



Unveiling the Layers of Failure to Rescue in Maternal Care: A Concept Analysis

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Abstract

This manuscript provides an in-depth analysis of "Failure to Rescue" (FTR) in U.S. obstetric care, identifying ten defining characteristics, outcomes, and empirical referents. FTR is defined as a significant shortfall in healthcare, characterized by the inability to prevent, identify, and manage complications in pregnant and postpartum women, leading to severe outcomes or death. It highlights systemic failures in early distress recognition, response, and adequate intervention.

A model case of Kira Johnson illustrates FTR through delayed recognition, systemic inadequacies, and resultant maternal death. A related case of Serena Williams discusses complications and obstetric racism, touching on FTR aspects. A contrasting case demonstrates effective obstetric care without FTR traits. Empirical referents like mortality and morbidity rates, response times, and guideline compliance provide measurable indicators of FTR.

The study emphasizes FTR as a systemic issue in maternity care, advocating for systemic reforms, improved surveillance, and addressing racial disparities. It suggests system-level interventions, such as enhanced communication, standardized protocols, and equitable care access, to mitigate FTR risks and improve maternal health.

The conclusion calls for urgent action on FTR in obstetric care, emphasizing the role of nursing professionals, patient-centered approaches, and robust FTR prevention strategies for systemic improvement in maternity care quality and mother health protection. It acknowledges limitations and urges further research and policy development to tackle FTR in various healthcare contexts.

Keywords: Failure to rescue; FTR; Maternal safety; Maternal morbidity and mortality; Maternal care

Introduction

The focal point of this analysis is 'Failure to Rescue' (FTR) in obstetric care, recognized as a crucial patient safety metric with significant implications for maternal health outcomes in the United States [1]. This concept analysis aims to a) comprehensively recognize the occurrence of FTR in the United States, b) establish a clear and functional definition of FTR in obstetric care, and c) inform future research, policy development, and clinical practice guidelines to mitigate FTR events in healthcare settings. FTR, defined as the inability of healthcare providers to prevent a potentially preventable death following complications [1], serves as a vital patient safety indicator within the healthcare system.

This analysis delves into FTR's definition, exploring its intersection with maternal morbidity beyond mere quality coding practices and assessments, and addresses the lived realities and systemic disparities leading to maternal harm. By examining FTR within the U.S. maternity care system, this study fosters a deeper understanding of the phenomenon, urging healthcare professionals to adopt a more compassionate and comprehensive approach to maternal care. Beyond its quantitative applications—such as mortality rates post-complications, benchmarking, performance analysis, and risk management [1]—FTR underscores the critical intersection of patient safety, clinical acuity, and system-wide responsiveness, especially pertinent in maternal healthcare.

FTR has emerged as a critical metric across various healthcare domains, including surgery, neonatal care, anesthesia, and social work, underscoring the importance of timely interventions post-complications [2-4]. The term's origin in the surgical discipline has evolved, with Silber et al. [5] among the first to quantify the FTR rate, establishing it as an indicator of hospital quality linked to nurse staffing levels.

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In neonatal care, FTR highlights the urgent need for recognizing and managing complications [6], paralleled in anesthesia practice through advancements in patient monitoring and risk assessment [7]. Furthermore, the concept's relevance in the psychosocial context of patient care emphasizes the importance of early identification and intervention in cases of distress [8,9]. The development of rapid response teams and other interventions underscores the seminal research by Hillman et al. [10], demonstrating their efficacy in reducing in-hospital cardiac arrests and FTR incidents.

With approximately 75% of maternal deaths in the United States associated with preventable conditions [11], and disparities particularly acute among Black, Indigenous, and rural women [12], the need for governmental action, such as the "Maternal Health Blueprint" issued by the Biden-Harris Administration [13,14], has become increasingly evident. This analysis contributes to the broader understanding and operationalization of FTR, advocating for a comprehensive approach to patient safety and quality care [15]. The diverse origins of FTR highlight the necessity for interdisciplinary collaboration to reduce preventable mortality and enhance patient outcomes [16].

Methods

This study employs Walker and Avant's [17] concept analysis framework to scrutinize Failure to Rescue (FTR) within U.S. obstetric care, given its growing impact on maternal health outcomes. This iterative approach allowed for a comprehensive exploration of FTR's dimensions, including its defining attributes, antecedents, consequences, and empirical referents, essential for understanding and addressing FTR in obstetric contexts.

