COUNCIL ON PATIENT SAFETY
IN WOMEN'S HEALTH CARE
safe health care for every woman

PRACTICING FOR PATIENTS

Team Review and Debriefing Form: Severe Hypertension

READINESS

	Yes/No	Opportunity for Improvement
Standard early warning signs, monitoring and diagnostic criteria established for severe preeclampsia/eclampsia		
Severe hypertension treatment algorithm available		
Triage process for pregnant/postpartum hypertensive women established for all service areas, including outpatient and non-obstetric areas		
Anti-hypertension medications immediately available		
Escalation plan in place, including criteria for consultation and maternal transport (if indicated)		

RECOGNITION & PREVENTION

Review proper technique for measurement of blood pressure (describe proper technique):

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Review maternal early warning signs for preeclampsia/eclampsia (list signs):

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RESPONSE

ASSESSMENT/ACTION	EVALUATION				
Provider or team:	**Done**	**Not Done**	**Improvement Opportunity**	**N/A for Scenario**	**Notes**
Recognizes severe hypertension in a timely manner					
Calls for additional assistance					
Elicits patient history of severe symptoms (headache, vision changes and/or RUQ pain)					
Orders labs (CBC, Cr, AST) and urine protein/creatinine					
Administers antihypertensive agent for severe range hypertension					
Orders magnesium sulfate for seizure prophylaxis					
Considers Foley catheter placement to monitor urine output					
Reassesses BP and re-treats severe range blood pressures at appropriate intervals					
Communicates about preeclampsia/eclampsia diagnosis and management plan					

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RESPONSE, continued

ASSESSMENT/ACTION	EVALUATION				
Provider or team:	**Done**	**Not Done**	**Improvement Opportunity**	**N/A for Scenario**	**Notes**
Eclamptic Seizure Management					
Rolls the patient to her left side					
Ensures bed side rails are up					
Provides supplemental oxygen via facemask and places pulse ox (if not already in place)					
Administers magnesium sulfate (correct dose/route)					
Post-Seizure Management					
Reassesses patient's mental status post-seizure					
Considers need for head imaging					
Assesses fetal status					
Discusses need for and approach to delivery					
Discusses maintenance rate for magnesium sulfate based on patient's serum creatinine					
Discusses the diagnosis/plan with the patient and her family					
Considers need for transfer to other facility (if applicable)					

TEAMWORK & COMMUNICATION REVIEW

How Well Did the Team:	Very Well (5)	Well (4)	Adequately (3)	Poorly (2)	Very Poorly (1)	Did Not Do (0)
Orient new members (SBAR) to the scenario as they arrived?						
Call for additional assistance in a timely manner?						
Use call-outs to communicate important information to the entire team?						
Utilize closed-loop communication (check-backs)?						
Maintain situational awareness?						
Provide mutual support and task-assistance to other team members?						
Explain the situation to the patient using patient friendly language and tone?						
Please rate the following:						
Overall team communication during the simulation						
Overall team performance during the simulation						

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TEAMWORK & COMMUNICATION REVIEW, continued

Additional notes/summarize and review any lessons learned:

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TEAM REVIEW AND DEBRIEFING NOTES

Common medications for postpartum hemorrhage (including contraindications)

MEDICATION	DOSE	CONTRAINDICATIONS
Labetalol	10-20 mg IV (initial dose) 20-80 mg every 10-30 minutes Maximum cumulative dose 300 mg OR continuous infusion 1-2 mg/minutes	Asthma Preexisting myocardial disease Decompensated heart failure Bradycardia or heart block
Hydralazine	5 mg IV or IM (initial dose) 5-10 mg IV every 20-40 minutes Maximum cumulative dosage of 20 mg OR continuous infusion 1-2 mg/minutes	Coronary artery disease Mitral valve rheumatic heart disease
Nifedipine (immediate release)	10-20 mg oral (initial dose) Repeat 10-20 mg in 20 minutes 10-20 mg every 2-6 hours thereafter Maximum daily dose of 180 mg	ST-elevation myocardial infarction
Magnesium sulfate	IV: 4-6 g loading dose (given over 15-20 minutes) then 1-3 g/hr continuous infusion *Additional 2-4 g IV bolus can be given over 5 minutes for recurrent seizures IM: 10 g loading dose (5 mg/each buttock) then 5 g every 4 hours	Myasthenia gravis Severe renal failure (relative) Myocardial damage Heart block
Calcium gluconate	1 g IV over 2-5 minutes	Hypercalcemia
Lorazepam	4 mg IV over 2-5 minutes	Acute glaucoma
Diazepam	5-10 mg IV	Acute glaucoma

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TEAM REVIEW AND DEBRIEFING NOTES, continued

- Severe hypertension in a pregnant or postpartum woman requires repeat assessment in 15 minutes followed by antihypertensive treatment within 30-60 minutes for persistent severe range blood pressures.
- Magnesium sulfate is the first line treatment for seizure prevention in patients with preeclampsia. In patients with mild renal failure (serum creatinine 1.0-1.5 mg/dL) or oliguria (less than 30 mL urine output per hour for more than 4 hours), the loading dose of 4-6 gm should be followed by a maintenance dose of only 1 gm/hour. Using a lower loading dose, such as 4 gm, may be associated with subtherapeutic levels for at least 4 hours after loading.
- Fetal bradycardia is common immediately after an eclamptic seizure and does not necessitate emergency cesarean delivery unless the fetal heart rate does not improve within 10-15 minutes despite resuscitative efforts, at which point it may be indicated.
- Eclampsia is considered an absolute contraindication to expectant management; however, this does not necessarily preclude induction and trial of labor.
- Preeclampsia with severe features does not necessarily preclude induction and trial of labor.
- It is important to counsel the patient about her diagnosis and keep the patient and family informed of the situation and management plan.

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Standardization of health care processes and reduced variation has been shown to improve outcomes and quality of care. The Council on Patient Safety in Women's Health Care disseminates patient safety tools to help facilitate the standardization process. This tool reflects emerging clinical, scientific, and patient safety advances as of the date issued and is subject to change. The information should not be construed as dictating an exclusive course of treatment or procedure to be followed. Although the components of a particular tool may be adapted to local resources, standardization within an institution is strongly encouraged.

The Council on Patient Safety in Women's Health Care is a broad consortium of organizations across the spectrum of women's health for the promotion of safe health care for every woman.

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