NORTH CAROLINA RESPIRATORY CARE BOARD
1100 Navaho Drive, Suite 242
Raleigh, NC 27609
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VIA CERTIFIED MAIL, RETURN RECEIPT REQUESTED

November 13, 2014

Paul C. Parsons
3713 Laurel Bluff Circle
High Point, NC 27265

Re: Revocation of Your License as a Respiratory Care Practitioner

Dear Mr. Parsons:

A hearing was held by the North Carolina Respiratory Care Board on October 9, 2014, regarding the matters described in the Notice of Hearing that was sent on August 20, 2014 to the address of record that you have provided to the Board. You did not appear for the hearing, but as was stated in the Notice of Hearing, the Board proceeded in your absence. Based on its review of the testimony and exhibits introduced into evidence at the hearing, the Board determined to revoke your respiratory care practitioner license. This letter and the attached Final Board Decision serve as official notice of the Board's Findings of Fact, Conclusions of Law, and its Final Board Decision, and of your right to appeal this Final Board Decision.

Appeal Right – You have the right to appeal the Board's decision by filing a Notice of Appeal of the Board's decision in Superior Court, and you should seek legal advice about an appeal. ***Please note--The North Carolina Administrative Procedure Act states that these appeals must be filed in the Superior Court for the North Carolina county where you currently reside.*** The appeal must be filed within 30 days from your receipt of this letter and the attached Final Board Decision. The date of the signature on the signature card that the Board receives back will define the start of the 30-day period, and to compute the 30-day period, you should count the day after this letter is signed for by you or by anyone else at your address as the first of the 30 days. The deadline for the actual receipt of your appeal at the Superior Court is ***before 5 PM on the thirtieth day***, unless that day falls on a weekend or on a holiday recognized by North Carolina State Government. ***Please note--putting the appeal in the mail or sending it by some other means on the deadline is not sufficient. Any appeal must be actually received in the Superior Court for the appropriate county before the deadline.*** Also note that North Carolina does not have the same holidays as other states or the United States Government. If the thirtieth day falls on a weekend, or on a holiday that is recognized by the State of North Carolina, then your appeal must be received at the Superior Court no later than 5 PM on the next business day. If you do not file an appeal on time, or if you not file in the correct county, you will lose your right to appeal.

Should you have any questions regarding any aspect of this letter, please do not hesitate to contact me.

Sincerely,

William L. Croft, PhD, RRT, RCP
Executive Director

BEFORE THE NORTH CAROLINA RESPIRATORY CARE BOARD

IN THE MATTER OF THE LICENSE	)	
OF PAUL C. PARSONS TO	)	**FINAL BOARD DECISION**
PRACTICE RESPIRATORY CARE	)	**REVOKING LICENSE**
LICENSE NO. 2521	)	

This hearing came before the North Carolina Respiratory Care Board on October 9, 2014, as part of the Board's regularly scheduled meeting on that date.

PROCEDURAL HISTORY OF THIS CASE

The subject of this hearing is the Board's decision to revoke License Number 2521, held by the Licensee, Mr. Paul C. Parsons. This matter came to the attention of the Board when it was informed in April 2013 that the Licensee had been terminated from his position at Novant Hospital due to performance issues.

APPEARANCES & WITNESSES TESTIFYING AT THE HEARING

At the hearing, neither the Licensee, Paul C. Parsons, nor any other person appeared on his behalf. The case for the Board was presented by its counsel, William R. Shenton.

BOARD EVIDENCE

As witnesses for the Board, Mr. Shenton called: Dr. William L. Croft, Executive Director of the Board; and the following Respiratory Care Practitioners from the Respiratory Department at Forsyth Medical Center: Mr. Scott Best, RCP; Mr. Nathan Bush, RCP; Mr. Dan Jonas, RCP; Ms. Maria Perkins, RCP; and Mr. Ken Young, RCP.

