER: KDC2

EVENT: section 3 of report edited through PREVIEW (PCI)

ORIGINAL:

The Cardiovascular tech was called to the room to assist Dr. King with arterial

000477

RUN DATE: 09/24/12
RUN TIME: 1045
RUN USER: DLC7

DEACONESS ORDER ENTRY *** LIVE ***
REPORT'S AUDIT TRAIL

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DEPARTMENT: DUTRAN
REPORT: 1204-0012 PROC NOTE
PATIENT: DX2769908 CLONINGER, GLEN A

line placement and perform arterial blood gas analysis. Ultrasound was brought to the room to assist in arterial line placement. The defibrillator pads were placed as was the pacer pad. Both left wrist and left groin were sterilely prepped.

EDITED:

The Cardiovascular tech was called to the room to setup an arterial line transducer and perform arterial blood gas analysis. Ultrasound was brought to the room to assist in arterial line placement. Left wrist was prepped in a sterile fashion. Arterial line was placed under ultrasound guidance by Dr. King during CPR with RN holding the patient's left arm steady. Arterial line placement was verified by positive blood draw back and a sample was collected for analysis. There was no arterial line tracing; No pulsatile wave form was observed.

DATE: 12/07/10
TIME: 1823
USER: KDC2

EVENT: section 3 of report edited through PREVIEW (PCI)

ORIGINAL:

CPB was suspended and no pulse was found HR=28. CPR was resumed and 4mg epinephrine and atropine .4mg was flushed through the IV. No cuff pressure was obtainable and Sats rose back into the 92-95% range and ETCO2=48-55. I placed a right internal jugular double lumen central venous catheter without difficulty utilizing sterile technique. IV fluids were attached to both lumens and run wide open. Another liter was added to the periferal IV.

EDITED:

DATE: 12/07/10
TIME: 1823
USER: KDC2

EVENT: section 3 of report edited through PREVIEW (PCI)

ORIGINAL:

CPR was briefly suspended for arterial line placement which was achieved very quickly by Dr. King. Arterial line placement was verified by positive draw back and a sample collected for analysis. Arterial BP was not registering. No pulsatile wave form was seen. Heart rate was 24 with P-waves absent then V-tach followed by V-fib was seen and defirilated at 200J x 2 with resumption of a bradycardic rythm at 17bpm. No pulse was found and CPR was resumed. Lidocaine 100mg was given through the right IJ central line followed by Vasopressin 40U, atropine .4mg IV, 1 Amp of bicarb, and (2) 1mg epinephrine syringes were give. All subsequent medications were also given through the

0000478

RUN DATE: 09/24/12
RUN TIME: 1045
RUN USER: DLC7

DEACONESS ORDER ENTRY *** LIVE ***
REPORT'S AUDIT TRAIL

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DEPARTMENT: DTRAN
REPORT: 1204-0012 PROG NOTE
PATIENT: DX3769908 CLONTNER, GLEN A

right IJ central line. More CPR staff were added and assisted with CPR by trading off every 1-2 minutes.

EDITED:

CPR was suspended following arterial line placement and no pulse was found but HR was observed at 28bpm. CPR was resumed and 4mg epinephrine and atropine .4mg was flushed through the IV. Arterial line tracing was consistent with chest compressions; Now with an arterial line in place, CPR could be optimized and blood pressures were then initially seen 68/22 and soon rose to 90-93/28-34; Sats rose back into the 92-95% range and ETCO2=48-55. Right neck was prepped in a sterile fashion for right internal jugular double lumen central venous catheter. I placed a right internal jugular double lumen central venous catheter without difficulty utilizing sterile technique. IV fluids were attached to both lumens and run wide open. Another liter was added to the periferal IV. Coincident with my placment of the right internal jugular central venous catheter, Dr. King had prepped the left groin in a sterile fashion and placed a left femoral double lumen central venous catheter under ultrasound guidance. IV fluids were attached to a single lumen of the central venous catheter.

DATE: 12/07/10
TIME: 1823
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)
ORIGINAL:

EDITED:

Heart rate was 24 with P-waves absent then V-tach followed by V-fib was seen and defirilated at 200J x 2 with resumption of a bradycardic rythm at 17bpm. No pulse was found and CPR was resumed. Lidocaine 100mg was given through the right IJ central line followed by Vasopressin 40U, atropine .4mg IV, 1 Amp of bicarb, and (2) 1mg epinephrine syringes were give. All subsequent medications were also given through the right IJ central line. More CPR staff were added and assisted with CPR by trading off every 1-2 minutes.

DATE: 12/07/10
TIME: 1823
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)

000479

RUN DATE: 09/24/12
RUN TIME: 1045
RUN USER: DLC7

DEACONESS ORDER ENTRY *** LIVE ***
REPORT'S AUDIT TRAIL

PAGE 68

DEPARTMENT: DTRAN
REPORT: 1204-0012 PROG NOTE
PATIENT: DX3769908 CLONINGER, GLEN A

ORIGINAL:

Dr. King was successful in placing a left femoral central line. Two liters of IV fluid were hung and run wide open.

Medications were rapidly being consumed so another drug tray was ordered to the room. Now with an arterial line in place and CPR resumed following the run of V-tach/V-fib defibrillation sequence, CPR could be optimized and blood pressures now were initially seen 68/22 and soon rose to 90-93/28-34. High concentration epinephrine from pharmacy was ordered. ETCO2=20-30, Sats increased from initial post defibrillation values of 62% into the 92-96% range over about 2 minutes. Pressures drifted down into the 70s. Epinephrine 2mg x 3, Calcium Chloride 1g and 2 Amps of Bicarb were administered. With on-going CPR, pressures increased to 110-112/38-40 for several minutes then to the 135/45 range for 10 minutes. Blood pressures rose as high as 170/100 for about 45 seconds. Sats remained 94-97% while pressures above 90 were being generated and ETCO2 slowly decreased from an eventual high of 78 down into the 42-44 range. CPR was suspended to check for rate, rhythm and pulse. HR=32 and arterial blood pressure fell from CPR levels of 135/45 to 42/12. Transcutaneous pacing failed and V-tach then V-fib was seen requiring defibrillation x 2 at 200J for return of a brady rhythm of 24bpm and no BP. CPR resumed, lidocaine 100mg, atropine .4mg, 2mg epinephrine and 2 Amps Bicarb was given and blood pressures increased over several minutes into the 94-97/28-40 range, Sats soon increased to 94-97% and ETCO2=60 initially and then declining to 28-32.

EDITED:

DATE: 12/07/10
TIME: 1823
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)

000480

RUN DATE: 09/24/12
RUN TIME: 1045
RUN USER: DLC7

DEACONESS ORDER ENTRY *** LIVE ***
REPORT'S AUDIT TRAIL

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DEPARTMENT: DTRAN
REPORT: 1204-0012 PROG NOTE
PATIENT: DX3769908 CLONINGER, GLEN A

ORIGINAL:

room. Now with an arterial line in place and CPR resumed following the run of V-tach/V-fib defibrillation sequence, CPR could be optimized and blood pressures now were initially seen 68/22 and soon rose to 90-93/28-34. High concentration epinephrine from pharmacy was ordered. ETCO2=20-30, Sats increased from initial post defibrillation values of 62% into the 92-96% range over about 2 minutes. Pressures drifted down into the 70s. Epinephrine 2mg x 3, Calcium Chloride 1g and 2 Amps of Bicarb were administered. With on-going CPR, pressures increased to 110-112/38-40 for several minutes then to the 135/45 range for 10 minutes. Blood pressures rose as high as 170/100 for about 45 seconds. Sats remained 94-97% while pressures above 90 were being generated and ETCO2 slowly decreased from an eventual high of 78 down into the 42-44 range. CPR was suspended to check for rate, rythm and pulse. HR=32 and arterial blood pressure fell from CPR levels of 135/45 to 42/12. Transcutaneous pacing failed and V-tach then V-fib was seen requiring defibrillation x 2 at 200J for return of a brady rythm of 24bpm and no BP. CPR resumed, lidocaine 100mg, atropine .4mg, 2mg epinephrine and 2 Amps Bicarb was given and blood pressures increased over several minutes into the 94-97/28-40 range, Sats soon increased to 94-97% and ETCO2=60 initially and then declining to 28-32.

Asystole was never seen during the conduct of CPR.

EDITED:

room. High concentration epinephrine from pharmacy was ordered. ETCO2=20-30, Sats increased from initial post defibrillation values of 62% into the 92-96% range over about 2 minutes. Pressures drifted down into the 70s. Epinephrine 2mg x 3, Calcium Chloride 1g and 2 Amps of Bicarb were administered. During CPR, the arterial line pressures were observed to be 110-112/38-40, CPR was halted and patient observed to have a junctional rhythm 30bpm which within seconds deteriorated to ventricular tachycardia and fibrillation. Patient was defibrillated with 200J which resulted in a sinus rhythm around 70bpm with several minutes of blood pressures in the 135/45 range for 1 minute then rose as high as 170/100 for about 45 seconds. Sats remained 94-97% while pressures above 90 were being generated and ETCO2 slowly decreased from an eventual high of 78 down into the 42-44 range. Due to sinus rythm and adequate pressures at the time, Dr. King left the room to resume his clinical responsibilities.

DATE: 12/07/10
TIME: 1823
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)
ORIGINAL:

000481

RUN DATE: 09/24/12
RUN TIME: 1045
RUN USER: DLC7

DEACONESS ORDER ENTRY *** LIVE ***
REPORT'S AUDIT TRAIL

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DEPARTMENT: DTRAN
REPORT: 1204-0012 PROG NOTE
PATIENT: DX3769908 CLONINGER, GLEN A

EDITED:

The patient's heart rate then dropped into the 30's bpm, pressures also fell, and CPR was then resumed. The following medications were given: lidocaine 100mg, atropine 0.4mg, 2mg epinephrine and 2 Amps Bicarb was given and blood pressures increased over several minutes into the 94-97/28-40 range, Sats soon increased to 94-97% and ETCO2=60 initially and then declining to 28-32. With these vitals, we began transcutaneous pacing which failed to pace. Then V-tach was observed which was followed by V-fib requiring defibrillation x2 at 200J for return of a bradycardic rhythm of 24bpm without BP.

