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BEFORE THE
RESPIRATORY CARE BOARD
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: JOSEPH ERNEST CARRILLO 795 Marlboro Court Claremont, California 91711 Respiratory Care Practitioner License No. 18493 Respondent.	Case No. R-1969 **A C C U S A T I O N**

Complainant alleges:

PARTIES

1. Stephanie Nunez (Complainant) brings this Accusation solely in her official capacity as the Executive Officer of the Respiratory Care Board of California, Department of Consumer Affairs.

2. On or about January 5, 1996, the Respiratory Care Board issued Respiratory Care Practitioner License Number 18493 to Joseph Ernest Carrillo (Respondent). This license was in full force and effect at all times relevant to the charges brought herein and will expire on September 30, 2005, unless renewed.

JURISDICTION

3. This Accusation is brought before the Respiratory Care Board (Board), Department of Consumer Affairs, under the authority of the following laws. All section references

are to the Business and Professions Code unless otherwise indicated.

4. Section 3710 of the Code states: "The Respiratory Care Board of California, hereafter referred to as the board, shall enforce and administer this chapter [Chapter 8.3, the Respiratory Care Practice Act]."

5. Section 3718 of the Code states: "The board shall issue, deny, suspend, and revoke licenses to practice respiratory care as provided in this chapter."

6. Section 3750 of the Code states:

"The board may order the denial, suspension or revocation of, or the imposition of probationary conditions upon, a license issued under this chapter, for any of the following causes:

" . . .

"(f) Negligence in his or her practice as a respiratory care practitioner.

" . . .

"(o) Incompetence in his or her practice as a respiratory care practitioner. . . ."

7. Section 3755 of the Code states:

"The board may take action against any respiratory care practitioner who is charged with unprofessional conduct in administering, or attempting to administer, direct or indirect respiratory care. Unprofessional conduct includes, but is not limited to, repeated acts of clearly administering directly or indirectly inappropriate or unsafe respiratory care procedures, protocols, therapeutic regimens, or diagnostic testing or monitoring techniques, and violation of any provision of Section 3750. The board may determine unprofessional conduct involving any and all aspects of respiratory care performed by anyone licensed as a respiratory care practitioner."

COST RECOVERY

8. Section 3753.5, subdivision (a) of the Code states:

"In any order issued in resolution of a disciplinary proceeding before the board, the board or the administrative law judge may direct any practitioner or applicant found to have committed a violation or violations of law to pay to the board a sum not to exceed the costs of the

investigation and prosecution of the case."

9. Section 3753.7 of the Code states:

"For purposes of the Respiratory Care Practice Act, costs of prosecution shall include attorney general or other prosecuting attorney fees, expert witness fees, and other administrative, filing, and service fees."

10. Section 3753.1, subdivision (a) of the Code states:

"An administrative disciplinary decision imposing terms of probation may include, among other things, a requirement that the licensee-probationer pay the monetary costs associated with monitoring the probation."

FIRST CAUSE FOR DISCIPLINE

(Negligence)

11. Respondent is subject to disciplinary action under section 3750, subdivision (f) of the Code, in that he was negligent in his practice as a respiratory care practitioner. The circumstances are as follows:

A. Respondent was employed as the Respiratory Director at Desert Valley Hospital (DVH) on April 25, 2003. Patient O.H., a sixty-five year old female, was admitted to DVH on November 9, 2003, with diagnoses including respiratory failure with possible pneumonia, diabetes, and chronic renal failure. O.H. was on a ventilator for breathing due to respiratory failure. Because she could not be weaned off the ventilator, on November 21, 2003, she underwent a tracheostomy, a procedure in which a tube was surgically placed through her throat into her trachea to create an airway. There were no complications during the procedure.

B. On November 25, 2003, at 9:05 a.m. a nurse informed the pulmonologist of an air leak in O.H.'s tracheostomy tube cuff. At this time, the ventilator records and blood gas reports showed the patient to be very stable with no adverse effects from the leak in the tracheostomy tube cuff. The pulmonologist suggested the tracheostomy tube be changed and he would ask the surgeon to do it. On November 25, 2003, at 9:10 a.m., the pulmonologist wrote an order on the Physician's Order Sheet to call

the surgeon to change the trach tube from a 6 to an 8 that day. The hospital's policy was that a respiratory therapist could change a tracheostomy tube only with a physician's order.

C. At 9:30 a.m. respondent arrived with another respiratory therapist and told the nurse not to call the physician. Respondent changed the patient's trach tube from a size 6 to a size 8. During the change, there was some blood-tinged sputum and mild resistance. The patient was placed back on the ventilator and within a few seconds she appeared dusky, lost her pulse due to a lack of ventilation, and began to suffer from subcutaneous emphysema, a condition where she swelled up from air that entered the tissue in her arms, chest and face. A code blue was called at about 9:35 a.m. and the patient was resuscitated. The emergency department physician was called at about 9:40 a.m., and he put a size 6 tracheostomy tube back into the patient's trachea.

