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How We are Doing

Implementation of the Aim Hypertension Bundle

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Just a reminder

READINESS

Every Unit

- Standards for early warning signs, diagnostic criteria, monitoring and treatment of severe preeclampsia/eclampsia (include order sets and algorithms)
- Unit education on protocols, unit-based drills (with post-drill debriefs)
- Process for timely triage and evaluation of pregnant and postpartum women with hypertension including ED and outpatient areas
- Rapid access to medications used for severe hypertension/eclampsia: Medications should be stocked and immediately available on L&D and in other areas where patients may be treated. Include brief guide for administration and dosage.
- System plan for escalation, obtaining appropriate consultation, and maternal transport, as needed

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RECOGNITION & PREVENTION

Every Patient

- Standard protocol for measurement and assessment of BP and urine protein for all pregnant and postpartum women
- Standard response to maternal early warning signs including listening to and investigating patient symptoms and assessment of labs (e.g. CBC with platelets, AST and ALT)
- Facility-wide standards for educating prenatal and postpartum women on signs and symptoms of hypertension and preeclampsia

RESPONSE

Every case of severe hypertension/preeclampsia

- Facility-wide standard protocols with checklists and escalation policies for management and treatment of:
  - Severe hypertension
  - Eclampsia, seizure prophylaxis, and magnesium over-dosage
  - Postpartum presentation of severe hypertension/preeclampsia
- Minimum requirements for protocol:
  - Notification of physician or primary care provider if systolic BP =/> 160 or diastolic BP =/> 110 for two measurements within 15 minutes
  - After the second elevated reading, treatment should be initiated ASAP (preferably within 60 minutes of verification)
  - Includes onset and duration of magnesium sulfate therapy

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  - Notification of physician or primary care provider if systolic BP =/> 160 or diastolic BP =/> 110 for two measurements within 15 minutes
  - After the second elevated reading, treatment should be initiated ASAP (preferably within 60 minutes of verification)
  - Includes onset and duration of magnesium sulfate therapy
  - Includes escalation measures for those unresponsive to standard treatment
  - Describes manner and verification of follow-up within 7 to 14 days postpartum
  - Describe postpartum patient education for women with preeclampsia
- Support plan for patients, families, and staff for ICU admissions and serious complications of severe hypertension

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REPORTING/SYSTEMS LEARNING

Every unit

- Establish a culture of huddles for high risk patients and post-event debriefs to identify successes and opportunities
- Multidisciplinary review of all severe hypertension/eclampsia cases admitted to ICU for systems issues
- Monitor outcomes and process metrics

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What we have done recently

Chart Reviews

- 12-16 cases per month that meet criteria for review
- 10-14 that meet criteria
- 1-2 fall outs
  - Waiting on orders
  - Procedural
  - Recent administration of medications

- Update the Admin Instructions within all OB Hypertension medications so the Diastolic Blood Pressure (DBP) notification references 110.
  - If no Intravenous access: give nifedipine 20 mg, orally.
  - If Intravenous access present: give labetalol or hydralazine.
- Remove the ‘red’ banner for acute cocaine and amphetamines being a contraindication for labetalol use