The following exhibits were introduced at the hearing by the Board:

Board Exhibit # 1 – A copy of the Notice of Hearing and attachments, mailed to the Licensee's address of record on August 20, 2014, along with the certified mail receipt and signature card.

Board Exhibit # 2 – A copy of the first page of the Licensee's initial application for licensure.

Board Exhibit # 3 – A copy of a print screen from the Board's disciplinary database with the Licensee's data.

Board Exhibit # 4 – A copy of a subpoena issued by the Board to Ms. Paula Mendenhall, RCP at Forsyth Medical Center.

Board Exhibit # 5 - A copy of various records from the Licensee's personnel file at Forsyth Medical Center

LICENSEE EVIDENCE

Neither the Licensee nor a representative of the Licensee appeared, and no evidence was offered on his behalf.

FINDINGS OF FACT

1. The Board has issued License Number 2521 for the Practice of Respiratory Care to the Licensee.

2. On October 24, 2013, the Licensee entered a Consent Order with the Board as a result of his conduct while employed at Cone Health Hospital in Greensboro, where it was reported that the Licensee had failed to provide acceptable care to patients, had failed to follow physician orders, and had failed to enter proper documentation in patient records. In this Consent Order, the Licensee agreed that if the allegations against him were proven, that they would constitute violations of N.C. Gen. Stat. § 90-659 (a)(1)(d) and N.C. Gen. Stat. § 90-659 (a)(4) and violations of 21 NCAC 61 .0307 (10) and (15). A true copy of the Consent Order is included within Board Exhibit 1, the Notice of Hearing.

3. In the Consent Order, the Licensee also agreed to the issuance of a Board Reprimand and assessment of a civil penalty and costs; and agreed to appear before the Board's Investigation and Informal Settlement Committee and present an essay addressing the importance of following physician orders, communication with other health care providers, and proper documentation of all respiratory care provided.

4. The Licensee submitted the required essay, which included the following statements:

   - [A physician's order] "communicates and lays out a plan of care for the patient and all personal (sic) involved with the care of that patient knows what and where the plan of care is and the progress the patient is making."
   - "Charting when and sometimes how treatments and interventions were done is another form of communication. It tells the healthcare team how long it has been since an intervention, medication administration or procedure was done."
   - "Charting the intervention and how they were done ensure (sic) that it was done with consistency and with all safety precautions done and considered for that patient."
   - "End of shift or hand off report is important because it communicates the interventions that was (sic) ordered for a certain patient and how that patient reacted to the intervention."

   A true copy of this essay is also contained within Board Exhibit 1.

5. After the conclusion of his employment at Cone Health Hospital, the Licensee was employed by Forsyth Medical Center in Winston Salem as a respiratory care practitioner.

6. The documentation policy at Forsyth requires, among other things that ventilator checks be performed every four hours for patients on ventilators, that the documentation must include numbers, not just check marks; and also requires that the following items must be documented.

   - Ventilator checks must contain ventilator numbers;
   - The first initial and last name of the therapist from whom report is received at the beginning of a shift;
   - The inclination of the head of the patients' bed ("HOB");
   - Any change in ventilator settings must be accompanied by a note explaining why the change was made and the outcome/tolerance of the change;
   - A shift summary must be completed at the end of each shift on all ventilated patients.

7. Respiratory Care Practitioners who fail to follow the established documentation policies of the organization where they practice put patient care at risk because they are failing to provide commonly accepted documentation on which other practitioners are accustomed to rely on to provide safe and effective patient care.

8. The Licensee received training on the policies and procedures at Forsyth that pertain to respiratory care; and after completing training, the Licensee was assigned to the night shift, working from 7 PM in the evening to 7 AM the following morning.

9. The Licensee was terminated from employment at Forsyth Medical Center on April 9, 2014, after several prior counseling sessions and warnings about his job performance.

10. Prior to termination, the Licensee had received a written warning on February 27, 2014 and was counseled about failing to properly document ABG samples on several patients; and the Licensee admitted that he was responsible for some inadequately documented ABG specimens.