A systematic literature review [18] was conducted across PubMed, CINAHL, MEDLINE, Google Scholar, and The Cochrane Library, from 1992 until November 6th, 2023. The search aimed to capture peer-reviewed articles, clinical guidelines, and grey literature that explicitly mention "failure to rescue" alongside related terms like "maternal morbidity and mortality," "patient safety," and "severe maternal morbidity." This strategy yielded pivotal studies and articles, with a selection process favoring those that directly contribute to defining FTR in obstetric care. The search was intentionally broad to include diverse sources due to the anticipated scarcity of literature specifically addressing the FTR indicator in obstetrics.

The analysis identified key attributes and conditions necessary for FTR occurrences, alongside their immediate and long-term effects on maternal health. Kira Johnson's case was highlighted as a model instance of FTR, serving as a benchmark for understanding FTR's real-world implications. Additional cases were examined to refine the distinction between FTR and related phenomena. This comprehensive review process, aligned with the Walker and Avant method, ensured a thorough exploration of FTR, aiming to provide a solid foundation for improving patient outcomes and informing healthcare practices.

The gathered literature, summarized in an organized overview, supports the concept analysis by highlighting definitions and concepts closely tied to FTR. This methodological approach contributes to a deeper understanding of FTR and its practical implications in obstetrics, aiming to mitigate FTR events and enhance patient safety within the U.S. healthcare landscape.

Results

The Agency for Healthcare Quality and Research (AHRQ, 2023)

recognized FTR as a critical parameter in assessing the quality of maternal healthcare [1]. FTR represents a systemic shortfall characterized by the inability of healthcare providers to prevent potentially reversible complications from advancing to morbidity or mortality, particularly in pregnant and postpartum women. This definition gains further depth and specificity when including the Patient Safety Indicator 4 (PSI-4) [19], a quality measure utilized by institutions such as The Leapfrog Group and the Centers for Medicare & Medicaid Services to evaluate hospital performance [20].

In maternal health, PSI-4 is a valuable tool for scrutinizing how effectively hospitals identify and manage severe medical complications that occur within a critical timeframe post-surgery or intervention [20]. These complications include conditions directly relevant to maternal health such as sepsis, hemorrhage, and shock-conditions that, if not promptly and properly and adequately addressed, can lead to FTR [21].

Deploying PSI-4 in monitoring FTR is not without its challenges. The measure's reliability can be compromised by coding inconsistencies and documentation practices that may not accurately reflect patient conditions [22]. This has led to debates over the measure's validity, with the National Quality Forum ultimately rescinding its endorsement of PSI-4 due to such concerns [20]. Despite these problems, PSI-4's emphasis on stringent criteria-such as Monitoring, Evaluation, Assessment, and Treatment (MEAT), supports the idea that only verified diagnoses contribute to FTR statistics [20]. Technical details, including the accuracy of procedural timing, are essential in determining whether a complication adds to a hospital's FTR rate.

As the maternal health crisis persists, precise, actionable metrics become paramount. In conjunction with PSI-4, FTR provides a framework for healthcare systems to analyze and enhance their response to maternal emergencies [20,23]. Combining these measures is not only about statistical accuracy; using both improves maternal outcomes, addresses disparities in maternal care, and saves lives. By holding healthcare systems accountable through such measures, the aim is to bridge the gaps in care that contribute to the maternal health crisis and ensure a higher standard of care for all mothers as shown in Table 1.

Discussion

Antecedents

Walker & Avant [17] defined antecedents in their context as the necessary precursors to set the stage for the occurrence of a concept-in this analysis, (FTR) in maternal healthcare [28]. The specific antecedents for FTR in the United States' maternal health crisis include several factors. For example, systemic healthcare factors such as FTR often stems from inadequate staffing ratios, insufficient training specific to maternal emergencies, and lack of necessary medical equipment [29,30]. These systemic deficiencies can delay the recognition of and response to acute maternal complications, leading to a cascade of failures that culminate in FTR. Similarly, poor communication linked to care coordination can affect incidents of FTR [3]. Effective communication and care coordination are crucial for preventing FTR. Breakdowns in these areas can result in fragmented care, where critical information is lost, and cohesive, timely interventions are not implemented.

Another related antecedent includes socioeconomic disparities that contribute to significant barriers that limit access to quality

Table 1: A summary of included studies.