DATE: 12/07/10
TIME: 1823
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)
ORIGINAL:

EDITED:

DATE: 12/07/10
TIME: 1823
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)
ORIGINAL:

Dopamine arrived prior to isoproterenol arrival. Dopamine was drawn up into a 20 mL syringe a 5ml bolus given and then administered 2-3 mL at a time directly into the right IJ central line. Bicarb 2 amps IV were given over 5 minutes. CPR was stopped several times to check for rate, rythm and pulse. Interspersed between checks additional epinephrine by 1mg syringe was given three more times as well as epinephrine drawn up into syringe from the high concentration epinephrine bag. Atropine .4mg and an additional 2 amps of bicarb was given.

EDITED:

DATE: 12/07/10
TIME: 1823

000482

RUN DATE: 09/24/12
RUN TIME: 1045
RUN USER: DLC7

DEACONESS ORDER ENTRY *** LIVE ***
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DEPARTMENT: DTRAN
REPORT: 1204-0012 PROG NOTE
PATIENT: DX3769908 CLONINGER, GLEN A

USER: KDC2

EVENT: section 3 of report edited through PREVIEW (PCI)

ORIGINAL:

Transvenous pacing equipment was now in the OR and was prepared for placement. Three medication drips were now running. Amiodarone at 1mg/min, epinephrine 50mcg/min and dopamine 20mcg/min.

EDITED:

DATE: 12/07/10

TIME: 1823

USER: KDC2

EVENT: section 3 of report edited through PREVIEW (PCI)

ORIGINAL:

as well as epinephrine drawn up into syringe from the high concentration epinephrine bag. Atropine .4mg and an additional 2 amps of bicarb was given.

Transvenous pacing equipment was now in the OR and was prepared for placement. Three medication drips were now running. Amiodarone at 1mg/min, epinephrine 50mcg/min and dopamine 20mcg/min.

Total bicarb amps not reflected on the anesthetic record were 9-10; the record only shows 4. There is another inconsistency in the written record in my anesthesia CPR events note. I wrote a page and a half note and the inconsistency is in the arrival sequence of Dr. King. My note actually talks about him arriving and starting the A-line and femoral central line, when in fact he arrived and did place the 8-0 endotracheal tube and then placed the ART line and central line.

EDITED:

as well as epinephrine drawn up into syringe from the high concentration epinephrine bag. Atropine 0.4mg and an additional 2 amps of bicarb was given.

DATE: 12/07/10

TIME: 1823

USER: KDC2

EVENT: section 3 of report edited through PREVIEW (PCI)

000483

RUN DATE: 09/24/12
RUN TIME: 1045
RUN USER: DLC7

DEACONESS ORDER ENTRY *** LIVE ***
REPORT'S AUDIT TRAIL

PAGE 72

DEPARTMENT: DTRAN
REPORT: 1204-0012 PROG NOTE
PATIENT: DK3769908 CLONINGER, GLEN A

ORIGINAL:

EDITED:

Transvenous pacing equipment was no in the OR and was prepared for placement. Three medication drips were now running. Amiodarone at 1mg/min, epinephrine 50mcg/min and dopamine 20mcg/min.

DATE: 12/07/10

TIME: 1823

USER: KDC2

EVENT: section 3 of report edited through PREVIEW (PCI)

ORIGINAL:

a sustainable heart rate and blood pressure that continued to steadily improved from that time forward. The patient at this time still require 2-3 ml boluses

EDITED:

a sustainable heart rate and blood pressure that continued to steadily improve from that time forward. The patient at this time still required 2-3 ml boluses

DATE: 12/07/10

TIME: 1823

USER: KDC2

EVENT: section 3 of report edited through PREVIEW (PCI)

ORIGINAL:

BP=140-150/42-44. Sats had remained 92-97% will was CPR in progress. End

EDITED:

BP=140-150/42-44. Sats had remained 92-97% as CPR was in progress. End

DATE: 12/07/10

TIME: 1823

USER: KDC2

EVENT: section 3 of report edited through PREVIEW (PCI)

ORIGINAL:

The drips continued, including amiodarone at one mcg per minute, epinephrine at 50 mcg per minute and dopamine at 20 mcg per kilo per minute. Dr. Huber arrived just following the arrival of the Echo Tech, the echo probe was placed and the exam was performed. The findings can be found in the medical record in further detail, but there were no focal segmental defects, both atria were equally enlarged with no significant valvular abnormalities. The heart was globally depressed, however, but by the time we were ready to leave the operating room, the ejection fraction had improved from roughly 15-20% to 40%. The 12 lead EKG showed no acute changes and no evidence of injury. There was obviously a bradycardic rhythm and there was a junctional rhythm with nonspecific ST and T-wave changes.

EDITED:

000484

RUN DATE: 09/24/12
RUN TIME: 1045
RUN USER: DLC7

DEACONESS ORDER ENTRY *** LIVE ***
REPORT'S AUDIT TRAIL

PAGE 73

DEPARTMENT: DTRAN
REPORT: 1204-0012 PRG NOTE
PATIENT: DX2769908 CLONINGER, GLEN A

DATE: 12/07/10
TIME: 1823
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)
ORIGINAL:

EDITED:

The drips continued, including amiodarone at 1mcg per minute, epinephrine at 50mcg per minute and dopamine at 20mcg per kilo per minute. Dr. Huber arrived just following the arrival of the Echo Tech, the echo probe was placed and the exam was performed. The findings can be found in the medical record in further detail, but there were no focal segmental defects, both atria were equally enlarged with no significant valvular abnormalities. The heart was globally depressed, but by the time we were ready to leave the operating room, the ejection fraction had improved from roughly 15-20% to 40%. The 12 lead EKG showed no acute changes and no evidence of injury. There was a bradycardic rhythm and it was a junctional rhythm with nonspecific ST and T-wave changes.

DATE: 12/07/10
TIME: 1823
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)
ORIGINAL:

Later in the day I met with the family, specifically the patients wife, one of the daughters and her significant other and discussed in detail the events of

000485

RUN DATE: 09/24/12
RUN TIME: 1045
RUN USER: DLC7

DEACONESS ORDER ENTRY *** LIVE ***
REPORT'S AUDIT TRAIL

PAGE 74

DEPARTMENT: DTRAN
REPORT: 1204-0012 PROG NOTE
PATIENT: DX3760900 CLONINGER, GLEN A

EDITED:
Later in the day I met with the family, specifically the patient's wife, one of the daughters and her significant other and discussed in detail the events of

DATE: 12/07/10
TIME: 1834
USER: KDC2
EVENT: report printed on D-MRLJ1

DATE: 12/07/10
TIME: 1843
USER: KDC2
EVENT: report printed on D-MRLJ1

DATE: 12/07/10
TIME: 1855
USER: KDC2
EVENT: Draft report viewed in PCI

DATE: 12/07/10
TIME: 1935
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)
ORIGINAL:
perioperative period. I meet the patient on the morning of 12/01/2010 in the

EDITED:
perioperative period. I met the patient on the morning of 12/01/2010 in the

DATE: 12/07/10
TIME: 1935
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)
ORIGINAL:
history of Obstructive sleep apnea. He did admit to some occasional acid

EDITED:
history of obstructive sleep apnea. He did admit to some occasional acid

DATE: 12/07/10
TIME: 1935
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)
ORIGINAL:
Morbidly obese 66 year old male in no acute distress. Height: 5'9" Weight: 104 KG (230 LBS)
HEENT: The patient had the following dental work:
Crowns, caps and bridges. Airway exam revealed normal extension with a class I airway.

EDITED:
Gen: Morbidly obese 66 year old male in no acute distress. Height: 5'9"

000486

RUN DATE: 09/24/12
RUN TIME: 1045
RUN USER: DLC7

DEACONESS ORDER ENTRY *** LIVE ***
REPORT'S AUDIT TRAIL

PAGE 75

DEPARTMENT: DTRAN
REPORT: 1204-0012 PROC NOTE
PATIENT: DX3769908 CLOMINGER, GLEN A

Weight: 104 KG (230 LBS)
HEENT: The patient had the following dental work: Crowns, caps and bridges.
Airway exam revealed normal extension with a class I airway.

DATE: 12/07/10
TIME: 1935
USER: KDC2

EVENT: section 3 of report edited through PREVIEW (PCI)

ORIGINAL:

endotracheal anesthetic be done in order for the procedure to safely proceed;
Other factors also discussed were patient positioning for the two distinct

EDITED:

endotracheal anesthetic be done in order for the procedure to safely proceed;
Other factors also discussed were patient positioning for the two distinct

DATE: 12/07/10
TIME: 1935
USER: KDC2

EVENT: section 3 of report edited through PREVIEW (PCI)

ORIGINAL:

Heart rate rose briefly following intubation from the high 60s into the mid to
high 70s, and briefly after a few minutes of anesthesia touched 90 and then

EDITED:

Heart rate rose briefly following intubation from the high 60s into the mid to
high 70s, and briefly after a few minutes of anesthesia touched 90 and then

DATE: 12/07/10
TIME: 1935
USER: KDC2

EVENT: section 3 of report edited through PREVIEW (PCI)

ORIGINAL:

procedure was abandoned. Near the end of Lithotrypsy the patients train of
four was verified as 4/4. Neostigmine 2mg with .4mg of glycopyrolate was

EDITED:

procedure was abandoned. Near the end of Lithotrypsy the patients train of
four was verified as 4/4. Neostigmine 2mg with 0.4mg of glycopyrolate was

DATE: 12/07/10
TIME: 1935
USER: KDC2

EVENT: section 3 of report edited through PREVIEW (PCI)

ORIGINAL:

the procedure.

Ventilator respiratory rate was decreased from 10 to 8, and tidal volumes
remained at 700-750mls. End tidal CO2 levels rose into the low 40s over two
minutes and the anesthesia machine placed on bag and the patients ventilations
assisted for another 3 minutes.