The notes of respondent and the nurse confirm these events.

D. The emergency physician's progress note at 9:40 a.m. states that "a code blue was called. Patient arrested. Subcutaneous emphysema, no good breathing sounds with ventilation via bag/ endotracheal tube (which appears to be out of the trachea) a 6.0 tracheostomy tube was placed by myself into the trachea."

E. The attending physician's progress note at 10:30 a.m. indicated "patient had problems while the tracheostomy tube was being replaced. She became pulseless for about one minute because of loss of ventilation. T-tube was being replaced 4 days after the tracheostomy was done. Spoke with (surgeon). He feels that it was too early to change the tube." The physician documented that the patient's condition was critical and her prognosis was grave.

F. The surgeon's progress note at 10:30 a.m. indicated the patient was reintubated by the respiratory therapist with an 8 tube after he removed the 6 tube. The surgeon was never notified of the pulmonologist's order to change the tracheostomy tube. He indicated he would have waited another few days. He explained that four days after a tracheostomy, the patient's tract is not mature enough to attempt such an exchange, especially not with a larger tube. He further stated the subcutaneous emphysema was

probably due to the collapse of the trachea during the tube exchange.

G. Another code blue was called at 1:35 p.m. and O.H. expired at 1:40 p.m. The surgeon's report dictated on November 26, 2003, indicated O.H. sustained a cardiorespiratory arrest during the manipulation of her tracheostomy tube by the respiratory therapist. The death summary dictated by O.H.'s attending physician on February 6, 2004, indicated she developed respiratory failure while the tracheostomy tube was being replaced. She developed cardiac arrhythmia and passed away because of multiorgan failure secondary to respiratory failure.

H. In an interview on August 5, 2004, with the health facilities evaluator from the Department of Health Service, respondent confirmed there was no physician's order for him to change the trach. In respondent's declaration dated December 7, 2004, he stated that on November 25, 2003, at about 9:30 a.m. he changed O.H.'s trach tube from a 6 to an 8. The patient was placed back on the ventilator, the alarm sounded, and the patient's oxygen saturation fell. The patient was then taken off the ventilator and manually ventilated. When her oxygen saturation continued to fall, the emergency room physician was called. The emergency room physician replaced the trach tube back to a 6.

Negligent Acts

I. Respondent committed acts of negligence regarding the care and treatment of O.H. which included, but were not limited to, the following:

(1) Respondent changed the patient's tracheostomy tube from a size 6 to a size 8 without a physician's order.

(2) Respondent failed to follow the hospital's policy which stated a respiratory therapist could change a tracheostomy tube only upon a physician's order.

(3) Respondent ignored the specific order of the pulmonologist to have the surgeon change the trach tube.

(4) Respondent substituted his own clinical judgment for that of the physician, thereby failing to ensure the safety of the patient and placing her at risk.

(5) Respondent failed to place the trach tube back in the trachea correctly,

temporarily depriving the patient of oxygen which led to her becoming pulseless.

(6) As a result of respondent changing the trach tube, the patient's trachea collapsed and she suffered subcutaneous emphysema when the volume of gas went under her skin tissue instead of into her trachea. She then went into cardiac arrest, her condition became critical and she expired a few hours later..

SECOND CAUSE FOR DISCIPLINE

(Incompetence)

12. Respondent is subject to disciplinary action under section 3750, subdivision (o) of the Code, in that he was incompetent in his practice as a respiratory care practitioner. The facts and circumstances, set forth in Paragraph 11 of this Accusation, are incorporated herein by reference.

THIRD CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

13. Respondent is subject to disciplinary action under section 3755 of the Code, in that he engaged in unprofessional conduct in his practice as a respiratory care practitioner. The facts and circumstances, set forth in Paragraph 11 of this Accusation, are incorporated herein by reference.

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PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Respiratory Care Board issue a decision:

1. Revoking or suspending Respiratory Care Practitioner License Number 18493, issued to Joseph Ernest Carrillo;

2. Ordering Joseph Ernest Carrillo to pay the Respiratory Care Board the costs of the investigation and enforcement of this case, and if placed on probation, the costs of probation monitoring;

3. Taking such other and further action as deemed necessary and proper.

DATED: February 28, 2005

Original signed by Liane Zimmerman for:
STEPHANIE NUNEZ
Executive Officer
Respiratory Care Board of California
Department of Consumer Affairs
State of California
Complainant