EFFECTIVE AS A FINAL ORDER

DATE: 4/7/2022

FILED
APR 07 2022
KS State Board of Healing Arts

BEFORE THE BOARD OF HEALING ARTS OF THE STATE OF KANSAS

In the Matter of	)	
	)	**KSBHA Docket No. 22-HA**00033
HUAN N. FRITTS, R.T.	)	
Kansas License No. 16-04951	)	

SUMMARY ORDER

NOW ON THIS 7th day of April, 2022, this matter comes before Susan Gile, Acting Executive Director, Kansas State Board of Healing Arts ("Board"), in summary proceedings under K.S.A. 77-537.

Under K.S.A. 77-537 and K.S.A. 77-542, this Summary Order shall become effective as a Final Order, without further notice, if no written request for a hearing is made within 15 days of service. Upon review of the agency record and being duly advised in the premises, the following findings of fact, conclusions of law, and order are made for and on behalf of the Board:

Findings of Fact

1. Huan N. Fritts, R.T. ("Licensee") is or has been entitled to engage in the practice of respiratory therapy in Kansas, having been issued License No. 16-04951 on September 8, 2017, and having last renewed such license on approximately March 8, 2022.

2. Licensee's license to practice respiratory therapy in Kansas is currently Active.

3. Licensee's last known mailing address to the Board is: CONFIDENTIAL

CONFIDENTIAL .

4. The relevant facts upon which this Order is based are as follows:

a. On or about CONFIDENTIAL, a 51-year-old male patient ("Patient 1") was admitted to CONFIDENTIAL Hospital for oral surgery to treat an abscess that was narrowing his airway. Patient 1 was intubated with an endotracheal tube ("ET tube") and admitted to the Critical Care Unit following the surgery.

b. At approximately 4:40 a.m. on CONFIDENTIAL, Patient 1 partially extubated himself. Licensee was called to evaluate the ET tube placement and a chest x-ray was ordered to confirm ET tube placement.

c. Licensee documented that the ET tube was placed at 18 cm at the lip and should have been at 23 cm. Licensee advanced the ET tube to 23 cm and re-secured it in place. Licensee reports that both she and a nurse verified the ET tube placement by listening to Patient 1's lungs and hearing bilateral air movement; however it does not appear that Licensee listened to Patient 1's abdomen to verify ET tube placement.

d. Radiology arrived soon thereafter to perform a chest x-ray. Records indicate the x-ray was completed at approximately 5:03 a.m. Both Licensee and the attending physician report that on an initial evaluation the image on the portable x-ray screen lacked sufficient clarity to verify incorrect ET tube placement. However, upon later review the physician confirmed the x-ray image clearly showed the ET tube was not in Patient 1's trachea.

e. Licensee reports that, while looking at the x-ray image, she saw Patient 1's blood pressure and heartrate monitors alerting and returned to Patient 1's room. A nurse informed Licensee she could not hear air movement. Licensee reports listening to

Patient 1's lungs again and hearing an unusual noise, which the nurse told her was likely coming from the IV pump.

f. Licensee reports observing Patient 1's face at this time and noticing he appeared cyanotic. Licensee and the nurse agreed to call a code blue.

g. CONFIDENTIAL reports receiving a call from Licensee to come assist with Patient 1 and arriving to Patient 1's room soon after the code blue was called, approximately 5:10 a.m. CONFIDENTIAL reports observing Licensee bagging Patient 1 through the ET tube as he arrived. CONFIDENTIAL documented that the chest x-ray, stomach distention, and lack of air moving into Patient 1's lungs indicated the ET tube was placed in the esophagus.

h. The ET tube was eventually pulled at approximate 5:15 a.m., and a bag valve mask was used on Patient 1 until anesthesia arrived.

i. At approximately 5:18 a.m., anesthesia arrived and successfully re-intubated Patient 1.

j. For approximately 30 minutes thereafter, a combination of CPR, medication, and shocks were administered to Patient 1.

k. At approximately 5:52 a.m., Patient 1 was pronounced dead. The immediate cause of death listed for Patient 1 was acute hypoxic respiratory failure, resulting from esophageal intubation and tracheal deviation.

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did, however, provide its written policy and procedure for Endotracheal Intubation. This policy states that ET tube placement should be immediately assessed utilizing a CO2 detector or an ET tube detector, manually ventilating the patient while listening for bilateral equal breath sounds and observing for good chest excursion, checking for "gurgling" sounds in the stomach during positive pressure breaths which indicates esophageal intubation, and ET tube placement should be confirmed with an x-ray.

Applicable Law

5. Under K.S.A. 65-5510, a licensee's license may be revoked, suspended or limited, or the licensee may be publicly or privately censured "where the licensee . . . has been guilty of unprofessional conduct which has endangered or is likely to endanger the health, welfare or safety of the public."

6. Under K.A.R. 100-55-5, "unprofessional conduct" means:

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(k) being professionally incompetent, as defined in K.S.A. 65-2837 and amendments thereto.

7. Under K.S.A. 65-2837(a), "professional incompetency" means:

(1) One or more instances involving failure to adhere to the applicable standard of care to a degree that constitutes gross negligence, as determined by the board;

(2) Repeated instances involving failure to adhere to the applicable standard of care to a degree that constitutes ordinary negligence, as determined by the board; or

(3) A pattern of practice or other behavior that demonstrates a manifest incapacity or incompetence to practice the healing arts.