As emergence proceeded, the patient became gradually more and more restless,

700487

RUN DATE: 09/24/12
RUN TIME: 1045
RUN USER: DLC7

DEACONESS ORDER ENTRY *** LIVE ***
REPORT'S AUDIT TRAIL

PAGE 76

DEPARTMENT: DTRAN
REPORT: 1204-0012 PROG NOTE
PATIENT: DX3769908 CLONINGER, GLEN A

requiring 3 nursing staff to restrain him. This was done so that the endotracheal tube would not be prematurely dislodged from the trachea and also to prevent the patient from injuring himself. The patient was verbally reassured that surgery was over and he needed to remain still and take deep breaths. Sats at that time remained at 98%. Respiratory rate was assisted at 8-12bpm, spontaneous tidal volumes remained inadequate at about 275mls to 400 unassisted (TV=750-850 assisted), and heart rate continued below 60 at roughly 56-58, blood pressure by cuff was 97/53. The nurses and I verbally continued to reassure the patient, that everything was going well, that he was just waking up from surgery and to lay still so that he would not hurt himself or pull his endotracheal tube out prematurely. This went on for approximately 2 more minutes, at which point the patient started demonstrating a stable pattern of respirations and tidal volumes with good sats and acceptable CO2. The patients tidal volumes were now 750 to 1150 with a rate of 18-24, Sats=98%, end tidal CO2=38-42, HR=48 and BP=97/53. About 75 mls of clear yellow fluid was suctioned from the patients stomach and the oral cavity suctioned and cleared of any secretions after which the patient was extubated.

EDITED:

the procedure. Ventilator respiratory rate was decreased from 10 to 8, and tidal volumes remained at 700-750mls. End tidal CO2 levels rose into the low 40s over two minutes and the anesthesia machine placed on bag and the patients ventilations assisted for another 3 minutes. As emergence proceeded, the patient became gradually more and more restless, requiring 3 nursing staff to restrain him. This was done so that the endotracheal tube would not be prematurely dislodged from the trachea and also to prevent the patient from injuring himself. The patient was verbally reassured that surgery was over and he needed to remain still and take deep breaths. Sats at that time remained at 98%. Respiratory rate was assisted at 8-12bpm, spontaneous tidal volumes remained inadequate at about 275mls to 400 unassisted (TV=750-850 assisted), and heart rate continued below 60 at roughly 56-58, blood pressure by cuff was 97/53. The nurses and I verbally continued to reassure the patient, that everything was going well, that he was just waking up from surgery and to lay still so that he would not hurt himself or pull his endotracheal tube out prematurely. This went on for approximately 2 more minutes, at which point the patient started demonstrating a stable pattern of respirations and tidal volumes with good sats and acceptable CO2. The patients tidal volumes were now 750 to 1150 with a rate of 18-24, Sats=98%, end tidal CO2=38-42, HR=48 and BP=97/53. About 75 mls of clear yellow fluid was suctioned from the patients stomach and the oral cavity suctioned and cleared of any secretions after which the patient was extubated.

DATE: 12/07/10
TIME: 1935
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)
ORIGINAL:

instituted however, this time the laryngospasm was not successfully relieved in approximately 15 to 20 seconds. Noting the patients heart rate dropping to 34 and a rapid desaturation from 92% into the 70s and 60s. I administered 200 mg

000488

RUN DATE: 09/24/12
RUN TIME: 1045
RUN USER: DLC7

DEACONESS ORDER ENTRY *** LIVE ***
REPORT'S AUDIT TRAIL

PAGE 77

DEPARTMENT: DTRAN
REPORT: 1204-0012 PRG NOTE
PATIENT: DX3769908 CLONINGER, GLEN A

EDITED:

instituted however, this time the laryngospasm was not successfully relieved in approximately 15 to 20 seconds. Noting the patients heart rate dropping to 34 and a rapid desaturation from 92% into the 70s and 60s. I administered 200 mg

DATE: 12/07/10

TIME: 1935

USER: KDC2

EVENT: section 3 of report edited through PREVIEW (PCI)

ORIGINAL:

in place. Ventilations were successful. After three breaths, Dr. King was at my side with a ready Glide Scope Size 4 blade and rigid J-stylet 8.0mm ETT. Dr. King instrumented the airway and easily intubated the patient with an 8.0mm endotracheal tube. The ET tube cuff was inflated; ETT was secured at 23cm at the teeth; positive ETCO2 verified; bilateral breath sounds were verified; ventilator was set at 20bpm with TV=850-900; no pulse found; HR=24 and CPR resumed. Epinephrine 3mg and atropine 0.4 mg were given IV and flushed through. Positive ETCO2=24 then rising to 48-50 and back down into the high 20s with continued CPR. Sats quickly rose back into the 90s and leveled of at 92-94% with ongoing CPR.

EDITED:

in place. Ventilations were successful. Sats remained 94-96%. After three breaths, Dr. King was at my side with a ready Glide Scope Size 4 blade and an 8.0mm ETT with a rigid J-style. CPR held. Dr. King instrumented the airway and easily intubated the patient with an 8.0mm endotracheal tube. The ET tube cuff was inflated; positive ETCO2 verified; bilateral breath sounds were verified; ETT was secured at 23cm @ teeth; ventilator was set at 20bpm with TV=850-900; no pulse found; HR=24 and CPR resumed. Epinephrine 3mg and atropine 0.4 mg were given IV and flushed through. Positive ETCO2=24 then rising to 48-50 and back down into the high 20s with continued CPR. Sats quickly rose back into the 90s and leveled of at 92-94% with ongoing CPR.

DATE: 12/07/10

TIME: 1935

USER: KDC2

EVENT: section 3 of report edited through PREVIEW (PCI)

ORIGINAL:

.4mg was flushed through the IV. Arterial line tracing was consistent with chest compressions; Now with an arterial line in place, CPR could be optimized and blood pressures were then initially seen 68/22 and soon rose to

EDITED:

0.4mg was flushed through the IV. Arterial line tracing was consistent with chest compressions; Now with an arterial line in place, CPR could be optimized and blood pressures were then initially seen 68/22 and soon rose to

DATE: 12/07/10

TIME: 1935

USER: KDC2

EVENT: section 3 of report edited through PREVIEW (PCI)

ORIGINAL:

700489

RUN DATE: 09/24/12
RUN TIME: 1045
RUN USER: DLC7

DEACONESS ORDER ENTRY *** LIVE ***
REPORT'S AUDIT TRAIL

PAGE 78

DEPARTMENT: DTRAN
REPORT: 1204-0012 PRGG NOTE
PATIENT: DX3769908 CLONINGER, GLEN A

to the periferal IV. Coincident with my placment of the right internal jugular central venous catheter, Dr. King had prepped the left groin in a sterile fashion and placed a left femoral double lumen central venous catheter under ultrasound guidance. IV fluids were attached to a single lumen of the central venous catheter.

EDITED:

to the peripheral IV. Coincident with my placment of the right internal jugular central venous catheter, Dr. King had prepped the left groin in a sterile fashion and placed a left femoral double lumen central venous catheter under ultrasound guidance. IV fluids were attached to a single lumen of the central venous catheter.

DATE: 12/07/10
TIME: 1935
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)

ORIGINAL:
and defirilated at 200J x 2 with resumption of a bradycardic rythm at 17bpm. No pulse was found and CPR was resumed. Lidocaine 100mg was given through the right IJ central line followed by Vasopressin 40U, atropine .4mg IV, 1 Amp of

EDITED:

and defibrilated at 200J x 2 with resumption of a bradycardic rythm at 17bpm. No pulse was found and CPR was resumed. Lidocaine 100mg was given through the right IJ central line followed by Vasopressin 40U, atropine .4mg IV, 1 Amp of

DATE: 12/07/10
TIME: 1935
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)

ORIGINAL:
seconds deteriorated to ventricular tachycardia and fibrillation. Patient was defibrillated with 200J which resulted in a sinus rhythm around 70bpm with several minutes of blood pressures in the 135/45 range for 1 minute then rose

EDITED:

seconds deteriorated to ventricular fibrillation. Patient was defibrillated with 200J which resulted in a sinus rhythm around 70bpm with several minutes of blood pressures in the 135/45 range for 1 minute then rose

DATE: 12/07/10
TIME: 1935
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)

ORIGINAL:
The patient's heart rate then dropped into the 30's bpm, pressures also fell, and CPR was then resumed. The following medications were given: lidocaine 100mg, atropine 0.4mg, 2mg epinephrine and 2 Amps Bicarb was given and blood pressures increased over several minutes into the 94-97/28-40 range, Sats soon increased to 94-97% and ET_{CO2}=60 initially and then declining to 28-32. With these vitals, we began transcutaneous pacing which failed to pace. Then V-tach

000490

RUN DATE: 09/24/12
RUN TIME: 1045
RUN USER: DLC7

DEACONESS ORDER ENTRY *** LIVE ***
REPORT'S AUDIT TRAIL

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DEPARTMENT: BTRAN
REPORT: 1204-0012 PROG NOTE
PATIENT: DX3769908 CLONINGER, GLEN A

was observed which was followed by V-fib requiring defibrillation x2 at 200J for return of a bradycardic rhythm of 24bpm without BP.

EDITED:

The patient's heart rate then dropped into the 30's bpm with drop in pressures. With these vitals, we attempted transcutaneous pacing which failed to pace. Then V-tach was observed which was followed by V-fib requiring defibrillation x2 at 200J for return of a bradycardic rhythm of 24bpm without blood pressure. CPR was resumed. The following medications were given: lidocaine 100mg, atropine 0.4mg, 2mg epinephrine and 2 Amps Bicarb was given and blood pressures increased over several minutes into the 94-97/28-40 range, Sats soon increased to 94-97% and ETCO2=60 initially and then declining to 28-32. CPR continued with checks for rate, rhythm and pulse several times. Asystole was never seen during the conduct of CPR.

DATE: 12/07/10
TIME: 1935
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)
ORIGINAL:
Asystole was never seen during the conduct of CPR.