Reference	Discipline/Country	Hierarchies/EBP Level	Concepts/Terms	Key Findings/Conclusions
Simpson KR [24]	Nursing/USA	Discussion/Level III	Failure to rescue, quality of care labor and birth	-FTR had not been explored as a potential method to evaluate quality of intrapartum care -FTR offers direct implications for perinatal patient safety and lessons to be learned
Gephart SM, et al. [25]	Nursing/USA	Discussion/Level III	Failure to rescue, neonatal care	-Describes how FTR is relevant in the neonatal intensive care unit -Outlines nursing and system actions that can be taken to rescue some of the hospital's most vulnerable patients
Guglielminotti J, et al. [39]	Obstetrics and Gynecology/USA	Qualitative/Level I	Failure to rescue and race disparities, SMM and death	-FTR from SMM remains a major contributing factor to excess maternal mortality in racial and ethnic minority women
Wright JD, et al. (2013)	Obstetrics and Gynecology/USA	Qualitative/Level I	Failure to rescue after major gynecologic surgery	-Treatment of complications is the most important factor to use to predict death after major gynecological surgery
Friedman AM, et al. [10]	Obstetrics and Gynecology/USA	Qualitative/Level I	Hospital delivery volume, SMM and FTR	-Low and high-volume hospitals are associated with increased risk for SMM and FTR
Matsuo K, et al. [42]	Obstetrics and Gynecology/USA	Qualitative/Level I	Failure to rescue considering SMM at cesarean delivery	-High FTR rates in Black women need further investigation -FTR rates in cesarean delivery procedures has not been previously examined
Ivory C. (2012)	Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN)	Nursing/Level III	Perinatal failure to rescue- consensus definitions Delphi study	Incorporation of perinatal FTR into electronic documentation systems may improve the ability to retrieve, equate and correspond the elements assisting with benchmarking facility outcomes
Schubert A, et al. [26]	Agency for Healthcare Research and Quality/USA	Regulatory/Level I	Failure to rescue as an indicator of PSI-4	PSI-4 is an indicator of FTR NQF retired the measure in 2019 due to biases in coding in medical documentation
Hastings-Tolsma M, et al. [29]	Nursing/USA	Nurse Midwifery/Level III	Reconceptualizing failure to rescue in midwifery- a concept analysis	Relevance to midwifery care mandates use of failure to rescue as both a process and an outcome measure
Fischer CF, et al. [12]	Medicine/USA	Surgical Medicine/Level I	Failure to rescue and Rapid response teams	-Need to clarify the definition of failure to rescue in childbirth and its defining attributes
Ward ST, et al. [27]	Medicine/USA	Surgical Medicine/Level I	Failure to rescue and hospital staffing models	Low FTR hospitals had significantly more staffing resources than high FTR hospitals
Beaulieu MJ, et al. [4]	Nursing/USA	Nursing/Level III	FTR response by a perinatal team	FTR patient safety indicator informed the basis for implementing unit specific education programs, certification, continuing education and documented competency in EFM education

maternal care [31]. These disparities often contribute to delays in seeking care and receiving appropriate responses to emergent conditions. Pre-existing maternal health conditions including comorbidities and pregnancy-related complications can increase the risk of FTR [12]. The intricate needs of patients with such conditions require vigilant monitoring and rapid response to prevent escalation to life-threatening scenarios. Moreover, FTR is also contingent on geographical and societal context. That is, variations in healthcare policy, infrastructure, and resource allocation across different regions in the United States can influence the prevalence of FTR [32]. These antecedents are not isolated factors but interwoven into areas where the healthcare system, societal structures, and individual patient factors converge. Recognizing and addressing these antecedents is paramount in constructing effective strategies to mitigate the risk of FTR [33], ultimately improving maternal health outcomes

and reducing the maternal mortality and morbidity that currently challenge the United States [34].

Defining attributes

For the concept analysis of FTR in obstetrics, 10 attributes are considered. First, recognition and response Delays characterize FTR in this context. These delays constitute lags in the recognition and response to critical maternal health conditions, including a healthcare system's lack of identifying and acting upon complications promptly. Appropriate timing is, crucial to prevent maternal morbidity and mortality [6,35]. Secondly, FTR is often marked by inadequate clinical monitoring and failure to implement necessary interventions, which are vital in the acute care of obstetric patients [5,29]. Related to the first two attributes is the third: deficiencies in training healthcare professionals regarding obstetric emergencies and proper protocols for managing deteriorating patients are also defining attributes of