11. During the night shift on December 22-23, 2013, the Licensee documented on two of the three ventilator checks for a patient receiving care in Forsyth Medical Center; and there was no assessment of the patient documented between Midnight and the end of the shift.

12. When counseled about this lapse, the Licensee did not deny failing to perform the required ventilator check, and did not exhibit any insight about how serious a lapse this was. His response was that the Respiratory Department had more important things to be focused on than catching improper or incomplete documentation.

13. On the night shift from November 21-22, 2013, the Licensee failed to follow a written physician order to change a patient from a tracheotomy collar to a ventilator at night. This order was plainly visible on the order sheet that the Licensee reviewed and signed at the start of his shift.

14. On the night shift on October 31-November 1, 2013, the Licensee failed to perform, or to properly document, required ventilator checks on several patients in a 10-bed unit at Forsyth Medical Center, which was his only area of responsibility during that shift. There were also a number of other lapses in his documentation:

    - The Licensee failed to document the percentage inclination of the head of patients' bed;
    - The Licensee failed to document from whom the Licensee received report at the beginning of his shift;
    - The Licensee failed to document the basis for a ventilator rate change which was noted; and
    - The Licensee failed to do a shift summary in the notes section of the medical record;

15. Respiratory Care Practitioners, at Forsyth Medical Center, including the Supervisors have cell phones and pagers which can be used to communicate and they are trained to reach out to other staff members for assistance with assigned tasks when necessary.

16. On the night shift on October 4-5, 2013, when the Licensee's only responsibility was a 10-bed ICU unit, the Licensee failed to complete or document any ventilator check for one patient between 8:15 PM and 4:45 AM.

17. When he was counseled about this and asked why he did not conduct the ventilator check the Licensee said that he was busy, but when asked why he did not call someone else for assistance, his only response was "I just didn't."

18. The testimony of other practitioners who worked with the Licensee, and the records which the Board subpoenaed from Forsyth Medical Center that were admitted as Board Exhibit 5, show that during his employment at Forsyth Medical Center, the Licensee repeatedly failed to follow physician orders, failed to complete proper documentation relating to respiratory care, and failed to perform critical aspects of respiratory care for ventilator patients, who depend on their ventilators for respiration.

19. The evidence admitted at the hearing shows that in spite of the Consent Order that he entered with the Board and the statements that he made in the essay he submitted, the Licensee continues to exhibit the same careless behavior towards documentation and following physician orders that resulted in his termination from employment at Cone Health and the prior Consent Order with the Board that he entered on October 24, 2013.

20. By his actions and statements while employed at Forsyth Medical Center and his failure to attend the Hearing, the Licensee has shown a lack of insight and refusal to accept responsibility for unprofessional conduct.

CONCLUSIONS OF LAW

Based upon the foregoing Finding of Fact, the Board enters the following Conclusions of Law:

1. While employed at Forsyth Medical Center as a Respiratory Care Practitioner, the Licensee engaged in unprofessional conduct related to the delivery of respiratory care for patients under his care, and in acts that are hazardous to the health, safety and welfare of patients under his care, in violation of N.C. Gen. Stat. § 90-659 (a)(1)(d) and in violation of 21 NCAC 61 .0307 (10).

2. While employed at Forsyth Medical Center as a Respiratory Care Practitioner, the Licensee failed to create and maintain respiratory care records documenting the assessment, treatment and progress of the patients under his care, in violation of 21 NCAC 61 .0307 (15).

3. While employed at Forsyth Medical Center as a Respiratory Care Practitioner, the Licensee failed to comply with the terms of the Consent Order in violation of 21 N.C. Admin. Code § 61 .0307(3).

FINAL DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the Board determined that the license of Paul C. Parsons to practice respiratory care in North Carolina shall be permanently revoked effective October 9, 2014.

IT IS SO ORDERED.

Effective by Order of the Board on the 9th day of October 2014.

William L. Croft, PhD, RRT, RCP
Executive Director
North Carolina Respiratory Care Board