8. Under Kansas law, "gross negligence" is generally not considered a greater degree of negligence but a different kind of conduct, synonymous with "wanton conduct." *See Elliot v. Peters,* 163 Kan. 631, 635-36 (1947); *Stout v. Gallemore*, 138 Kan. 385 (1933). While Kansas law is unclear regarding the definition of "gross negligence" in the context of K.S.A. 65-2837(a)(1), there is no precedent in Kansas that suggests any standard other than "wanton conduct" would be more appropriate to apply. *See Fieser v. Kansas State Bd. of Healing Arts*, 281 Kan. 268, 273-74 (2006). "Wanton conduct" is "doing something knowing that it is dangerous, and either being completely indifferent to the danger or recklessly disregarding the danger." PIK Civ. 4th 103.03.

Conclusions of Law

9. The Board has jurisdiction over Licensee as well as the subject matter of this proceeding, and such proceeding is held in the public interest.

10. The Board finds that Licensee violated K.S.A. 65-5510 by engaging in unprofessional conduct, as defined under K.A.R. 100-55-5(i), in that Licensee was CONFIDENTIAL CONFIDENTIAL for acts or conduct that would constitute grounds for denial, refusal to renew, suspension, or revocation of a license under K.S.A.

65-5510 and amendments thereto; specifically, CONFIDENTIAL for her failure to adhere to the applicable standard of care in the treatment of Patient 1.

11. The Board finds that Licensee violated K.S.A. 65-5510 by engaging in unprofessional conduct, as defined under K.A.R. 100-55-5(k), in that Licensee was professionally incompetent in her care of Patient 1 by failing to adhere to the applicable standard of care to a degree that violated the mandates of K.S.A. 65-2837(a)(1), (2), and/or (3), to wit: after advancing Patient 1's ET tube, Licensee failed to take the steps necessary to verify the ET tube was properly placed in Patient 1's trachea, despite Licensee's knowledge of the significant dangers associated with improper ET tube placement.

12. Based on the facts and circumstances set forth herein, the use of summary proceedings in this matter is appropriate, in accordance with the provisions set forth in K.S.A. 77-537(a), in that the use of summary proceedings does not violate any provision of law and the protection of the public interest does not require the Board to give notice and opportunity to participate to non-parties.

IT IS HEREBY ORDERED that Licensee is **PUBLICLY CENSURED** for violations of the Kansas Respiratory Therapy Practice Act.

IT IS FURTHER HEREBY ORDERED that Licensee shall attend and successfully complete a Board approved **EDUCATIONAL COURSE** on the subject of Endotracheal Intubation for violations of the Kansas Respiratory Therapy Practice Act.

13. Licensee must notify the Board's Compliance Coordinator prior to registering for such course to determine whether such course satisfies the requirements of Board with respect to this Summary Order.

14. Licensee shall attend and successfully complete the Educational Course on or before October 1, 2022.

15. Licensee shall provide proof of successful completion of the Educational Course to the Board within thirty (30) days of successfully completing such course.

16. All costs and expenses associated with the Educational Course shall be at Licensee's own expense, including, without limitation, any registration fees, the cost of travelling to and from such course, and the cost of accommodations while attending such course.

17. All documentation required under this Summary Order shall be mailed to the Board certified and addressed to:

Compliance Coordinator
Kansas State Board of Healing Arts
800 SW Jackson, Lower Level – Suite A
Topeka, Kansas 66612
KSBHA_ComplianceCoordinator@ks.gov

PLEASE TAKE NOTICE that upon becoming effective as a Final Order, this document shall be deemed a public record and be reported to any reporting entities authorized to receive such disclosure.

Dated this 7th **day of** April, **2022.**

KANSAS STATE BOARD OF HEALING ARTS

Susan Gile

Susan Gile
Acting Executive Director

FINAL ORDER NOTICE OF RIGHTS

PLEASE TAKE NOTICE that this is a Final Order. A Final Order is effective upon service. A party to an agency proceeding may seek judicial review of a Final Order by filing a petition in the District Court as authorized by K.S.A. 77-601, *et seq*. Reconsideration of a Final Order is not a prerequisite to judicial review. A petition for judicial review is not timely unless filed within 30 days following service of the Final Order. A copy of any petition for judicial review must be served upon Susan Gile, Acting Executive Director, Kansas Board of Healing Arts, 800 SW Jackson, Lower Level-Suite A, Topeka, KS 66612.

CERTIFICATE OF SERVICE

I, the undersigned, hereby certify that I served a true and correct copy of the above and foregoing **FINAL ORDER** by depositing the same in the United States Mail, postage prepaid, on this 27th day of April 2022, addressed and emailed to:

Huan N. Fritts, R.T.
CONFIDENTIAL

Licensee

And a copy was hand-delivered to:

Matthew Gaus, Associate Litigation Counsel
Kansas State Board of Healing Arts
800 SW Jackson, Lower Level-Suite A
Topeka, Kansas 66612
matthew.gaus@ks.gov

Compliance Coordinator
Kansas State Board of Healing Arts
800 SW Jackson, Lower Level-Suite A
Topeka, Kansas 66612

Office of the General Counsel
Kansas State Board of Healing Arts
800 SW Jackson, Lower Level-Suite A
Topeka, Kansas 66612

And the original was filed with the office of the Executive Director.

Jennifer Cook
Staff Signature