

Reducing Risks Associated With Failure to Rescue

The concept of failure to rescue (FTR) generally refers to a failure to recognize and respond to a patient's complications from a medical procedure or disease process. The term often is used to describe situations in which postoperative patients develop complications and subsequently die due to lack of, or delayed, intervention.

FTR is a complex and significant patient safety and quality issue in healthcare.¹ Research has shown that FTR is more closely associated with hospital characteristics than with patient illness severity² — and these characteristics can occur at a macro or micro level, making them challenging to address.

A study in *Health Affairs* noted that some of the macrosystem issues associated with FTR are difficult to change due to financial and logistical constraints; however, interventions at the microsystem level — for example, in relation to teamwork and communication — may help providers more quickly recognize and respond to patients who are deteriorating.³

The following risk tips are based on research and guidance related to FTR.⁴ These tips can help healthcare organizations and providers identify areas of focus for improving the identification and management of patient complications, responding to crises, increasing resiliency, and preventing poor outcomes.

1

Use the [five core principles of high-reliability organizations](#) to support an environment and workforce that is collaborative and resilient, and to help drive quality improvement initiatives.

2

Build redundant systems to address potential failures that might occur. For example, make sure on-call physicians have a back-up contact in the event that staff cannot reach them.

3

Review your organization's chain-of-command protocol to ensure that staff members can quickly escalate concerns if they have difficulty reaching a provider or if a conflict occurs. All bedside staff should be trained regarding their authority and responsibility to use these protocols when appropriate.

4

Maintain accurate, up-to-date, on-call lists for all appropriate medical specialties. On-call lists are a requirement for hospitals under the Emergency Medical Treatment and Labor Act, and they are vital from a patient safety and liability standpoint.

5

Ensure adequate and reliable patient monitoring is in place to help detect changes and abnormalities in physiological measures, such as heart rate, blood pressure, respiratory rate, oxygen saturation, and urine output. Consider whether implementation of continuous vital sign monitoring could help promote the early detection and treatment of postoperative complications.

6

Make sure that staff members who are responsible for patient assessment and monitoring are doing so at the appropriate intervals, adequately documenting patient status in the electronic health record, and ensuring timely documentation and communication of critical test results. Routinely audit documentation to ensure adherence to policies.

7

Develop and implement a multidisciplinary rapid response team that can provide early intervention for patients who experience high-risk complications. The team may include nurses, physicians, and other specialists based on organizational needs and requirements.

8

Develop criteria that will help guide staff in knowing when to activate the rapid response team (e.g., abnormal physiological measures, uncontrolled pain, and behavioral or mental changes). Make sure patients/families also are aware of the rapid response team and how/when they should activate it.

9

Work with healthcare providers to recognize trends in patient recovery and deterioration. Consider developing postoperative milestones to help providers recognize when patients are deviating from expected outcomes, and make sure they are aware that even subtle changes that fall within normal values might indicate potential complications.

10

Determine specific guidelines for [handoffs](#) in relation to patients who are at high-risk of complications. Handoff communication might necessitate a discussion of baseline physiological measures, current physiological measures, recent lab values, and subtle changes over the course of care.

11

Promote an environment that supports teams with cognitive diversity and eliminates traditional clinical hierarchies. Doing so will encourage a culture of [psychological safety](#) in which providers and staff members feel comfortable speaking up about potential patient safety issues and concerns.

12

Provide comprehensive training to providers that addresses the key factors that contribute to FTR, such as poor teamwork and communication. Use programs and tools such as [TeamSTEPPS®](#), [call-out](#), [check-back](#), [I-PASS](#), [I PASS THE BATON](#), and [SBAR](#) to help breakdown communication barriers and foster collaboration.

**13**

Run simulation drills to help providers prepare for various scenarios that might result in FTR. Following the drills, having meaningful debrief conversations with participants about effective interventions, communication, and teamwork.

FTR usually is associated with care occurring in hospitals; however, these situations also can occur in ambulatory surgery centers (ASCs), as evidenced by this [MedPro case study](#). To mitigate risks associated with FTR, ASCs should ensure that (a) healthcare providers go through a thorough credentialing process, (b) healthcare providers have adequate training to manage the types of emergencies that might occur in the facility, (c) appropriate emergency supplies and equipment are available and staff members know how to access and use them, and (d) well-defined policies and procedures are in place for handling medical emergencies and transferring patient care.

In some instances, FTR might occur after a patient leaves the hospital or ambulatory surgery center, as this [MedPro case study](#) discusses. Thus, patients should receive thorough discharge instructions that clearly specify potential warning signs and indicate when they should contact the healthcare facility or contact emergency medical services. Further, facilities should have processes to ensure that patients' concerns are promptly managed and triaged.

Resources

For more information about issues associated with FTR and ways to address it, see MedPro's [Risk Resources: Failure to Rescue](#).

Endnotes

- ¹ Hall, K. K., Lim, A., & Gale, B. (2020). Failure to rescue. In *Making healthcare safer III: A critical analysis of existing and emerging patient safety practices*. Rockville, MD: Agency for Healthcare Research and Quality. Retrieved from <https://www.ncbi.nlm.nih.gov/books/NBK555513/>
- ² Silber, J. H., Williams, S. V., Krakauer, H., & Schwartz, J. S. (1992). Hospital and patient characteristics associated with death after surgery. A study of adverse occurrence and failure to rescue. *Medical Care*, 30(7), 615–629. <https://doi.org/10.1097/00005650-199207000-00004>
- ³ Smith, M. E., Wells, E. E., Friese, C. R., Krein, S. L., & Ghaferi, A. A. (2018, November). Interpersonal and organizational dynamics are key drivers of failure to rescue. *Health Affairs*, 37(11), 1,870-1,876. <https://doi.org/10.1377/hlthaff.2018.0704>
- ⁴ Agency for Healthcare Research and Quality. (2019, September 7). *Patient safety primer: Failure to rescue*. Retrieved from <https://psnet.ahrq.gov/primer/failure-rescue>; Smith, et al., Interpersonal and organizational dynamics are key drivers of failure to rescue; Hall, et al., Failure to rescue; Verrillo, S. C., & Winters, B. D. (2018). Review: Continuous monitoring to detect failure to rescue in adult postoperative inpatients. *Biomedical Instrumentation & Technology*, 52(4), 281–287. <https://doi.org/10.2345/0899-8205-52.4.281>

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