UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF NEW YORK

PAUL MURPHY, Regional Director of Region 3 of the National Labor Relations Board, for and on behalf of the NATIONAL LABOR RELATIONS BOARD,

Petitioner,

v.

CAYUGA MEDICAL CENTER ,

Respondent.

DECLARATION OF KAREN AMES

Civil Action No.: 3:17-MC-00004 (TJM)(ATB)

STATE OF NEW YORK)
) ss.:
COUNTY OF TOMPKINS)

I, Karen Ames, declare, upon personal knowledge and under penalty of perjury that the following is true and correct:

1. I am employed by CMC as Chief Patient Safety Officer & Director of Quality and Patient Safety. I have held this position since April 2010.

2. In this role, among other responsibilities, I am responsible for investigating patient safety complaints.

3. On September 11, 2016, Charge Nurse, RN Scott Goldsmith received a complaint from a patient who regularly received blood transfusions at CMC and was therefore familiar with the verification process. The patient recognized and reported that on September 11 the two nurses who performed the transfusion failed to properly verify both her ID and the blood to be used in the transfusion before starting the blood transfusion process. In fact, only one nurse was in the room at that time. Thereafter, Mr. Goldsmith entered the complaint into the incident reporting system. A copy of the incident report is attached as **Exhibit A**.

4. Loran Lamb and Anne Marshall had been the assigned nurses to perform the blood transfusion on September 11.

5. In my capacity as Chief Patient Safety Officer, I proceeded to conduct an investigation of the September 11 incident upon receipt of the incident report.

6. I, along with Deb Raupers, Director of Patient Services, interviewed the patient on September 16. I entered the information gathered during the interview into the incident reporting system. That information is attached as **Exhibit B.** Ms. Raupers also documented the interview. That information is attached as **Exhibit C.**

7. The patient also provided a written statement in connection with the investigation. That statement is attached as **Exhibit D.** The patient concluded "All previous nurses had made me aware of this protocol and led me through it – this nurse did none . . . I need the hospital to be aware of this breech [sic] of protocol and seriousness I felt being vulnerable in my bed."

8. As part of this investigation, Ms. Raupers and I spoke with the patient's sister, who was present in the room when the incident took place, and who is also a critical care RN in Maine. She reported that when asked "where is the 2nd nurse for the blood transfusion, [Ms. Marshall's] reply [was] 'We don't have to do that;' [and when] questioned why another nurse did, [Marshall's] reply [was] 'That must have been a new nurse.'" The sister also stated that, "As an experienced critical care RN, I was shocked by the responses."

9. I reviewed the September 11 Blood Transfusion Card for this patient completed by Ms. Marshall and Ms. Lamb. In the box with the heading "Below information must be verified at Patient Bedside" both nurses provided their initials and signed the card certifying that the correct procedures had been followed, even though according to the patient's report, and the family member's report, this was not the case. A copy of this card is attached as **Exhibit E.**

10. Blood transfusions are a critical procedure that could have a lethal outcome if an error results in transfusion of the wrong blood type. Therefore, CMC has maintained a Blood Product Administration Policy since at least 2013 to put in place as many safeguards as possible to ensure that a transfusion patient receives the correct blood. The Blood Product Administration Policy in effect at the time of the September 11 incident is attached as **Exhibit F**.

11. This policy requires two verifications by two nurses. The first verification occurs before the blood can be brought into the room. The two nurses must examine the patient information as well as the information on the blood bag from the laboratory. Both nurses must verify that everything matches, at which point the blood can be brought into the patient's room. This requirement was added to the policy in 2013 after a near-miss incident in October 2012 where a patient almost received the wrong blood.

12. The second verification occurs once the blood is in the patient's room. Again, the two nurses must verify the patient's name and date of birth (which requires the nurses to check the patient's identification bracelet), and checking the order and label on the bag. At that point, the blood bag can be hung and the infusion commenced. This second verification has at all times been a part of CMC's Blood Product Administration Policy and is a national standard of care.

13. This final two-person bedside verification process is absolutely fundamental as a final safeguard against a potentially fatal error prior to starting a blood transfusion. Please see the relevant section of Lippincott's, the authoritative source on standards for nursing practices, attached as **Exhibit G.**

14. In fact, it is the final bedside verification that saved the patient in October 2012 from receiving the wrong blood. It is the last line of defense before a patient receives blood and is imperative in ensuring patient safety.

15. Once the transfusion is complete, both nurses are required to complete the Blood Transfusion Card in the medical record certifying that every step of the verification process was followed and that the transfusion was administered in accordance with all of the necessary safeguards set forth in the Blood Product Administration Policy. It is my, and CMC's expectation, that the Blood Transfusion Card is filled out correctly and falsification of such a medical record, as with any other medical record, would be grounds for discipline, including, termination.