EDITED:

DATE: 12/07/10
TIME: 1935
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)
ORIGINAL:
Transvenous pacing equipment was no in the OR and was prepared for placement. Three medication drips were now running. Amiodarone at 1mg/min, epinephrine 50mcg/min and dopamine 20mcg/min.

EDITED:
Transvenous pacing equipment was in the OR and was prepared for placement. Three medication drips were now running: Amiodarone at 1mg/min, epinephrine 50mcg/min and dopamine 20mcg/min.

DATE: 12/07/10
TIME: 1936
USER: KDC2
EVENT: report printed on D-MRLJ1

DATE: 12/07/10
TIME: 1936
USER: KDC2
EVENT: report printed on D-MRLJ1

000491

RUN DATE: 09/24/12
RUN TIME: 1045
RUN USER: DLC7

DEACONESS ORDER ENTRY *** LIVE ***
REPORT'S AUDIT TRAIL

PAGE 80

DEPARTMENT: DTRAN
REPORT: 1204-0012 BRG NOEE
PATIENT: DK3769908 CLONINGER, GLEN A

DATE: 12/07/10
TIME: 1936
USER: KDC2
EVENT: report printed on D-MRLJ1

DATE: 12/07/10
TIME: 1936
USER: KDC2
EVENT: report printed on D-MRLJ1

DATE: 12/08/10
TIME: 1009
USER: MMB33
EVENT: Draft report viewed in PCI

DATE: 12/08/10
TIME: 1045
USER: SJAB
EVENT: Draft report viewed in PCI

DATE: 12/08/10
TIME: 1127
USER: CXB56
EVENT: Draft report viewed in PCI

DATE: 12/08/10
TIME: 1132
USER: CXB56
EVENT: Draft report printed in PCI

DATE: 12/08/10
TIME: 1217
USER: TLH71
EVENT: Draft report viewed in PCI

DATE: 12/09/10
TIME: 0734
USER: CLJ
EVENT: Draft report viewed in PCI

DATE: 12/09/10
TIME: 1012
USER: KDC2
EVENT: Draft report viewed in PCI

DATE: 12/09/10
TIME: 1051
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)
ORIGINAL:
the procedure. Ventilator respiratory rate was decreased from 10 to 8, and

000492

RUN DATE: 09/24/12
RUN TIME: 1045
RUN USER: DLC7

DEACONESS ORDER ENTRY *** LIVE ***
REPORT'S AUDIT TRAIL

PAGE 81

DEPARTMENT: DTRAN
REPORT: 1204-0012 PROC NOTE
PATIENT: DXS769908 CLONINGER, GLEN A

tidal volumes remained at 700-750mls. End tidal CO2 levels rose into the low 40s over two minutes and the anesthesia machine placed on bag and the patients ventilations assisted for another 3 minutes. As emergence proceeded, the patient became gradually more and more restless, requiring 3 nursing staff to restrain him. This was done so that the endotracheal tube would not be prematurely dislodged from the trachea and also to prevent the patient from injuring himself. The patient was verbally reassured that surgery was over and he needed to remain still and take deep breaths. Sats at that time remained at 98%. Respiratory rate was assisted at 8-12bpm, spontaneous tidal volumes remained inadequate at about 275mls to 400 unassisted (TV=750-850 assisted), and heart rate continued below 60 at roughly 56-58, blood pressure by cuff was 97/53. The nurses and I verbally continued to reassure the patient, that everything was going well, that he was just waking up from surgery and to lay still so that he would not hurt himself or pull his endotracheal tube out prematurely. This went on for approximately 2 more minutes, at which point the patient started demonstrating a stable pattern of respirations and tidal volumes with good sats and acceptable CO2. The patients tidal volumes were now 750 to 1150 with a rate of 18-24, Sats=98%, end tidal CO2=38-42, HR=48 and BP=97/53. About 75 mls of clear yellow fluid was suctioned from the patients stomach and the oral cavity suctioned and cleared of any secretions after which the patient was extubated.

EDITED:

the procedure. Following 4-5 minutes of mechanical ventilation with anesthetic agents off the ventilator respiratory rate was decreased from 10 to 8, and tidal volumes remained at 700-750mls. End tidal CO2 levels rose into the low 40s over two minutes and the anesthesia machine placed on bag and the patients ventilations assisted for another 3-4 minutes. As emergence proceeded, the patient became gradually more and more restless, requiring 3 nursing staff to restrain him. This was done so that the endotracheal tube would not be prematurely dislodged from the trachea and also to prevent the patient from injuring himself. The patient was verbally reassured that surgery was over and he needed to remain still and take deep breaths. Sats at that time remained at 98%. Respiratory rate was assisted at 8-12bpm, spontaneous tidal volumes remained inadequate at about 275mls to 400 unassisted (TV=750-850 assisted), and heart rate continued below 60 at roughly 56-58, blood pressure by cuff was 97/53. The nurses and I verbally continued to reassure the patient, that everything was going well, that he was just waking up from surgery and to lay still so that he would not hurt himself or pull his endotracheal tube out prematurely. This went on for approximately 2-3 more minutes, at which point the patient started demonstrating a stable pattern of respirations and tidal volumes with good sats and acceptable CO2. The patients tidal volumes were now 750 to 1150 with a rate of 18-24, Sats=98%, end tidal CO2=38-42, HR=58 and BP=97/53. About 75 mls of clear yellow fluid was suctioned from the patients stomach and the oral cavity suctioned and cleared of any secretions after which the patient was extubated.

DATE: 12/09/10
TIME: 1051
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)

000493

RUN DATE: 09/24/12
RUN TIME: 1045
RUN USER: DLC7

DEACONESS ORDER ENTRY *** LIVE ***
REPORT'S AUDIT TRAIL

PAGE 82

DEPARTMENT: DTRAN
REPORT: 1204-0012 PRG NOTE
PATIENT: DX2769908 CLONINGER, GLEN A

ORIGINAL:

to breath adequately throught the mask for about 20 seconds with RR=18-22, tidal volumes of 550mls to 900mls, Sats=97%, ETCO2=42-44, HR=48. The patient

EDITED:

to breath adequately throught the mask for about 30 seconds with RR=18-22, tidal volumes of 550mls to 900mls, Sats=97%, ETCO2=42-44, HR=58. The patient

DATE: 12/09/10
TIME: 1051
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)

ORIGINAL:

was placed and jaw thrust applied with continued 100% oxygen.

EDITED:

was placed and jaw thrust applied. Airway obstruction was relieved and the patient continued to ventilate with TV=650-1200 for approximatley a minute. Sats=92-96% with the anesthesia machine bag visibly collapsing and filling.

DATE: 12/09/10
TIME: 1051
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)

ORIGINAL:

for approximately 1 minute with Sats=92% and tidal volumes of 750-850. He then began to laryngospasm once again. Positive pressure bag/mask ventilation was instituted however, this time the laryngospasm was not successfully relieved in approximately 15 to 20 seconds. Noting the patients heart rate dropping to 34 and a rapid desaturation from 92% into the 70s and 60s. I administered 200 mg of succinylcholine, 100 mg of propofol, epinephrine 500mcg and atropine 400mcg. Rescue medications had no effect on HR as it remained in the 20s and no pulse was palpable. Blood pressure cuff continued to search for a pressure. Pulseless electrical activity was obvious. EKG showed bradycardia at 32 bpm then 24bpm. The remaining 500mcg of epinephrine was then administered and

EDITED:

for approximately 1 minute with Sats=92-94% and tidal volumes of 750-850. He then began to laryngospasm once again. Positive pressure bag/mask ventilation was instituted however, this time the laryngospasm was not successfully relieved in approximately 15 to 20 seconds. Noting the patients heart rate dropping to 34 and a rapid desaturation from 92% into the 70s and 60s. I administered 200 mg of succinylcholine, 100 mg of propofol, epinephrine 500mcg and atropine 400mcg. Rescue medications had no effect on HR as it remained in the 30s and no pulse was palpable. Blood pressure cuff continued to search for a pressure. Pulseless electrical activity was obvious. EKG showed bradycardia at 34 bpm. The remaining 500mcg of epinephrine was then administered and

DATE: 12/09/10
TIME: 1051

000494

RUN DATE: 09/24/12
RUN TIME: 1045
RUN USER: DLC7

DEACONESS ORDER ENTRY *** LIVE ***
REPORT'S AUDIT TRAIL

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DEPARTMENT: ETRAN
REPORT: 1204-0012 PROC NOTE
PATIENT: DX3769908 CLONINGER, GLEN A

USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)
ORIGINAL:

to the room to assist in arterial line placement. Left wrist was prepped in a sterile fashion. Arterial line was placed under ultrasound guidance by Dr. King during CPR with RN holding the patient's left arm steady. Arterial line placement was verified by positive blood draw back and a sample was collected for analysis. There was no arterial line tracing; No pulsatile wave form was observed.

EDITED:
to the room to assist in arterial line placement. The left wrist was prepped in a sterile fashion. An arterial line was placed under ultrasound guidance by Dr. King during CPR with the RN holding the patient's left arm steady. Arterial line placement was verified by positive blood draw back and a sample was collected for analysis. There was no arterial line tracing; No pulsatile wave form was observed.

