

BEFORE THE IOWA BOARD OF
RESPIRATORY CARE EXAMINERS

IN THE MATTER OF:) CASE NO. 05-004
) DIA NO. 06DPHRC001
RICHARD A. CARR,)
) FINDINGS OF FACT,
) CONCLUSIONS OF LAW,
Respondent) DECISION AND ORDER

On January 23, 2006, the Iowa Board of Respiratory Care Examiners (Board) filed a Statement of Charges against Richard A. Carr (Respondent) alleging negligence and lack of professional competency, in violation of Iowa Code sections 147.55(2)(8), 152B.12, 272C.10(2)(2005) and 645 IAC 263.2(10) and 263.2(2)(b), (c), and (d). The Circumstances supporting the Statement of Charges were provided in a confidential attachment. On February 6, 2006, a Notice of Hearing was issued scheduling the hearing for April 24, 2006.

The hearing was held on April 24, 2006 at 10:10 a.m. at the Lucas State Office Building, Fifth Floor Conference Room, Des Moines, Iowa. At the time scheduled for hearing, Respondent called the Board and asked to appear for the hearing by telephone. The state's exhibits were sent to Respondent prior to the hearing. Respondent was self-represented. Assistant Attorney General John Baty represented the state of Iowa.

The following Board members served as the presiding officers for the hearing: Kerry George, RRT, Board Chair; Robert Zeman, RRT; Kathelene Semke, RRT; and Craig Bainbridge, MD. The hearing was closed to the public at Respondent's request, pursuant to Iowa Code section 272C.6(1). The hearing was recorded by a certified court reporter. Administrative Law Judge Margaret LaMarche assisted the Board in conducting the hearing. Following the hearing, the Board convened in closed executive session, pursuant to Iowa Code section 21.5(1)(f), for deliberations. The administrative law judge was instructed to prepare the Board's Findings of Fact, Conclusions of Law, Decision and Order, in conformance with their deliberations.

THE RECORD

The record includes the testimony of the witnesses and the following exhibits:

State Exhibit 1: Notice of Hearing
State Exhibit 2: Statement of Charges
State Exhibit 3: Confidential Attachment
State Exhibit 4: Proof of Service, exhibits 1-3
State Exhibit 5: "Passport"
State Exhibit 6: Complaint, dated 6/28/05
State Exhibit 7: Investigation, 9/6/05
State Exhibit 8: Proof of Service, State's Exhibits
State Exhibit 9: 645 IAC 263.2

Respondent Exhibit A: Midwest Sleep Services, Inc. Report,
3/24/05

FINDINGS OF FACT

1. On February 12, 1999, Respondent was issued license number 306-01465 to practice respiratory care in the state of Iowa. Respondent's license lapsed on March 31, 2006 and had not been renewed as of the date of the hearing. If a license is not renewed within thirty days, it automatically becomes inactive. (Testimony of Marilyn Ubaldo; State Exhibit 5)

2. At times relevant to this Decision and Order, Respondent was employed as a respiratory care practitioner by Harmony House Health Care Center in Waterloo, Iowa. Thomas Kelleher, the Director of Nursing at Harmony House, filed a complaint with the Board on June 30, 2005. Kelleher reported that Respondent had been suspended without pay and then terminated on June 22, 2005, due to his failure to complete required job duties, thereby placing patients at risk. Corey Powell, Investigator III with the Iowa Department of Inspections and Appeals, was assigned to investigate the complaint. Kelleher interviewed witnesses, obtained documentation from Harmony House Health Care Center, and prepared an investigative report. (Testimony of Corey Powell; State Exhibits 6, 7)

3. Harmony House Health Care Center documented numerous instances of substandard respiratory care provided by Respondent while working third shift in June 2005.

a. On June 2, June 3, June 7, June 8, June 10, June 11, and June 12, Respondent signed that a resident's oxygen was on, per physician's order. However, on these dates the oncoming shift and co-workers on the third shift found the resident was not receiving oxygen.

b. On June 8, 2005, first shift staff came on duty and discovered that cuff on the tracheostomy tube of a resident's was not holding pressure. When questioned about the leak, Respondent reported that he had been putting air in the cuff all night. The minimum standard of care required Respondent to change the tracheostomy tube if the cuff was leaking.