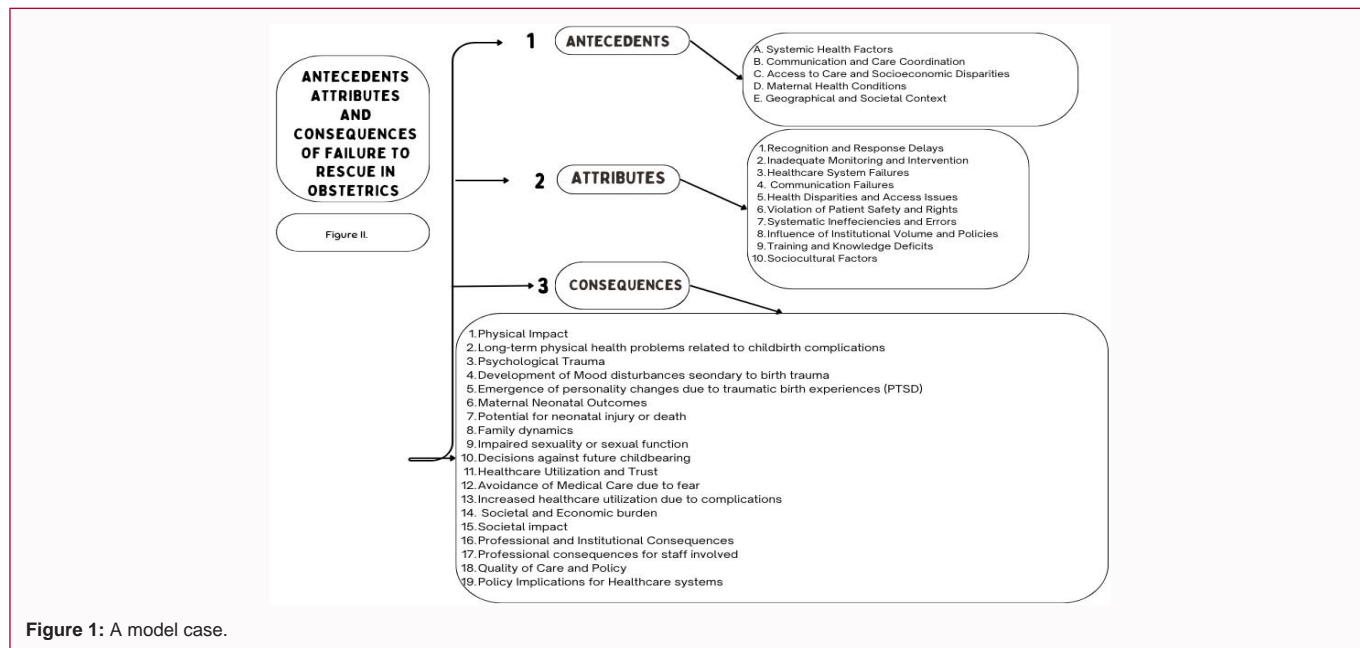


Figure 1: A model case.

FTR [5]. For example, the fourth characteristic concerns breakdowns in communication, which significantly increase the incidence of FTR. Lack of communication among healthcare team members is critical and can lead to errors in judgment and delays in treatment that could prevent adverse outcomes [3].

A broader set of concerns is captured in the fifth characteristic of FTR, regarding systemic inefficiencies and errors at a systemic level. These inefficiencies and errors are linked to organizational errors and ineffectiveness within healthcare delivery systems, underlying preventable adverse events [15,36,37]. The sixth attribute includes that FTR is sometimes preceded by system level failures, including staffing inadequacies, lack of resources, and poor healthcare policies [8]. The seventh consideration is linked to policies concerning the relationship between hospital delivery volume and implementing institutional policies which also shape the attributes of FTR, affecting both the incidence and outcomes [30].

The eighth characteristic of FTR regards socioeconomic inequities which often lead to disparities in health and access to care among vulnerable populations. Disparities in healthcare access directly influence the quality-of-care obstetric patients receive. These disparities can affect the likelihood of FTR in vulnerable populations [12,32]. Ninth and related to socioeconomic status, are sociocultural factors. Sociocultural dynamics, including the stigma surrounding maternal issues and the societal value placed on maternal health, are underlying attributes that can mitigate or exacerbate FTR [38]. The tenth attribute concerns a broader issue: An FTR can signify a violation of patient safety standards and the human rights of women particularly when patients have not consented or coerced into interventions.