16. I interviewed Ms. Lamb on September 21st. Ms. Lamb admitted she never even entered the patient's room for this transfusion. She said she made a mistake and said she was sorry. Ms. Lamb went on to acknowledge that: (1) she understood the Blood Products Administration Policy; (2) she recently completed and understood the blood product training; and (3) that she knew that blood administration is a high risk process and that an error could be fatal for the patient. When asked about any contributing factors, Ms. Lamb said that the unit was busy at the time, but she knew that this was no excuse for not completing the two-person check at the bedside.

17. As part of CMC's investigation, this incident was submitted to CMC's Nursing Peer Review Committee, which is comprised of 6-12 RNs from across different care areas at CMC. As standard practice, after reviewing all relevant information concerning the incident, each committee member renders one of four possible judgments:

1 – Most experienced, competent practitioners would have managed the case in a similar manner

2 – Most experienced, competent practitioners might have managed the case differently

3 – Most experienced, competent practitioners would have managed the case differently

0 – Reviewer uncertain, needs committee discussion

The Committee unanimously concluded that, "3 – Most experienced, competent practitioners would have managed the case differently." A summary of this peer review and the conclusions reached is attached as **Exhibit H**.

18. We also provided information to Dr. Daniel Sudilovsky, Chairman of Pathology and Laboratory Medicine and Medical Director of Laboratories for CMC, concerning the incident. He concluded that the conduct was significantly severe enough that the two nurses should not be allowed to continue to provide services at CMC. All blood products are administered under Dr. Sudilovsky's license.

19. I reviewed the staffing records to evaluate Ms. Lamb's claim that the unit was busy. My review showed that: (1) each ICU nurse had two patients, which is the normal ratio; (2) the charge nurse had no patient assignment and was readily available to assist as needed; and (3) there was a RN designated as on-call who could have been (but was not) called in.

20. I also followed up with Charge Nurse Goldsmith to evaluate the claim that the nurses were busy. An email summarizing that conversation is attached as **Exhibit I**. It confirmed that staffing was at the normal ratio and there were no emergencies.

21. Ms. Marshall had been on a pre-scheduled vacation, and we were unable to speak with her about the incident until October 4. In this interview, Ms. Marshall admitted that she knew the policy but chose not to follow it because she was busy at the time. She argued that the policy is flawed and glibly diminished the importance of a fundamental patient safety/nursing practice protocol by asserting that she is fully capable of doing the final verification outside the patient's room while multi-tasking. This is particularly reckless since CMC policy declares blood product administration to be a "safety zone process", meaning that all steps must be

performed from start to finish without interruption, and if an interruption does occur the process must be restarted at the beginning and carried through to completion without interruption.

22. Finally, Deb Raupers and I reviewed the incident reporting system to confirm that no similar complaints regarding the failure to follow this protocol had been made. All of the hospital's records at least since the near miss incident in October 2012 reflect that all blood transfusions by nurses across all CMC units are conducted in accordance with the Blood Product Administration Policy, including the final two-RN bedside verification. My staff pulled all records during this relevant period; they were reviewed by Ms. Raupers and myself.

23. Additionally, although no other case is exactly like the misconduct committed by Ms. Lamb and Ms. Marshall, a somewhat comparable example occurred on June 23, 2016, where RN V. Comstock was discharged for failing to conduct checks before administering a medication, including failing to scan the patient bracelet. A copy of this discipline is attached as **Exhibit J**. In addition, there have been several cases where CMC employees were immediately discharged for falsifying medical records.

24. As a result of the investigation, CMC concluded that Ms. Marshall and Ms. Lamb (1) knowingly and deliberately violated policy and committed a fundamental breach of patient safety that placed the patient in danger of a potential lethal outcome; (2) caused the vulnerable patient fear and distress because she was aware of the nurses' disregard of the necessary safety precautions; and (3) falsified the Blood Transfusion Card by certifying that the bedside verification had been performed. In addition, Ms. Marshall disregarded the patient's own concern about following the proper protocol, and Ms. Lamb failed to even enter the patient's room despite certifying that she had.

25. Under these circumstances, I concluded that the nurses' actions were reckless and posed a substantial and unjustifiable risk to the patient.

26. I had no knowledge regarding Ms. Lamb's alleged pro-union feelings or sentiments.

Dated: March 2, 2017

Karen Ames

Karen Ames

Sworn to before me this
2nd ~~th~~ day of March, 2017.

Robin L Tilton
NOTARY PUBLIC

ROBIN L TILTON
Notary Public, State of New York
No. 01TI6160254
Qualified in Tompkins County
Commission Expires February 05, 2019