c. A resident was found on June 11, 2005 without oxygen connected to his system. The resident did not have the CPAP mask applied and the CPAP generator was not connected to the electrical outlet. When first shift staff found the resident, his oxygen saturation (S_{pO_2}) was 85%. Staff questioned whether Respondent had even checked on the resident.

d. Both a resident and an aide told Respondent that the resident needed suctioning to clear secretions, but Respondent failed to do so because he was on break and reading a book at the time of the call and forgot to perform suctioning following break. Respondent failed to give priority to the resident's needs.

e. First shift staff had to empty water (3 jars full) from the circuit of a ventilator connected to a resident at 6:15 a.m. because Respondent had not emptied water from the circuit on his shift. Respondent was responsible for emptying the water trap when he did rounds on the residents receiving respiratory therapy.

f. On June 8, 2005, Respondent failed to complete ventilator function checks for a resident at 3:00 a.m.

g. On June 3, 2005, Respondent charted in his respiratory assessment flow sheet that a resident was in respiratory distress and complained of pain at the tracheostomy stoma site. However, Respondent failed to chart having intervened in any way to address these problems in his progress notes.

h. Ventilator function checks must be performed every four hours, but Respondent failed to perform the required vent checks at 3:00 a.m. on June 12, 2005.

i. On June 8, 2005, Respondent was scheduled to work from 10:00 p.m. until 6:15 a.m. but left early without permission from his supervisor.

(Testimony of Thomas Kelleher; Corey Powell; State Exhibits 6, 7, Attachments B7-B11)

4. Respondent also had prior documented work performance problems at Harmony House, including when he was employed on the first shift from 6:00 a.m. until 2:15 p.m. On January 21, 2005, Respondent failed to give a resident a respiratory care treatment, reportedly because the resident's door was shut. On January 15, 2005, Respondent refused a request that he suction a resident because he was working on documentation. Although the nurse reminded him that patient care came first, Respondent refused to come out of the respiratory care office. On that same day, Respondent did not change a resident's vent that was not working properly and another resident complained that Respondent did not come to help him when his vent needed changing and he needed suctioning. (State Exhibit 7, pp. B2-B3) On January 30, 2005, a co-worker found Respondent asleep at the desk during the day shift. When schedules were changed, the Director of Nursing gave Respondent a choice of three schedules, and he chose to work thirty hours on the third shift. (Testimony of Thomas Kelleher; State Exhibit 6, attachment B2-B4)

On April 18, 2005, the Director of Nursing issued a Memo outlining four instances of substandard charting by Respondent on April 13, 2005. The inadequate charting raised issues of whether or not Respondent was assessing the residents and what he was doing to resolve respiratory distress. (Testimony of Thomas Kelleher; State Exhibit 7, Attachment B5)

5. On June 13, 2005, the Director of Nursing issued Respondent a disciplinary memo, outlining Respondent's deficient job performance in the previous week. Both Respondent and the Director of Nursing signed the disciplinary memo on June 15, 2005. Respondent was immediately suspended without pay until June 21, 2005, when the facility administrator was due to return from vacation. On June 21, 2005, the administrator met with Respondent and then terminated Respondent's employment after determining that his performance on the third shift was so grossly unacceptable, lacking appropriate concern and role execution, and so far below the acceptable minimum standards of care. (Testimony of Corey Powell; Thomas Kelleher; State Exhibit 7)

6. Respondent explained that he adopted a special needs child in November 2004 and had to take family leave in January 2005

when his child was sick in the hospital. Respondent attributes his performance related problems to a sleep disorder and blames his termination on a strained relationship with facility management concerning his work schedule. On March 24, 2005, Respondent was diagnosed at Midwest Sleep Services, Inc. with idiopathic hypersomnolence. Due to an insurance problem, Respondent reports that he was unable to start taking the prescribed medications for the disorder until the end of June 2005. However, Respondent never reported his sleep disturbances to his employer and did not challenge his termination. (Testimony of Respondent; Thomas Kelleher; Respondent Exhibit A; State Exhibit 7, p. 3)

7. Respondent is not currently practicing respiratory care and has not renewed his license because he cannot afford the continuing education. Respondent is currently providing full-time care for four special needs children in his home. (Testimony of Respondent)

CONCLUSIONS OF LAW

I. The Violations

Iowa Code section 147.55(2) and (8)(2005) provides, in relevant part:

A license to practice a profession shall be revoked or suspended when the licensee is guilty of any of the following acts or offenses:

...