Failure to rescue and maternal safety

Failure to Rescue (FTR) events in obstetrics are critical indicators of maternal care quality, directly influencing both immediate and long-term maternal and neonatal health outcomes. The physical consequences of FTR range from acute issues like hemorrhage and infection to chronic conditions such as pain and pelvic floor disorders, underscoring the necessity of swift and effective healthcare responses

to obstetric complications [3,6].

The psychological aftermath of FTR extends beyond the physical, contributing to mood disturbances, anxiety, depression, and PTSD among affected mothers, which further complicates maternal-neonatal bonding and can adversely affect neonatal development [3,6]. These outcomes not only highlight the direct impact on individual patients and families but also underscore the broader societal and economic costs associated with increased healthcare utilization, legal implications, and potential loss of productivity [9,20].

The occurrence of FTR events can erode trust in healthcare systems, influencing family dynamics and decisions about future childbearing. This lack of trust, compounded by fear of recurrence, may deter families from seeking necessary medical care, thereby perpetuating a cycle of risk for future pregnancies [39].

Addressing FTR requires a multifaceted approach that spans improvements in clinical practice, staff training, and patient communication to mitigate the root causes of FTR. Enhancements in monitoring, rapid response capabilities and interprofessional coordination are essential to reducing the incidence of FTR and improving patient safety in obstetric care [2,10,40,41].

The congruence between the antecedents and consequences of FTR illustrates a complex interplay of factors that necessitate comprehensive strategies for improvement. Healthcare systems must prioritize the development of protocols and resources that support a proactive approach to patient care, emphasizing the critical role of early intervention and continuous monitoring in preventing FTR events [29,32].

By adopting evidence-based practices and fostering a culture of safety and responsiveness, healthcare providers can significantly reduce the occurrence of FTR, ultimately enhancing the quality of care for mothers and newborns. The commitment to addressing FTR is not only a clinical imperative but a moral one, ensuring that all patients receive the highest standard of care during one of the most vulnerable periods of their lives [1,42].

Model case

A model case is a classic example of FTR that demonstrates all the defining attributes. This model case mirrors the concept of FTR underlying this analysis. The defining attributes are noted throughout the example with a parenthetical letter “A” after each occurrence and corresponding number of one to six for each attribute (Figure 1).

The case of Kira Johnson epitomizes Failure to Rescue (FTR) in obstetrics, showcasing every defining attribute of this critical concept. Kira, a 39-year-old expecting her second child, entered the hospital for a cesarean section. Despite a low-risk pregnancy and initial post-delivery optimism, Kira soon exhibited symptoms indicative of severe internal complications, such as noticeable abdominal swelling and a bluish tinge to her skin, signaling possible internal bleeding (A1, A2, A4).

Alarming, even as Kira and her family repeatedly voiced their concerns, the healthcare team's response was markedly slow and disjointed. Critical signs demanding immediate intervention was overlooked (A4, A7). This oversight underscored a failure to recognize the urgency of Kira's deteriorating condition, crucially narrowing the window for a potentially lifesaving intervention (A1, A2, D1, D2, D3, D6).

The delay in recognizing and responding to Kira's symptoms was not merely an issue of timing but reflected deeper systemic issues, including communication breakdowns and potential biases in patient care. These factors collectively contributed to a delayed diagnosis and treatment (B6, B7, B8, B9, B10, D1, D2, D3, D4), despite the hospital possessing the necessary resources for effective intervention (A1, A3, A4, A7, B2, D3, D4).

Ultimately, the delay proved fatal. Kira succumbed to her complications, leaving behind her newborn and family. Kira Johnson's story is a poignant illustration of FTR in obstetric care, underscoring the imperative for healthcare systems to address and rectify the gaps in care that lead to such avoidable losses [43]. By aligning with the antecedents of FTR as outlined in Figure, Kira's case highlights the critical areas for improvement within obstetric care. It serves as a call to action for healthcare professionals to enhance patient monitoring, communication, and responsiveness to prevent FTR and improve maternal outcomes.

Related case

This related case illustrates severe maternal morbidity in obstetrics, which contains issues similar to FTR but does not contain all its defining attributes. Severe Maternal Morbidity (SMM) refers to the survival of a life-threatening complication that occurred during pregnancy, childbirth or in the postpartum period. This term is used to describe instances where through timely and effective medical intervention or chance, a woman narrowly avoids a fatal outcome. The Centers for Disease Control and Prevention (CDC) identifies SMM using 21 indicators that reflect serious, potentially life-threatening complications or procedures intended to treat or ameliorate the effects of severe complications during or after labor and delivery [44]. These indicators facilitate identifying cases where the mother's health is at significant risk during the peripartum period.

