Failure to Rescue

Center 9

Failure to Rescue
Denominator: All cases having serious complication, dead or alive.
Numerator: All cases with mortality, preceded by complication Severity II or III.

Grade II Complications

- Decubitus Ulcer
- DVT: Lower Extremity
- DVT: Upper Extremity
- Enterocutaneous Fistula
- Extremity Compartment Syndrome
- Pneumonia
- PE
- Unplanned Return to OR
- Unplanned Admit to ICU

Grade III Complications

- Acute Lung Injury/ARDS
- Acute Kidney Injury
- Cardiac Arrest with CPR
- Mortality
- Myocardial Infarction
- Severe Sepsis
- Stroke/CVA
- Renal Insufficiency
- Unplanned intubation
- C. Difficile Colitis

Failure to Rescue

Complications Drill-Down - Failure to Rescue

50%
40%
30%
20%
10%
0%

LEGEND ■ Other Hospitals - All ⁞ 95% Confidence Interval

Center 9

- Level II Adult Trauma Center
- Service area is 9 counties in MI
- Acute Care Surgery/Trauma Service
  - 5 Attending's with 2 prn taking call
  - Residents in conjunction with WMED
  - 1 Advanced Practice Provider M-F days.

Demographics

- 12 patients from Nov 1, 2015-Jan 31, 2018
- 10 over the age of 65
- 7/12 Palliative Care/Withdrawal of Support
- Ground Level Fall-4
- MVC-6
- Bike vs Car-1
- Assault-1

Drilldown

- This is a very broad data definition
- 3 Categories of patients:
  – True “Failure to Rescue”…critical systems or personnel failures (Cat. 1)
  – General categories of decline possibly indicating a blind spot in your system (Cat 2)
  – Clear palliative or “end of life” care without the ability to rescue, despite the premorbid identification of a severe complication (Cat 3)

Drilldown II

- Of those 12 patients,

1 Cat 1

5 Cat 2

6 Cat 3

Category 1 patient

- Elderly woman t-boned on drivers side brought hypotensive to ED with pelvic fracture, transient responder, diagnosed rapidly, taken to IR.
- Both trauma staff surgeon and ED resuscitative nurse left IR suite. IR nurse removed binder in haste as patient was declining; lost pulses, died.

Category 2

- Elderly anticoagulated pt with multiple comorbidities admitted to ICU with small subdural, reversed with 2 U FFP and Vit K, transferred stable to floor, PEA arrest on floor HD day 3.

Category 3

- Severely demented elderly pt GLF at AFC with small intraventricular hemorrhage. ICU, then floor. Severe aspiration/dysphagia, pneumonia diagnosed HD 2, declined on floor, returned to unit. Family requested comfort care only after discussion/clarification of goals of care with attending staff.

Why are we at this Status?

- We have a very low major complication rate within the collaborative, and mortality rate is on the high end.
- Nature of the cases and the philosophy with which our team handles them as noted previously

What we do well

- Well developed Palliative Care Program
- Acute Care Surgery Team comfortable initiating a conversation about end of life care
- Start conversations early with patients and family about long-term prognosis

Opportunities Identified

- Clarified the process of who follows with patients to ancillary departments for procedures.
- Clarified roles of nursing and physician staff in ancillary departments.
- I personally, and our attending staff learned some lessons about team management and situational awareness

How do we Sustain the Change

Review all charts that require patient going to ancillary departments.

- TPM attends trauma activations.

Moving Forward

- Continue monitoring of ED process for Tier 1 (Full activation) patients
- Continue to use this tool to identify my Category 2 patients to identify any patterns of failure not identified through our routine PI process.
- Surgeons and program staff also need to be paying attention to patterns, e.g.: hips.