Admin Closure
11/19/10

Administrative Closure

Out-of-Airway Management
Central Arkansas Veterans Healthcare System
North Little Rock, Arkansas (10N16)
MCI Number: 2010-03221-HI-0345

Healthcare Inspection – Out-of-Airway Management, Central Arkansas Veterans Healthcare System, North Little Rock, Arkansas (10N16)

Purpose

The VA Office of Inspector General (OIG), Office of Healthcare Inspections reviewed allegations that the Central Arkansas Veterans Healthcare System, North Little Rock (facility) implemented a policy regarding out-of-operating room emergency airway management that places patients at risk for potential harm and without informing them they are being used for training. The complainant specifically alleged that the facility's policy requires physician staff to demonstrate competency in airway management by completing endotracheal intubation[1] on a live patient in the operating room without their knowledge of the training, thus putting patients at harm.

Background

The facility serves as a teaching facility for more than 1,200 students and residents enrolled in approximately 90 educational affiliates. The principle affiliate is the University of Arkansas for Medical Sciences.

(b)(6) contacted the OIG Hotline Division with allegations regarding the facility's policy requiring clinical physician staff to complete endotracheal intubation competencies in the operating room and felt this training placed patients at risk for potential harm. The complainant stated patients are not aware that they are being used as "practice patients" or are they given the opportunity to choose not to continue with the procedure.

When interviewed, the complainant stated (b)(6) was not required to demonstrate competencies nor was (b) required to have advanced cardiac life support (ACLS) certification. (b) stated that the facility's policy required only those physicians who are required to be on call or act as house officers after hours to be ACLS certified. ACLS guidelines provide training for airway management, but not competency. Only ACLS certified physicians are required to check off competencies for endotracheal airway

[1] Insertion of a flexible plastic tube in the mouth and then down into the trachea (airway) to ventilate the lungs.

management on live patients in the operating room. When asked if (b)(6) had raised (b)(6) concerns with anyone at the facility (b)(6) stated (b)(6) had not because other concerns previously made were not well received.

Scope and Methodology

A review of current VHA directives and the facility's policy provided the following:

Prior to operative procedures, patients sign VA Form 10-0431a, *Consent for Clinical Treatment/Procedure*, which states VA hospitals are teaching facilities and trainees may participate in or observe this treatment/procedure.

VHA Directive 2005-031, *Out-of-Operating Room Airway Management*, dated August 8, 2005, states clinicians who will be performing out-of-operating room airway management must demonstrate endotracheal intubation procedural skills on actual patients to the Chief of Anesthesia or designee, to establish competency.

VHA recognizes that in order to ensure successful competency, procedural skills are demonstrated with an actual patient, not a mannequin. The Chief of Anesthesia is responsible for developing the specific subject-matter content for technical and procedural skills. The facility's policy is consistent with the VHA Directive; therefore, we made no recommendations and consider the issue closed.

Conclusions

The facility actions and policy follow VHA directives and policies. (b)(6) was not being asked to perform endotracheal competency. Patients are informed prior to operative procedures that training can occur. Staff are appropriately supervised during training with live patients. It is recommended this case be administratively closed.

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Prepared by: _____

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Linda G. DeLong, 54RD Date