The case of Serena Williams highlights the Severe Maternal Morbidity (SMM) spectrum, illustrating the challenges intersecting with Failure to Rescue (FTR) yet not encompassing its full scope. SMM encompasses life-threatening complications during pregnancy,

childbirth, or postpartum, where timely interventions avert mortality. The CDC utilizes 21 indicators to identify SMM, spotlighting critical risks to maternal health [44].

Serena Williams' experience underscores the intersection of obstetric care complications and systemic biases, notably obstetric racism. Despite overcoming initial postpartum complications, Williams faced a wound dehiscence from her cesarean section—a setback linked to earlier, nearly overlooked complications of deep vein thrombosis and pulmonary embolism, highlighting the imperative for vigilant postoperative care. This scenario exemplifies the lingering impact of care deficits, particularly for Black women, underscoring the need for comprehensive, bias-free postoperative monitoring and care. While Williams' proactive approach to her health care averted a dire outcome, her case reflects the broader issues of racial disparities in obstetric care. It demonstrates essential need for systemic healthcare reforms to ensure equitable, effective care for all women, preventing adverse outcomes stemming from systemic biases.

Contrary case

The contrary case does not contain the defining attributes of FTR in obstetrics. This case provides a clear example of the opposing concepts. In a stark contrast to FTR scenarios, Alia's case exemplifies optimal obstetric care devoid of FTR attributes. As a first-time mother diagnosed with pre-eclampsia at 32 weeks, Alia received vigilant, evidence-based care from her obstetric team. At the first sign of elevated blood pressure and proteinuria, she was promptly admitted for specialized care. The medical team's swift action to administer necessary medications and the comprehensive management plan underscored a proactive approach to her condition.

Throughout Alia's hospital stay, the team's commitment to open communication and shared decision-making ensured Alia was well-informed and involved in her care process. The seamless coordination among healthcare providers and the provision of psychological support created a nurturing environment conducive to Alia's well-being and confidence in her care. Postpartum, Alia's recovery was closely monitored, ensuring a return to normalcy, and equipping her with the knowledge for continued health vigilance.

Alia's case is a testament to the efficacy of preemptive, integrated care in obstetrics, highlighting how timely, coordinated interventions can successfully avert severe complications, embodying the antithesis of FTR and showcasing the potential for positive maternal and neonatal outcomes through exemplary healthcare practices.

Empirical referents

Empirical referents in maternal healthcare FTR are measurable indicators reflecting the capability of healthcare systems to manage and prevent complications. Mortality rates due to pregnancy, childbirth, and postpartum complications serve as a primary empirical referent, with higher rates indicating potential FTR incidents. Similarly, morbidity rates from severe complications like hemorrhage or eclampsia highlight FTR occurrences. The responsiveness of healthcare providers, measured through response times to emergencies, directly correlates with FTR effectiveness. Obstetric readmission rates post-discharge reflects on the initial treatment's quality and care continuity, serving as another FTR indicator. Hospital-acquired conditions during stays signify possible FTR situations due to care inadequacies. The AHRQ's patient safety indicators further identify potential in-hospital complications, underscoring FTR scenarios. Timeliness of clinical interventions,

patient feedback on care effectiveness, adherence to clinical guidelines, and outcomes from clinical audits and peer reviews collectively offer comprehensive empirical evidence of FTR presence or absence, guiding improvements in maternal healthcare practices [2,8,29,32,40,44,45].

Proposed maternal safety definition

The refined definition of Failure to Rescue (FTR) in obstetrics, as developed from this analysis, complements the principles of standardized maternity care advocated by U.S. Hospitals and the American College of Obstetricians and Gynecologists (ACOG). According to the ACOG's Levels of Maternal Care Obstetric Case Consensus document, standardized care involves applying uniform protocols and procedures in obstetric and maternal-fetal medicine to integrate systems effectively addressing maternal health needs. This strategy aims to reduce maternal morbidity and mortality by ensuring care aligns with the specific risk levels of perinatal patients, thereby promoting perinatal regionalization [46].