2. Professional incompetency.

...

8. Willful or repeated violations of the provisions of this Act.

Accord, Iowa Code section 272C.10(2) and (8)(2005).

Iowa Code section 152B.12 provides that the board may suspend, revoke or impose probationary conditions upon a license issued pursuant to the rules adopted in accordance with section 152B.6.

645 Iowa Administrative Code (IAC) 263.2 provides, in relevant part:

645-263.2(152B,272C) Grounds for discipline. The board may impose any of the disciplinary sanctions provided in rule 645-263.3(147,272C) when the board determines that the licensee is guilty of any of the following acts or offenses:

...

263.2(2) Professional incompetency. Professional incompetency includes, but is not limited to:

...

b. A substantial deviation from the standards of learning or skill ordinarily possessed and applied by other practitioners in the state of Iowa acting in the same or similar circumstances.

c. A failure to exercise the degree of care which is ordinarily exercised by the average practitioner acting in the same or similar circumstances.

d. Failure to conform to the minimal standard of acceptable and prevailing practice of a respiratory care practitioner in this state.

...

263.2(10) Negligence by the licensee in the practice of the profession. Negligence by the licensee in the practice of the profession includes a failure to exercise due care including negligent delegation of duties or supervision of employees or other individuals, whether or not injury results; or any conduct, practice or conditions which impairs the ability to safely and skillfully practice the profession.

The preponderance of the evidence established that the Respondent violated Iowa Code sections 147.55(2) and (8), 152B.12, 272C.10(2)(2005) and 645 IAC 263.2(2)(b), (c), (d), and 263.2(10) when he repeatedly failed to provide respiratory care services that conformed to the minimal standard of acceptable and prevailing practice of a respiratory care practitioner in this state. Respondent was unable to provide a satisfactory explanation for the substandard care that he provided. It appears that Respondent does not understand his professional obligations as a respiratory therapist.

II. Sanction

The Board considered the disciplinary sanctions listed in 645 IAC 263.3 and the relevant factors outlined at 645 IAC 263.4. The nature and number of incidents documented by Respondent's former employer raises serious doubt about Respondent's current ability to competently practice respiratory care, and the Board's first concern is protection of the public. Moreover, Respondent has not kept his license current and has not completed the required continuing education required for license renewal. Under these circumstances, the Board has no option but to indefinitely suspend Respondent's license to practice respiratory care until he can establish, by a preponderance of the evidence, that the reasons for the suspension no longer

exist and that it is in the public interest for his license to be reinstated. 645 IAC 11.31.

DECISION AND ORDER

IT IS THEREFORE ORDERED that license number 306-01465 issued to Respondent Richard A. Carr is hereby **INDEFINITELY SUSPENDED**.

IT IS FURTHER ORDERED that Respondent's license suspension will continue until Respondent establishes, through a reinstatement proceeding, that the basis for the suspension no longer exists, and that it is in the public interest for his license to be reinstated. An initial application for reinstatement may not be made until one year has elapsed from the date of this Decision and Order.

FINALLY, IT IS ORDERED that the Respondent shall pay a \$75.00 hearing fee and the \$90.00 fee for the court reporter. The \$165.00 shall be paid within thirty (30) days of receipt of this decision. If a transcript is ordered, the cost will be charged to the party requesting it. Iowa Code section 272C.6(6); 645 IAC 11.23.

This findings of fact, conclusions of law, decision and order are approved by the board on May 31, 2006.

Any appeal to the district court from a decision in a contested case shall be taken within 30 days from the date of issuance of the decision by the board. Iowa Code section 17A.19; 645 IAC 11.29.