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Reconceptualising failure to rescue in midwifery: A concept analysis

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ABSTRACT

Aim: to reconceptualise the concept of failure to rescue, distinguishing it from its current scientific usage as a surveillance strategy to recognise physiologic decline.

Background: failure to rescue has been consistently defined as a failure to save a patient's life after development of complications. The term, however, carries a richer connotation when viewed within a midwifery context. Midwives have historically believed themselves to be the vanguards of normal, physiologic processes, including birth. This philosophy mandates careful consideration of what it means to promote normal birth and the consequences of failure to rescue women from processes which challenge that outcome.

Data sources: the Medline, CINAHL, PsycINFO, PubMed, Web of Science and Google Scholar databases were searched from the period of 1992–2014 using the key terms of concept analysis, failure-to-rescue, childbirth, midwifery outcomes, obstetrical outcomes, suboptimal care, and patient outcomes. English language reports were used exclusively. The search yielded 45 articles which were reviewed in this paper.

Review method: a critical analysis of the published literature was undertaken as a means of determining the adequacy of the concept for midwifery practice and to detail how it relates to other concepts important in development of a conceptual framework promoting normal birth processes.

Findings: failure to rescue within the context of the midwifery model of care requires robust attention to a midwifery managed setting and surveillance based on a caring presence, patient protection, and midwifery partnership with patient.

Conclusion: clarifying the definition of failure to rescue in childbirth and defining its attributes can help inform midwifery providers throughout the world of the ethical importance of considering failure to rescue in clinical practice. Relevance to midwifery care mandates use of failure to rescue as both a process and outcome measure.

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Introduction

Failure to rescue is a concept that has gained considerable attention in the patient safety literature over the past 20 years. The concept has one overriding definition within health care and that is 'to save a patient's life after the development of complication' (Schmid et al., 2007). In simplest terms, failure to rescue is the period 'before Code Blue' where institutional and individual errors contribute to patient deaths (Aleccia, 2008).

Although an important concept in mapping complications experienced by hospitalised patients and influenced by many factors (Talsma et al., 2008), failure to rescue has not been demonstrated to be of utility in the care of low-risk patients experiencing normal, physiologic processes such as birth. And, when examined within a midwifery model of care, the concept fails to fit. The purpose of this paper is to clarify the concept of failure to rescue in midwifery practice through concept analysis. For this concept analysis, a critical review of the literature was undertaken to clarify and correct the concept for relevance within midwifery research and clinical practice.

Background

Failure to rescue was developed by Silber et al. (1992) who suggested the term as an indicator of quality of care with focus on surgical patients in the inpatient setting though others have since suggested including medical patients (Needleman et al., 2002). Failure to rescue was originally conceptualised as management of complications or preventing death after a complication and was operationalised to mean the number of patients that health care providers failed to save after developing surgical complications that were life-threatening (Silber et al., 1995). The original concept focused on recognition of unexpected though preventable events that influenced mortality. Subsequent effort has centred on the identification of interventions to reduce events through early recognition and the skills required to do so (Silber et al., 2010). Early detection of deterioration or complication has been advocated using continuous (e.g., gathering ongoing physiologic data to recognise early signs of deterioration), condition (i.e., dedicated resources for patients at risk for a particular problem), and surveillance (i.e., monitoring in anticipation of possible unexpected events) monitoring (Taenzer et al., 2011) with the subsequent initiation of rapid response strategies to avert hospital death after adverse event.

The concept of failure to rescue has largely been defined as an outcome measure and is currently identified as one of 16 patient safety indicators used to assess and improve patient safety in hospitals in the United States (U.S.) (AHRQ, 2011). As such and looking through a larger lens, failure to rescue is intended to screen for adverse events that patients experience as a result of

exposure to the health care system. As an outcome indicator, the concept has been identified as a powerful tool for focusing on hospital characteristics as a potent contributor to adverse outcome (Schmid et al., 2007).

Examination of hospital characteristics has included physician and nurse staffing, availability of technology, as well as response interventions. Response factors contributing to failure to rescue have been categorised in two processes: timely response (prompt recognition) and appropriate response (correct management and treatment) (Chaferi et al., 2009). These processes involve the right treatment at the right time and require parallel attention (Taenzer et al., 2011) as well as development of monitoring systems to predict deterioration and likely adverse outcome. Monitoring for prompt intervention has included both continuous and condition specific systems, as well as patient surveillance approaches. Continuous monitoring has been shown to have numerous shortcomings in the patient safety literature and without consistent high reliability (Taenzer et al., 2011). Overestimation and overuse of monitoring systems has been found to result in unnecessary monitoring and serious financial burden (Taenzer et al., 2011).

Although both continuous monitoring and condition monitoring have demonstrated utility in identifying deteriorating patient condition, usefulness in low-risk patients has not been proven. In fact, research supports the concept as a sensitive measure in flagging complications and death but lacking specificity for excluding patients who do not belong in failure to rescue specifications (Talsma et al., 2008). Consequently, some have advocated for surveillance monitoring, a strategy whereby all low-risk patients receive specific monitoring without exception because the *process and setting* is associated with unexpected events (Clarke, 2004).

Failure to rescue and birth

In theory, failure to rescue is a marker that should predict what could go wrong as patients interface with the health care system – even with low-risk patients who are undergoing simple procedures. Where normal, physiologic life events are placed in care settings designed for intervention and treatment of disease, failure to rescue takes on special meaning as a process aimed at the prevention of complications. The burden is to provide surveillance that protects against deterioration from normal processes such as in the fundamentally most normal event of all – women giving birth.

Women giving birth constitute the single most common reason for hospital admission in the U.S. (Pfundner et al., 2013), as well as in many other developed and middle-income developing countries (WHO, 2012). Birth for low-risk women is generally very safe. Despite this fact, there has been limited description of the adverse events experienced by low-risk women giving birth as a result of

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