Administrative Closure
Alleged Quality of Care Concerns
Dayton VA Medical Center, Dayton, Ohio
Anesthesia Section
(2011-01082-HI-0054)

I. Purpose and Objectives

The VA Office of Inspector General (OIG) Office of Healthcare Inspections received a confidential complaint alleging that the Anesthesia Section Chief demonstrated "flawed medical judgment that directly jeopardized the safety of patients and may have resulted in the intraoperative death of a patient…" The complainant specifically alleged that:

- The Anesthesia Section Chief employed providers who had questionable credentials and full-time jobs outside of the facility.
- An under qualified anesthesiologist was assigned two cases that resulted in one intraoperative patient death and one near death.
- The Anesthesia Section Chief exercised poor medical judgment when he agreed to administer anesthetic to a patient with a previous intracranial bleed without a further preoperative evaluation.

The purpose of the inspection was to determine if the allegations had merit.

II. Background

The facility provides a full continuum of care encompassing a broad range of inpatient and outpatient care services including acute medicine, surgery, and mental health. The facility has 500 operating beds and is affiliated with Boonshoft School of Medicine. In fiscal year 2010, the facility's medical care budget was $281 million. It is one of five facilities that comprise the Veterans Integrated Service Network (VISN) 10.

The facility's Anesthesia Section is organizationally aligned under Surgical Services. The facility's operative suite has seven rooms, and historically the optimal anesthesia staffing has been 11 full-time providers. Despite hiring efforts going back several years, in 2009, the facility's anesthesia staff was as low as five providers. In July 2009, the facility contracted with an outside group of anesthesia providers to address the staff shortage. However, in 2010, the facility was able to hire additional providers, including a new Anesthesia Section Chief, to meet its need for anesthesia services entirely with VA staff. Facility managers allowed the contract with the outside group to expire in April 2010.

III. Scope and Methodology

We conducted a site visit February 14–17, 2011. We interviewed the complainant, facility leaders, staff physicians, operating room registered nurses, and other clinical and administrative staff in the Anesthesia Section and Surgical Services. We reviewed three patient medical records and an autopsy report for cases identified by the complainant as resulting in a death, near death, and a cancelled surgical case. We also reviewed credentialing and privileging data for anesthesiologists and Certified Registered Nurse Anesthetists (CRNAs).

In addition, we conducted reviews of staffing and case workload schedules, relevant Veterans Health Administration and facility policies and procedures, moderate sedation tracking logs, surgical mortality data, and anesthesia incident reports from July 2009 through January 2011.

We conducted the inspection in accordance with *Quality Standards for Inspection and Evaluation* published by the Council of Inspectors General on Integrity and Efficiency.

IV. Inspection Results

We did not substantiate the allegation that the Anesthesia Section Chief exercised poor medical judgment or jeopardized patient safety. We identified no concerns with the Anesthesia Section Chief's leadership during our interviews, and the interviewees indicated that they were pleased with the quality of anesthesia services. They also reported that the Anesthesia Section Chief had improved access to anesthesia services. Our review found that anesthesia providers were properly credentialed and privileged to perform their assigned duties within the scope of their licenses. We found no evidence of performance issues or restricted or limited privileges for any of the anesthesia providers. The part-time anesthesiologist hired to provide 40-hour weekend coverage remained onsite when providing coverage and had adequate support from other anesthesiologists and CRNAs if additional coverage was needed.

We confirmed that an intraoperative patient death occurred; however, we did not find any deviation from the standard of care delivered to the patient or in anesthesia documentation. We found no evidence of a near death case as identified by the complainant involving the same anesthesiologist.

Furthermore, we did not substantiate that the Anesthesia Section Chief exercised poor medical judgment when he agreed to administer anesthetic to a patient with a previous intracranial bleed without further preoperative evaluation. The Acting Chief of Surgery cancelled the procedure due to differing clinical opinions between the contract CRNA and anesthesiologist and the vascular surgeon and the staff anesthesiologists.

V. Conclusion

Based on the inspection results, we made no recommendations and plan no further actions. We are closing this case.

for JOHN D. DAIGH, JR., M.D.
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Healthcare Inspections