DATE: 12/09/10
TIME: 1051
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)
ORIGINAL:

90-93/28-34; Sats rose back into the 92-95% range and ETCO2=48-55. Right neck was prepped in a sterile fashion for right internal jugular double lumen

EDITED:
90-93/28-34; Sats rose back into the 92-95% range and ETCO2=48-55. The right neck was prepped in a sterile fashion for right internal jugular double lumen

DATE: 12/09/10
TIME: 1051
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)
ORIGINAL:

2mg x 3, Calcium Chloride 1g and 2 Amps of Bicarb were administered. During CPR, the arterial line pressures were observed to be 110-112/38-40, CPR was halted and patient observed to have a junctional rhythm 30bpm which within seconds deteriorated to ventricular fibrillation. Patient was defibrillated with 200J which resulted in a sinus rhythm around 70bpm with several minutes of blood pressures in the 135/45 range for 1 minute then rose as high as 170/100 for about 45 seconds. Sats remained 94-97% while pressures

EDITED:
2mg x 3, Atropine .4mg, Calcium Chloride 1g and 2 Amps of Bicarb were administered. During CPR, the arterial line pressures were observed to be 110-112/38-40, CPR was halted and patient observed to have a junctional rhythm 34bpm which within seconds deteriorated to ventricular fibrillation. The patient was defibrillated with 200J which resulted in a sinus rhythm around 70bpm with several minutes of blood pressures in the 135/45 range rising as high as 170/100 for about 45 seconds. Sats remained 94-97% while pressures

700495

RUN DATE: 09/24/12
RUN TIME: 1045
RUN USER: DLC7

DEACONESS ORDER ENTRY *** LIVE ***
REPORT'S AUDIT TRAIL

PAGE 84

DEPARTMENT: DTRAN
REPORT: 1204-0012 PROG NOTE
PATIENT: DXE769908 CLONINGER, GLEN A

DATE: 12/09/10
TIME: 1051
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)
ORIGINAL:

The patient's heart rate then dropped into the 30's bpm with drop in pressures. With these vitals, we attempted transcutaneous pacing which failed to pace. Then V-tach was observed which was followed by V-fib requiring defibrillation x2 at 200J for return of a bradycardic rhythm of 24bpm without blood pressure. CPR was resumed. The following medications were given: lidocaine 100mg, atropine 0.4mg, 2mg epinephrine and 2 Amps Bicarb was given and blood pressures increased over several minutes into the 94-97/28-40 range, Sats soon increased to 94-97% and ETCO2=60 initially and then declining to 28-32. CPR continued with checks for rate, rhythm and pulse several times. Asystole was never seen during the conduct of CPR.

EDITED:

DATE: 12/09/10
TIME: 1051
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)
ORIGINAL:

EDITED:
The patient's heart rate then dropped into the 30's bpm range with a concomitant drop in pressures. With these vitals, we attempted transcutaneous pacing which failed to pace. Then V-tach was observed which was followed by

000496

RUN DATE: 09/24/12
RUN TIME: 1045
RUN USER: DLC7

DEACONESS ORDER ENTRY *** LIVE ***
REPORT'S AUDIT TRAIL

PAGE 85

DEPARTMENT: DTRAN
REPORT: L204-0012 PRGG NOTE
PATIENT: DX3769908 CLONINGER, GLEN A

V-fib requiring defibrillation x2 at 200J with the return of a bradycardic rhythm of 24bpm without blood pressure. CPR was resumed. The following medications were given: lidocaine 100mg, atropine 0.4mg, 2mg epinephrine x2 and 2 Amps Bicarb was given and blood pressures increased over several minutes into the 94-97/28-40 range, Sats soon increased to 94-97% and ETCO2=60 initially and then declining to ETCO2=28-32. CPR continued with checks for rate, rhythm and pulse several times. Asystole was never seen during the conduct of CPR.

DATE: 12/09/10
TIME: 1051
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)
ORIGINAL:

between checks additional epinephrine by 1mg syringe was given three more times as well as epinephrine drawn up into syringe from the high concentration epinephrine bag. Atropine 0.4mg and an additional 2 amps of bicarb was given.

EDITED:
between checks additional epinephrine by 1mg syringe was given three more times. Also administered was epinephrine drawn up into a syringe from the high concentration epinephrine bag. Atropine 0.4mg and an additional 2 amps of bicarb was given.

DATE: 12/09/10
TIME: 1051
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)
ORIGINAL:

BP=140-150/42-44. Sats had remained 92-97% as CPR was in progress. End

EDITED:
BP=140-150/42-44. Sats had remained 92-97% while CPR was in progress. End

DATE: 12/09/10
TIME: 1057
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)
ORIGINAL:

time remained at 98%. Respiratory rate was assisted at 8-12bpm, spontaneous

EDITED:
time remained at 98%. Respiratory rate was assisted at 12-14bpm, spontaneous

DATE: 12/09/10
TIME: 1057
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)
ORIGINAL:

to breath adequately throught the mask for about 30 seconds with RR=18-22,

000497

RUN DATE: 09/24/12
RUN TIME: 1045
RUN USER: DLC7

DEACONESS ORDER ENTRY *** LIVE ***
REPORT'S AUDIT TRAIL

PAGE 86

DEPARTMENT: BIRAN
REPORT: 1204-0012 PROC NOTE
PATIENT: DXS769908 CLONINGER, GLEN A

EDITED:
to breath adequately throught the mask for about 30 seconds with RR=18-24,

DATE: 12/09/10
TIME: 1057
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)
ORIGINAL:
arrival of the Code cart, defribillator pads were placed as was the pacer pad.

EDITED:
arrival of the Code cart, defribillator pads were placed as was the pacer pad.

DATE: 12/09/10
TIME: 1109
USER: KDC2
EVENT: report printed on D-MRLJ1

DATE: 12/09/10
TIME: 1113
USER: KDC2
EVENT: Draft report viewed in PCI

DATE: 12/09/10
TIME: 1142
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)
ORIGINAL:
patients ventilations assisted for another 3-4 minutes. As emergence proceeded, the patient became gradually more and more restless, requiring 3 nursing staff to restrain him. This was done so that the endotracheal tube would not be prematurely dislodged from the trachea and also to prevent the patient from injuring himself. The patient was verbally reassured that surgery was over and he needed to remain still and take deep breaths. Sats at that time remained at 98%. Respiratory rate was assisted at 12-14bpm, spontaneous tidal volumes remained inadequate at about 275mls to 400 unassisted (TV=750-850 assisted), and heart rate continued below 60 at roughly 56-58, blood pressure by cuff was 97/53. The nurses and I verbally continued to reassure the patient, that everything was going well, that he was just waking up from surgery and to lay still so that he would not hurt himself or pull his endotracheal tube out prematurely. This went on for approximately 2-3 more minutes, at which point the patient started demonstrating a stable pattern of respirations and tidal volumes with good sats and acceptable CO2. The patients tidal volumes were now 750 to 1150 with a rate of 18-24, Sats=98%, end tidal CO2=38-42, HR=58 and BP=97/53. About 75 mls of clear yellow fluid was suctioned from the patients stomach and the oral cavity suctioned and cleared of any secretions after which the patient was extubated.

EDITED:
patients ventilations assisted for another 3-4 minutes with ETCO2 42-44 and Sats=97-98%. As emergence proceeded, the patient became gradually more and

000498

RUN DATE: 09/24/12
RUN TIME: 1045
RUN USER: DLC7

DEACONESS ORDER ENTRY *** LIVE ***
REPORT'S AUDIT TRAIL

PAGE 87

DEPARTMENT: DTRAN
REPORT: 1204-0012 PROG NOTE
PATIENT: DX3769908 CLEONINGER, GLEN A

more restless, requiring 3 nursing staff to restrain him. This was done so that the endotracheal tube would not be prematurely dislodged from the trachea and also to prevent the patient from injuring himself. The patient was verbally reassured that surgery was over and he needed to remain still and take deep breaths. Sats at that time remained at 98%. Respiratory rate was assisted at 12-14bpm, spontaneous tidal volumes remained inadequate at about 275mls to 400 unassisted (TV=750-850 assisted), ETCO2=42-44 and heart rate continued below 60 at roughly 56-58, blood pressure by cuff was 97/53. The nurses and I verbally continued to reassure the patient, that everything was going well, that he was just waking up from surgery and to lay still so that he would not hurt himself or pull his endotracheal tube out prematurely. This went on for approximately 2-3 more minutes, at which point the patient started demonstrating a stable pattern of respirations and tidal volumes with good sats and acceptable CO2. The patients tidal volumes were now 750 to 1150 with a rate of 18-24, Sats=98%, end tidal CO2=38-42, HR=58 and BP=97/53. About 75 mls of clear yellow fluid was suctioned from the patients stomach and the oral cavity suctioned and cleared of any secretions after which the patient was extubated.

DATE: 12/09/10
TIME: 1142
USER: KDC2

EVENT: section 3 of report edited through PREVIEW (PCI)

ORIGINAL:

time frame. At that time, his sats had dipped to 78-82% region, but then

EDITED:

time frame. At that time, his sats had dipped to 82%, but then

DATE: 12/09/10
TIME: 1142
USER: KDC2

EVENT: section 3 of report edited through PREVIEW (PCI)

ORIGINAL:

for approximately 1 minute with Sats=92-94% and tidal volumes of 750-850. He then began to laryngospasm once again. Positive pressure bag/mask ventilation was instituted however, this time the laryngospasm was not successfully relieved in approximately 15 to 20 seconds. Noting the patients heart rate dropping to 34 and a rapid desaturation from 92% into the 70s and 60s. I administered 200 mg of succinylcholine, 100 mg of propofol, epinephrine 500mcg and atropine 400mcg. Rescue medications had no effect on HR as it remained in the 30s and no pulse was palpable. Blood pressure cuff continued to search for a pressure. Pulseless electrical activity was obvious. EKG showed bradycardia at 34 bpm. The remaining 500mcg of epinephrine was then administered and flushed through the IV tubing immediately followed by another 1mg of epinephrine.

EDITED:

for approximately 1 minute with Sats=92-94%, ETCO2=45 and tidal volumes of 750-850. He then began to laryngospasm once again. Positive pressure bag/mask ventilation was instituted however, this time the laryngospasm was not successfully relieved in approximately 15 to 20 seconds. Noting the patients heart rate dropping to 34 and a rapid desaturation from 92% into the 70s and

000499

RUN DATE: 09/24/12
RUN TIME: 1045
RUN USER: DLC7

DEACONESS ORDER ENTRY *** LIVE ***
REPORT'S AUDIT TRAIL

PAGE 88

DEPARTMENT: DTRAN
REPORT: 1204-0012 PROG NOTE
PATIENT: DX3769908 CLONINGER, GLEN A

60s. I administered 200 mg of succinylcholine, 100 mg of propofol, epinephrine 500mcg and atropine 400mcg. Rescue medications had no effect on HR as it remained in the 30s and no pulse was palpable. Blood pressure cuff continued to search for a pressure. Pulseless electrical activity was obvious. EKG showed bradycardia at 34 bpm. The remaining 500mcg of epinephrine was then administered and flushed through the IV tubing immediately followed by another 1mg of epinephrine.

