

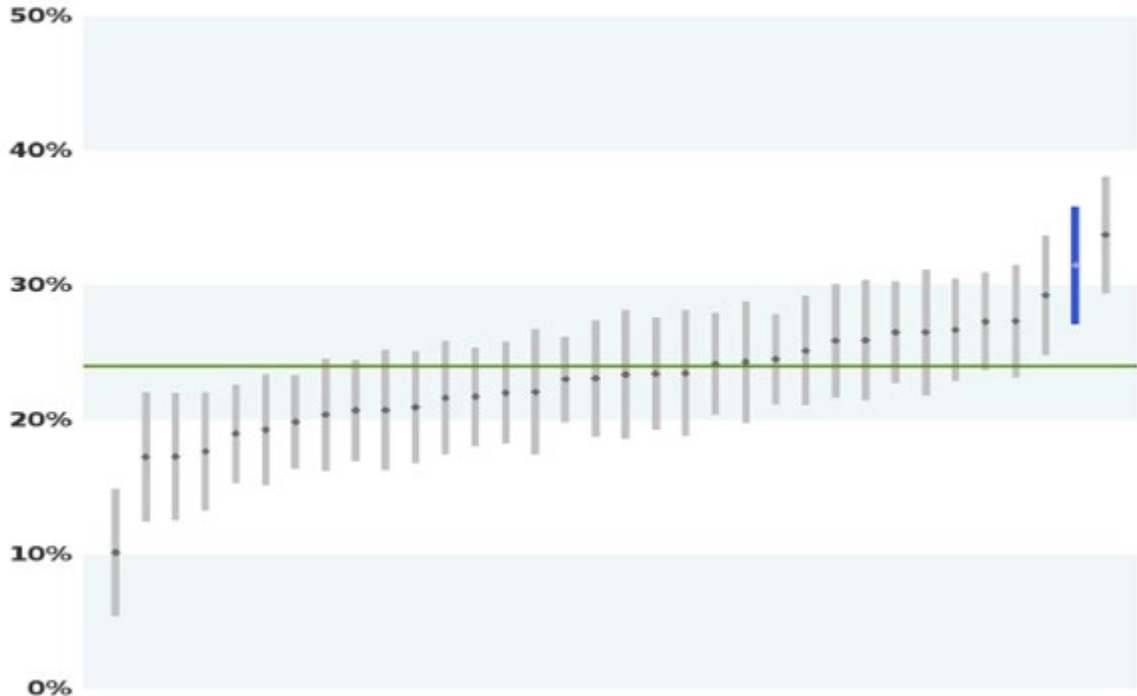
# Failure to Rescue

# About our facility...

- ACS verified Level II Adult Trauma Center
- Volume: 1000 trauma registry patients
  - 800 patients meet MTQIP inclusion criteria
  - 570 patients admitted to trauma service
  - 54% patients  $\geq$  65 years of age
  - 96% blunt MOI
- Composition of trauma service:
  - 6 trauma call surgeons
  - Consistent trauma service physician coverage 1 week at a time
  - Daily APP coverage 7a-5p, new nightshift APP coverage started 3/2018

# Failure to Rescue Status

Complications Drill-Down - Failure to Rescue



# Failure to Rescue

- Step # 1 understanding the definition...
- Exclude DOA

All deaths, admitted to trauma, ISS  $\geq$  5, that had grade 2 or 3 complication

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Total Patients with Grade 2 or 3 Complications

# Failure to Rescue Drill Down

Overall mortality and complications-not a high outlier, why failure to rescue??

- 18 patients included in FTR cohort
  - 3 patients died in ED
  - 15 patients admitted
    - 53% > 65
    - 12 patients withdrawal of care
- Clarify Data definitions:
  - 1 patient did not meet inclusion criteria-arrived without signs of life BP=0, HR=0, GCS=3. Clarification on registry data capture.

# Failure to Rescue Drill Down

- Common trends/themes?

## **Mortality Review:**

- Withdrawal of care- was it related to complication vs injury?
- Provider / process issues?

## **Complication Review:**

- Ventilator Associated Pneumonia: 4 patients
  - Hospital wide PI project to decrease VAE
    - Ventilator Protocols focused on decreasing VAE
    - Standardization of nursing/ RT care

# Failure to Rescue

## Conclusion...

- No “Smoking Gun” or overwhelming trend that contributed to our FTR rates.
  - Small volume makes it difficult to identify trends
- FTR is beneficial as a secondary audit filter for a high level overview for trends in complications/ mortality, and overall PI process.
  - VAP identified as a complication that needs addressed
  - Monitor provider trends

Questions??