Reflecting on the current maternal health crisis, this analysis introduces a revised FTR definition: "A critical shortfall within healthcare systems, characterized by the inability to prevent, identify, and manage complications in pregnant and postpartum women, potentially leading to severe morbidity or mortality." This definition underscores the systemic failures in early distress recognition, efficient response, and comprehensive intervention, highlighting the urgent need for healthcare systems to adopt proactive measures that adhere to the ACOG guidelines for quality improvement and patient safety in maternity care [47].

Discussion

FTR in obstetrics represents a significant challenge within maternity care systems. The body of literature examining FTR in obstetrics, including recent studies and reviews, underscores a multifaceted issue with dire consequences for maternal and neonatal outcomes. Research has consistently shown the critical importance of timely recognition and response to complications in pregnant and postpartum women to improve outcomes and prevent maternal morbidity and mortality.

The AHRQ [1] emphasizes that FTR involves a systemic failure rather than individual clinician's mistakes, suggesting that solutions must address broader organizational and process factors [48]. This perspective aligns with Bernstein et al. [5], who advocated for systemic changes to prevent FTR, including implementing robust acute care obstetrics teams and standardized response protocols to manage emergencies effectively [3]. Behling & Renaud proposed the developing of an obstetric vital sign alert system designed to improve outcomes by facilitating the early identification of patients at risk for FTR [2]. The efficacy of such systems could prove vital in combating the escalating maternal mortality rates and aligns with the CDC's Pregnancy Mortality Surveillance System, which advocates for better surveillance and data collection to inform preventive strategies [11].

The disparities in FTR outcomes are particularly pronounced among racial and ethnic minorities. Guglielminotti et al. [39] showed that racial and ethnic disparities are a significant factor in FTR cases, with a notable impact on mortality rates [10]. This necessitates an intersectional approach to address the social determinants of health and systemic biases that contribute to these disparities [49].

Studies by Friedman et al. [10] and Matsuo et al. [42] link hospital

delivery volume and staffing levels to FTR rates [50], suggesting that higher-volume centers with more specialized staff might better manage severe maternal morbidity [11,51]. This observation is particularly concerning when considering the association between the loss of hospital-based obstetric services in rural counties, as reported by Kozhimannil et al. [36], and increased adverse birth outcomes [29].

The literature presents a clear consensus that preventing FTR in obstetrics is contingent upon complex system-level interventions, including enhancing staff communication, implementing standardized protocols, and ensuring equitable access to quality care. These interventions, coupled with accountability systems and ongoing training, are key to mitigating the risks associated with FTR and improving maternal health outcomes. Addressing these challenges requires sustained commitment from healthcare providers, policymakers, and community stakeholders to transform obstetric care into a safer, more responsive system for all women.

Conclusion

The challenge of FTR in obstetric care is a critical concern that demands immediate and sustained attention. Due to frequent patient interaction and care, nursing professionals are crucial in mitigating FTR events. Their commitment to patient advocacy and ethical care is essential in preventing the progression of recoverable complications into severe morbidities or mortalities during childbirth.

This analysis has shed light on the necessity for strategic nurse-led interventions and a strengthened healthcare infrastructure that supports timely recognition, response, and management of obstetric emergencies. Empowering nurses with the resources, training, and authority to act swiftly in critical situations is paramount to improving maternal outcomes.

The research emphasizes the need for healthcare institutions to adopt a patient-centric approach, integrating rigorous FTR prevention strategies into the standard of care, and enhancing policies prioritizing mother's safety and well-being during childbirth. The institutionalization of such practices is crucial for ensuring that FTR is addressed as a system-wide priority and that necessary steps are taken to prevent such adverse events.

The findings from these studies call for a systemic transformation that elevates the quality of maternity care through a concerted focus on patient safety protocols, multidisciplinary communication, and continuous performance improvement. By doing so, the healthcare system can move towards a model of care where Failure to Rescue (FTR) is significantly reduced, thereby safeguarding the health and rights of mothers during one of the most vulnerable periods of their lives. It is important to acknowledge the limitations of these reviews.

Most studies predominantly focus on high-resource healthcare settings, potentially overlooking the unique challenges faced in low-resource environments. There is often a lack of comprehensive data on long-term maternal health outcomes post-discharge, which can provide a skewed understanding of the effectiveness of interventions. The variability in defining and measuring key concepts like 'failure to rescue' across different studies can lead to inconsistent findings, complicating the process of drawing generalized conclusions applicable to diverse healthcare systems.

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