DATE: 12/09/10
TIME: 1201
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)
ORIGINAL:
Sats=92-96% with the anesthesia machine bag visibly collapsing and filling.

EDITED:
Sats=92-96% with the anesthesia machine bag visibly collapsing and filling and ETCO2=45.

DATE: 12/09/10
TIME: 1201
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)
ORIGINAL:
time frame. At that time, his sats had dipped to 82%, but then quickly returned to 88% and then 94%. His heart rate at that time was 48. Positive pressure was then reduced and the patient was ventilating adequately for approximately 1 minute with Sats=92-94%, ETCO2=45 and tidal volumes of 750-850. He then began to laryngospasm once again. Positive pressure bag/mask

EDITED:
time frame. At that time, his sats had dipped to 82%, but then quickly returned to 88% and then 94%. His heart rate at that time was 48. Positive pressure was then reduced and the patient was ventilating adequately for approximately 1 minute with Sats=92-94%, ETCO2=45 and tidal volumes of 750-850. He then began to laryngospasm once again. Positive pressure bag/mask

DATE: 12/09/10
TIME: 1201
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)
ORIGINAL:
chest compressions; Now with an arterial line in place, CPR could be optimized and blood pressures were then initially seen 68/22 and soon rose to

EDITED:
chest compressions; Now with an arterial line in place, CPR could be optimized and blood pressures were then initially seen 68/22 and soon rose to

DATE: 12/09/10
TIME: 1201

000500

RUN DATE: 09/24/12
RUN TIME: 1045
RUN USER: DLC7

DEACONESS ORDER ENTRY *** LIVE ***
REPORT'S AUDIT TRAIL

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DEPARTMENT: BTRAN
REPORT: 1204-0012 PROG NOTE
PATIENT: DXS769908 CLONINGER, GLEN A

USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)
ORIGINAL:
the time, Dr. King left the room to resume his clinical responsibilities.

EDITED:
the time, Dr. King left the room to resume his clinical responsibilities. Two more liters of IV fluids were hung.

DATE: 12/09/10
TIME: 1201
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)
ORIGINAL:
comcomitant drop in pressures. With these vitals, we attempted transcutaneous

EDITED:
concomitant drop in pressures. With these vitals, we attempted transcutaneous

DATE: 12/09/10
TIME: 1201
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)
ORIGINAL:
bicarb was given.

EDITED:
bicarb was given. Another medication tray was requested.

DATE: 12/09/10
TIME: 1201
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)
ORIGINAL:
of dopamine to maintain acceptable blood pressures. Those initial pressures were in the high 80s and low 90s systolically, with heart rates 48-54. Both progressively increased over the following 20 minutes with HR=60-65 and BP=140-150/42-44. Sats had remained 92-97% while CPR was in progress. End tidal CO2 leveled off into the 40s with occasional 50s to high 60s seen.

EDITED:
of dopamine to maintain acceptable heart rate and blood pressures. Those initial pressures were in the high 80s and low 90s systolically, with heart rates 48-54. Both progressively increased over the following 20 minutes with HR=60-65 and BP=140-150/42-44. Sats had remained 92-97% while CPR was in progress. End tidal CO2 leveled off into the 40s with occasional 50s to high 60s seen.

DATE: 12/09/10
TIME: 1201

000501

RUN DATE: 09/24/12
RUN TIME: 1045
RUN USER: DLC7

DEACONESS ORDER ENTRY *** LIVE ***
REPORT'S AUDIT TRAIL

PAGE 90

DEPARTMENT: BTRAN
REPORT: 1204-0012 PROG NOTE
PATIENT: DX3769908 CLONINGER, GLEN A

USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)
ORIGINAL:
the 60s, end tidal CO2 was 28, sats were 96-97% with a respiratory rate on the
anesthesia ventilator of 20. Tidal volumes were maintained in the 850-900

EDITED:
the 50s-60s, end tidal CO2 was 28, sats were 96-97% with a respiratory rate on
the anesthesia ventilator of 20. Tidal volumes were maintained in the 850-900

DATE: 12/09/10
TIME: 1202
USER: KDC2
EVENT: report printed on D-MRLJ1

DATE: 12/09/10
TIME: 1202
USER: KDC2
EVENT: report printed on D-MRLJ1

DATE: 12/09/10
TIME: 1202
USER: KDC2
EVENT: report printed on D-MRLJ1

DATE: 12/09/10
TIME: 1202
USER: KDC2
EVENT: report printed on D-MRLJ1

DATE: 12/09/10
TIME: 1206
USER: KDC2
EVENT: Draft report viewed in PCI

DATE: 12/09/10
TIME: 1209
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)
ORIGINAL:
Preop EKG showed normal sinus rhythm with a rate of 68 beats per
minute. No injury pattern. No acute changes and only nonspecific T-wave

EDITED:
Preop EKG showed normal sinus rhythm with a rate of 68 beats per minute. No
injury pattern. No acute changes and only nonspecific T-wave

DATE: 12/09/10
TIME: 1209
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)
ORIGINAL:

000502

RUN DATE: 09/24/12
RUN TIME: 1045
RUN USER: DLC7

DEACONESS ORDER ENTRY *** LIVE ***
REPORT'S AUDIT TRAIL

PAGE 91

DEPARTMENT: DTRAN
REPORT: 1204-0012 PROG NOTE
PATIENT: BX3769908 CLONINGER, ELEN A

ventilate adequately on his own; Finally the potential for a lengthy procedure, for which success depended on the patients ability to hold still. We discussed that while oftentimes patients can just have sedation anesthesia for lithotripsy or cystoscopy, that in his case this would not be a prudent course of action and the reason for this was discussed as relating to his obesity and the potential for him experiencing airway obstruction as his sedation levels were increased to keep him comfortable and still for the procedure. It was explained to him that his feet would be up in stirrups and that would place further pressure on his enlarged abdomen; This would then place further pressure on his diaphragm and increase the work of breathing for him. I let him know that as levels of sedation increased that his respiratory efforts would likely become weaker, and he would have difficulty taking adequate breaths to stay properly oxygenated.

EDITED:

ventilate adequately on his own; Finally the potential for a lengthy procedure, for which success depended on the patients ability to hold still. We discussed that while oftentimes patients can just have sedation anesthesia for lithotripsy or cystoscopy, that in his case this would not be a prudent course of action and the reason for this was discussed as relating to his obesity and the potential for him experiencing airway obstruction as his sedation levels were increased to keep him comfortable and still for the procedure. It was explained to him that his feet would be up in stirrups and that would place further pressure on his enlarged abdomen; This would then place further pressure on his diaphragm and increase the work of breathing for him. I let him know that as levels of sedation increased that his respiratory efforts would likely become weaker, and he would have difficulty taking adequate breaths to stay properly oxygenated.

DATE: 12/09/10
TIME: 1209
USER: KDC2

EVENT: section 3 of report edited through PREVIEW (PCI)

ORIGINAL:

informed that cardiac arrest and death are rare events but can occur. We also discussed the unlikely potential for requiring post-operative ventilation on a ventilator. It was also discussed that during the procedure he would be given medications to make him comfortable for when he awakens from surgery and also medication to prevent postoperative nausea and vomiting. I also made him aware that medical staff would be with him at all times postoperatively so that if he should experience any discomfort or nausea, he could simply let us know and we would take the necessary measures to make him comfortable. The patient

EDITED:

informed that cardiac arrest and death are rare events but can occur. We also discussed the unlikely potential for requiring post-operative ventilation on a ventilator. It was also discussed that during the procedure he would be given medications to make him comfortable for when he awakens from surgery and also medication to prevent postoperative nausea and vomiting. I also made him aware that medical staff would be with him at all times postoperatively so that if he should experience any discomfort or nausea, he could simply let us know and we would take the necessary measures to make him comfortable. The patient

000503

RUN DATE: 09/24/12
RUN TIME: 1045
RUN USER: DLC7

DEACONESS ORDER ENTRY *** LIVE ***
REPORT'S AUDIT TRAIL

PAGE 92

DEPARTMENT: DTRAN
REPORT: 1204-0012 PROG NOTE
PATIENT: DX375990B CLONINGER, GLEN A

DATE: 12/09/10
TIME: 1209
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)

ORIGINAL:
in place. Ventilations were successful. Sats remained 94-96%. After three breaths, Dr. King was at my side with a ready Glide Scope Size 4 blade and an 8.0mm ETT with a rigid J-style. CPR held. Dr. King instrumented the airway and easily intubated the patient with an 8.0mm endotracheal tube. The ET tube cuff was inflated; positive ETCO2 verified; bilateral breath sounds were verified; ETT was secured at 23cm @ teeth; ventilator was set at 20bpm with TV=850-900; no pulse found; HR=24 and CPR resumed. Epinephrine 3mg and

EDITED:
in place. Ventilations were successful. Sats remained 94-96%. After three breaths, Dr. King was at my side with a ready Glide Scope Size 4 blade and an 8.0mm ETT with a rigid J-style. CPR held. Dr. King instrumented the airway and easily intubated the patient with an 8.0mm endotracheal tube. The ET tube cuff was inflated; positive ETCO2 verified; bilateral breath sounds were verified; ETT was secured at 23cm @ teeth; ventilator was set at 20bpm with TV=850-900; no pulse found; HR=24 and CPR resumed. Epinephrine 3mg and

DATE: 12/09/10
TIME: 1209
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)

ORIGINAL:
The 09:58 ABG values which were drawn upon arterial line placement are as follows: pH 7.3, pCO2 22.8, pO2 360, bicarb 11, base excess -13 with a sat of 99.6%. Hemoglobin 15 and hematocrit 45. Potassium was 4.5, sodium 143,

EDITED:
The 09:58 ABG values which were drawn upon arterial line placement are as follows: pH 7.3, pCO2 22.8, pO2 360, bicarb 11, base excess -13 with a sat of 99.6%. Hemoglobin 15 and hematocrit 45. Potassium was 4.5, sodium 143,

DATE: 12/09/10
TIME: 1210
USER: KDC2
EVENT: report printed on D-MRLJ1

DATE: 12/09/10
TIME: 1210
USER: KDC2
EVENT: report printed on D-MRLJ1

DATE: 12/09/10
TIME: 1210
USER: KDC2
EVENT: report printed on D-MRLJ1

000504

RUN DATE: 09/24/12
RUN TIME: 1045
RUN USER: DLC7

DEACONESS ORDER ENTRY *** LIVE ***
REPORT'S AUDIT TRAIL

PAGE 93

DEPARTMENT: BTRAN
REPORT: 1204-0012 PROG NOTE
PATIENT: DX3769908 CLONINGER, GLEN A

DATE: 12/09/10
TIME: 1215
USER: KDC2
EVENT: Draft report viewed in PCI

DATE: 12/09/10
TIME: 1221
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)
ORIGINAL:
CPR was stopped several times to check for rate, rythm and pulse. Interspersed between checks additional epinephrine by 1mg syringe was given three more times. Also administered was epinephrine drawn up into a syringe from the high

EDITED:
CPR was stopped several times to check for rate, rythm and pulse. Heart rate was in the mid 30s every time with 34bpm the usually seen rate and no p waves on EKG. Blood preesure during these checks were 40s/15-20 Interspersed between checks additional epinephrine by 1mg syringe was given three more times. Also administered was epinephrine drawn up into a syringe from the high

DATE: 12/09/10
TIME: 1221
USER: KDC2
EVENT: report printed on D-MRLJ1

DATE: 12/09/10
TIME: 1223
USER: KDC2
EVENT: report printed on D-MRLJ1

DATE: 12/09/10
TIME: 1231
USER: CXB56
EVENT: Draft report viewed in PCI

DATE: 12/09/10
TIME: 1231
USER: CXB56
EVENT: Draft report printed in PCI

DATE: 12/09/10
TIME: 1231
USER: KDC2
EVENT: report printed on D-MRLJ1

DATE: 12/09/10
TIME: 1232
USER: KDC2
EVENT: report printed on D-MRLJ1

000505

RUN DATE: 09/24/12
RUN TIME: 1045
RUN USER: DLC7

DEACONESS ORDER ENTRY *** LIVE ***
REPORT'S AUDIT TRAIL

PAGE 94

DEPARTMENT: DIFRAN
REPORT: 1204-0012 PROG NOTE
PATIENT: DX3769908 CLONINGER, GLEN A

DATE: 12/09/10
TIME: 1318
USER: RKT2
EVENT: Draft report viewed in PCI

DATE: 12/10/10
TIME: 1219
USER: KDC2
EVENT: Draft report viewed in PCI

DATE: 12/10/10
TIME: 1253
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)

ORIGINAL:

following initial ramp up of anesthetic levels equaled 140/80 with a HR=80. Heart rate rose briefly following intubation from the high 60s into the mid to high 70s, and briefly after a few minutes of anesthesia touched 90 and then over the next few minutes (10-15 minutes) dropped back down to roughly his baseline in the mid 60s, and remained in the 58-64 range for the remainder of

EDITED:

following initial titration of anesthetic levels, equaled 140/80 with a HR=80. Heart rate rose briefly following intubation from the high 60s into the mid to high 70s, and briefly after a few minutes of anesthesia touched 90 and then over the next few minutes (10-15 minutes) dropped back down to roughly his baseline in the low 60s, and remained in the 58-64 range for the remainder of

DATE: 12/10/10
TIME: 1253
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)

ORIGINAL:

end tidal CO2=38-42, HR=58 and BP=97/53. About 75 mls of clear yellow fluid was suctioned from the patients stomach and the oral cavity suctioned and cleared of any secretions after which the patient was extubated.

EDITED:

end tidal CO2=38-42, HR=58 and BP=97/53. Following more than one minute of this stable ventilatory pattern, 75 mls of clear yellow fluid was suctioned from the patients stomach and the oral cavity suctioned and cleared of any secretions after which the patient was extubated.

DATE: 12/10/10
TIME: 1253
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)

ORIGINAL:

the Glide Scope size 3 blade, gained a Grade III view (epiglottis only) and moved to intubate, but found a poor view which would not facilitate intubation.

000506

RUN DATE: 09/24/12
RUN TIME: 1045
RUN USER: DLC7

DEACONESS ORDER ENTRY *** LIVE ***
REPORT'S AUDIT TRAIL

PAGE 95

DEPARTMENT: DTRAN
REPORT: 1204-0012 PROG NOTE
PATIENT: BX3769908 CLONINGER, GLEN A

I removed the Glidescope Blade to resume bag mask ventilation with oral airway in place. Ventilations were successful. Sats remained 94-96%. After three breaths, Dr. King was at my side with a ready Glide Scope Size 4 blade and an 8.0mm ETT with a rigid J-style. CPR held. Dr. King instrumented the airway and easily intubated the patient with an 8.0mm endotracheal tube. The ET tube cuff was inflated; positive ETCO2 verified; bilateral breath sounds were verified; ETT was secured at 23cm @ teeth; ventilator was set at 20bpm with TV=850-900; no pulse found; HR=24 and CPR resumed. Epinephrine 3mg and atropine 0.4 mg were given IV and flushed through. Positive ETCO2=24 then rising to 48-50 and back down into the high 20s with continued CPR. Sats quickly rose back into the 90s and leveled off at 92-94% with ongoing CPR.

EDITED:

the Glide Scope size 3 blade and saw a Grade III view (epiglottis only). I removed the Glidescope Blade to resume bag mask ventilation with oral airway in place. Ventilations were successful. Sats remained 94-96%. After three breaths, Dr. King was at my side with a Glide Scope Size 4 blade and an 8.0mm ETT with a rigid J-style. CPR held. Dr. King instrumented the airway and easily intubated the patient with an 8.0mm endotracheal tube. The ET tube cuff was inflated; positive ETCO2 verified; bilateral breath sounds were verified; ETT was secured at 23cm @ teeth; ventilator was set at 20bpm with TV=850-900; no pulse found; HR=24 and CPR resumed. Epinephrine 3mg and atropine 0.4 mg were given IV and flushed through. Positive ETCO2=24 then rising to 48-50 and back down into the high 20s with continued CPR. Sats quickly rose back into the 90s and leveled off at 92-94% with ongoing CPR.

DATE: 12/10/10
TIME: 1253
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)
ORIGINAL:

Heart rate was 24 with P-waves absent then V-tach followed by V-fib was seen and defibrilated at 200J x 2 with resumption of a bradycardic rythm at 17bpm. No pulse was found and CPR was resumed. Lidocaine 100mg was given through the right IJ central line followed by Vasopressin 40U, atropine .4mg IV, 1 Amp of bicarb, and (2) 1mg epinephrine syringes were give. All subsequent medications were also given through the right IJ central line. More CPR staff were added and assisted with CPR by trading off every 1-2 minutes.

EDITED:

CPR was suspended briefly to check for rate, rythm and pulse. Heart rate was 24 with P-waves absent then V-tach followed by V-fib was seen and defibrilated at 200J x 2 with resumption of a bradycardic rythm at 17bpm. No pulse was found and CPR was resumed. Lidocaine 100mg was given through the right IJ central line followed by Vasopressin 40U, atropine .4mg IV, 1 Amp of bicarb, and (2) 1mg epinephrine syringes were give. All subsequent medications were also given through the right IJ central line. More CPR staff were added and assisted with CPR by trading off every 1-2 minutes.

DATE: 12/10/10

000507

RUN DATE: 09/24/12
RUN TIME: 1045
RUN USER: DLC7

DEACONESS ORDER ENTRY *** LIVE ***
REPORT'S AUDIT TRAIL

PAGE 96

DEPARTMENT: DTRAN
REPORT: 1204-0012 PROG NOTE
PATIENT: DX3769908 CLONINGER, GREEN A

TIME: 1253
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)
ORIGINAL:
and 2 Amps Bicarb was given and blood pressures increased over several minutes into the 94-97/28-40 range, Sats soon increased to 94-97% and ETCO2=60 initially and then declining to ETCO2=28-32. CPR continued with checks for rate, rhythm and pulse several times. Asystole was never seen during the conduct of CPR.

EDITED:
syringes plus 2 amps 1mg epinephrine and 2 Amps Bicarb was given and blood pressures increased over several minutes into the 94-97/28-40 range, Sats soon increased to 94-97% and ETCO2=60 initially and then declining to ETCO2=28-32. CPR continued with checks for rate, rhythm and pulse several times. Asystole was never seen during the conduct of CPR.

DATE: 12/10/10
TIME: 1253
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)
ORIGINAL:
base excess -22.5 with a sat of 90.8% Hemoglobin 13.9 and hematocrit 41.

EDITED:
base excess -22.5 with a sat of 90.8% Hemoglobin 13.9 and hematocrit 41.

DATE: 12/10/10
TIME: 1253
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)
ORIGINAL:
concentration epinephrine bag. Atropine 0.4mg and an additional 2 amps of bicarb was given. Another medication tray was requested.

EDITED:
concentration epinephrine bag; This was done several times. Atropine 0.4mg and an additional 2 amps of bicarb was given. Another medication tray was requested.

DATE: 12/10/10
TIME: 1253
USER: KDC2
EVENT: report printed on D-MRLJ4

DATE: 12/10/10
TIME: 1253
USER: KDC2
EVENT: report printed on D-MRLJ4

DATE: 12/10/10

000508

RUN DATE: 09/24/12
RUN TIME: 1045
RUN USER: DLC7

DEACONESS ORDER ENTRY *** LIVE ***
REPORT'S AUDIT TRAIL

PAGE 97

DEPARTMENT: DTRAN
REPORT: 1204-0012 PROG NOTE
PATIENT: DX3769908 CLONINGER, GLEN A

TIME: 1257
USER: KDC2
EVENT: Draft report viewed in PCI

DATE: 12/10/10
TIME: 1258
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)
ORIGINAL:
following initial titration of anesthetic levels, equaled 140/80 with a
EDITED:
following initial titration of anesthetic levels, equaled 140/80 with a

DATE: 12/10/10
TIME: 1306
USER: KDC2
EVENT: Draft report viewed in PCI

DATE: 12/10/10
TIME: 1309
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)
ORIGINAL:
returned to 88% and then 94%. His heart rate at that time was 48. Positive pressure was then reduced and the patient was ventilating adequately for approximately 1 minute with Sats=92-94%, ETCO2=45 and tidal volumes of 750-850. He then began to laryngospasm once again. Positive pressure bag/mask ventilation was instituted however, this time the laryngospasm was not successfully relieved in approximately 15 to 20 seconds. Noting the patients heart rate dropping to 34 and a rapid desaturation from 92% into the 70s and 60s. I administered 200 mg of succinylcholine, 100 mg of propofol, epinephrine 500mcg and atropine 400mcg. Rescue medications had no effect on HR as it remained in the 30s and no pulse was palpable. Blood pressure cuff continued to search for a pressure. Pulseless electrical activity was obvious. EKG showed bradycardia at 34 bpm. The remaining 500mcg of epinephrine was then administered and flushed through the IV tubing immediately followed by another 1mg of epinephrine.

EDITED:
returned to 88% and then 94% over about 30 seconds. His heart rate at that time was 48. Positive pressure was then reduced and the patient was ventilating adequately for approximately 1 minute with Sats=92-94%, ETCO2=45 and tidal volumes of 750-850. He then began to laryngospasm once again. Positive pressure bag/mask ventilation was instituted however, this time the laryngospasm was not successfully relieved in approximately 15 to 20 seconds. Noting the patients heart rate dropping to 34 and a rapid desaturation from 92% into the 70s and 60s. I administered 200 mg of succinylcholine, 100 mg of propofol, epinephrine 500mcg and atropine 400mcg. Rescue medications had no effect on HR as it remained in the 30s and no pulse was palpable. Blood pressure cuff continued to search for a pressure. Pulseless electrical activity was obvious. EKG showed bradycardia at 34 bpm. The remaining 500mcg

000509

RUN DATE: 09/24/12
RUN TIME: 1045
RUN USER: DLC7

DEACONESS ORDER ENTRY *** LIVE ***
REPORT'S AUDIT TRAIL

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DEPARTMENT: DTRAN
REPORT: 1204-0012 PROG NOTE
PATIENT: DX3769908 CLONINGER, GLEN A

of epinephrine was then administered and flushed through the IV tubing immediately followed by another 1mg of epinephrine.

DATE: 12/10/10
TIME: 1314
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)

ORIGINAL:
ventilating adequately for approximately 1 minute with Sats=92-94%, ETCO2=45 and tidal volumes of 750-850. He then began to laryngospasm once again. Positive pressure bag/mask ventilation was instituted however, this time the laryngospasm was not successfully relieved in approximately 15 to 20 seconds. Noting the patients heart rate dropping to 34 and a rapid desaturation from 92% into the 70s and 60s. I administered 200 mg of succinylcholine, 100 mg of propofol, epinephrine 500mcg and atropine 400mcg. Rescue medications had no effect on HR as it remained in the 30s and no pulse was palpable. Blood pressure cuff continued to search for a pressure. Pulseless electrical activity was obvious. EKG showed bradycardia at 34 bpm. The remaining 500mcg of epinephrine was then administered and flushed through the IV tubing immediately followed by another 1mg of epinephrine.

EDITED:
ventilating adequately for more than 1 minute with Sats=92-94%, ETCO2=45, RR=18-24 and tidal volumes of 750-850. He then began to laryngospasm once again. Positive pressure bag/mask ventilation was instituted however, this time the laryngospasm was not successfully relieved in approximately 15 to 20 seconds. Noting the patients heart rate dropping to 34 and a rapid desaturation from 92% into the 70s and 60s. I administered 200 mg of succinylcholine, 100 mg of propofol, epinephrine 500mcg and atropine 400mcg. Rescue medications had no effect on HR as it remained in the 30s and no pulse was palpable. Blood pressure cuff continued to search for a pressure. Pulseless electrical activity was obvious. EKG showed bradycardia at 34 bpm. The remaining 500mcg of epinephrine was then administered and flushed through the IV tubing immediately followed by another 1mg of epinephrine.

DATE: 12/10/10
TIME: 1315
USER: KDC2
EVENT: report printed on D-MRLJ4

DATE: 12/10/10
TIME: 1332
USER: KDC2
EVENT: Draft report viewed in PCI

DATE: 12/10/10
TIME: 1335
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)

ORIGINAL:
and (2) 1mg epinephrine syringes were give. All subsequent medications were also given through the right IJ central line. More CPR staff were added and

000510

RUN DATE: 09/24/12
RUN TIME: 1045
RUN USER: DLC7

DEACONESS ORDER ENTRY *** LIVE ***
REPORT'S AUDIT TRAIL

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DEPARTMENT: DTRAN
REPORT: 1204-0012 PROG NOTE
PATIENT: DX3769908 CLONINGER, GLEN A

assisted with CPR by trading off every 1-2 minutes.

EDITED:
and (2) 1mg epinephrine syringes plus (3) 1mg epinephrine amps were given. All subsequent medications were also given through the right IJ central line. More CPR staff were added and assisted with CPR by trading off every 1-2 minutes.

DATE: 12/10/10
TIME: 1336
USER: KDC2
EVENT: report printed on D-MRLJ4

DATE: 12/10/10
TIME: 1340
USER: KDC2
EVENT: Draft report viewed in PCI

DATE: 12/10/10
TIME: 1340
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)
ORIGINAL:

ETT with a rigid J-style. CPR held. Dr. King instrumented the airway and

EDITED:
ETT with a rigid J-stylet. CPR held. Dr. King instrumented the airway and

DATE: 12/10/10
TIME: 1345
USER: KDC2
EVENT: section 3 of report edited through PREVIEW (PCI)
ORIGINAL:

was inflated; positive ETCO2 verified; bilateral breath sounds were verified; ETT was secured at 23cm @ teeth; ventilator was set at 20bpm with TV=850-900; no pulse found; HR=24 and CPR resumed. Epinephrine 3mg and atropine 0.4 mg were given IV and flushed through. Positive ETCO2=24 then rising to 48-50 and back down into the high 20s with continued CPR. Sats quickly rose back into the 90s and leveled off at 92-94% with ongoing CPR.

EDITED:
was inflated; positive ETCO2 verified (with CPR resumed); bilateral breath sounds were verified; ETT was secured at 23cm @ teeth; ventilator was set at 20bpm with TV=850-900; no pulse found; HR=24 and CPR resumed. Epinephrine 3mg and atropine 0.4 mg were given IV and flushed through. Positive ETCO2=24 then rising to 48-50 and back down into the high 20s with continued CPR. Sats quickly rose back into the 90s and leveled off at 92-94% with ongoing CPR.

DATE: 12/10/10
TIME: 1345
USER: KDC2
EVENT: report printed on D-MRLJ4

000511

RUN DATE: 09/24/12
RUN TIME: 1045
RUN USER: DLC7

DEACONESS ORDER ENTRY *** LIVE ***
REPORT'S AUDIT TRAIL

PAGE 100

DEPARTMENT: ETRAN
REPORT: 1204-0012 PROG NOTE
PATIENT: DX3769908 CLONINGER, GLEN A

DATE: 12/10/10
TIME: 1349
USER: KDC2
EVENT: report printed on D-MRLJ4

DATE: 12/10/10
TIME: 1349
USER: KDC2
EVENT: report printed on D-MRLJ4

DATE: 12/10/10
TIME: 1349
USER: KDC2
EVENT: report printed on D-MRLJ4

DATE: 12/14/10
TIME: 0933
USER: CLJ
EVENT: Draft report printed in PCI

DATE: 12/21/10
TIME: 0959
USER: KDC2
EVENT: Draft report viewed in PCI

DATE: 12/21/10
TIME: 1003
USER: KDC2
EVENT: status edited
ORIGINAL:
Draft

EDITED:
Signed

DATE: 12/21/10
TIME: 1003
USER: CHEKI
EVENT: report signed electronically for Kim D Chen

DATE: 12/21/10
TIME: 1003
USER: KDC2
EVENT: report printed on CC

DATE: 12/22/10
TIME: 0822
USER: MOH
EVENT: Signed report viewed in PCI

DATE: 12/27/10
TIME: 0829

000512

RUN DATE: 09/24/12
RUN TIME: 1045
RUN USER: DLC7

DEACONESS ORDER ENTRY *** LIVE ***
REPORT'S AUDIT TRAIL

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DEPARTMENT: DTRAN
REPORT: 1204-0012 PROG NOTE
PATIENT: DX3769908 CLONINGER, GLEN A

USER: CXB56
EVENT: Signed report viewed in PCI

DATE: 12/27/10
TIME: 0829
USER: CXB56
EVENT: Signed report viewed in PCI

DATE: 01/11/11
TIME: 1434
USER: DLC7
EVENT: report printed on D-MRLJ4

DATE: 04/11/11
TIME: 0012
USER: System
EVENT: Signed report compressed

DATE: 12/02/11
TIME: 1721
USER: DRG4
EVENT: Signed report printed in PCI

DATE: 01/18/12
TIME: 1343
USER: CXB56
EVENT: Signed report viewed in PCI

DATE: 04/11/12
TIME: 1010
USER: BDB15
EVENT: Signed report viewed in PCI

DATE: 04/11/12
TIME: 1010
USER: BDB15
EVENT: Signed report printed in PCI

000513

APPENDIX B



APPENDIX B

Spokane County No. 11204888-2
Cloninger v. Chen, et al.
Exhibit No. D-106
Disposition _____