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Integration into the EMR

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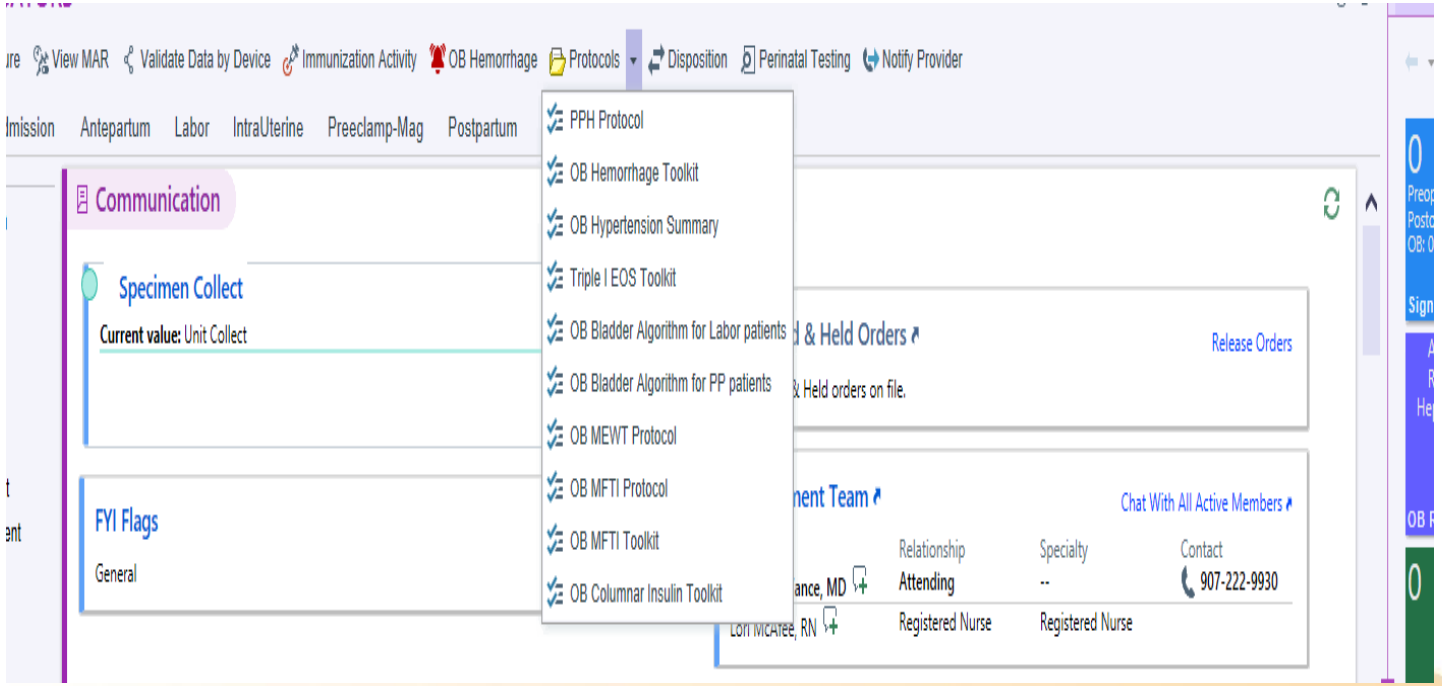
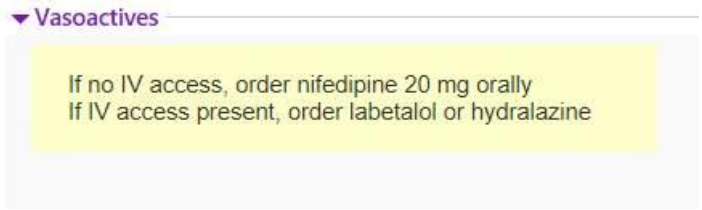
OB NAVIGATORS

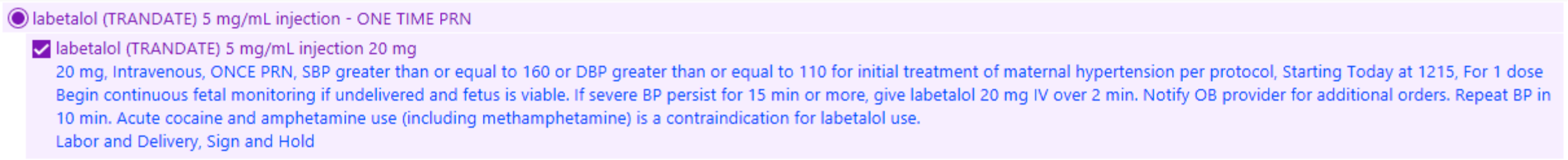
Pre-Procedure | View MAR | Validate Data by Device | Immunization Activity | OB Hemorrhage | Protocols | Disposition | Perinatal Testing | Notify Provider



Update OB Hypertension - Screenshots



Updated Banner & Removal of a Red Banner



MEWT

Status	OB MEWT
PP C/S	0
PP C/S	0
PP Vag	0
PP Vag	0
PP C/S	0
PP Vag	0
PP Vag	0
PP Vag	0
PP C/S	1
PP Vag	0
PP C/S	0
PP C/S	0

Row Information

Vital Signs	2	1	0	1	2
Heart Rate	<40	40-49	50-109	110-130	>130
Respiratory Rate	<10		11-23	24-30	>30
Systolic BP		<=79	80-159	>=160	
Diastolic BP		<=44	45-104	>=105	
Oxygen Saturation	<90	90-94	>=95		
Temp		<=36	36.1-38.9		>=39
FHR			<=160	>160	

Provider Notification Parameters
(Does not trigger MEWT)
Follow notification guidelines outlined in EPIC/standard

Abnormal

***Step 1*: Maternal Assessment**
Temp, Pulse Ox, HR, RR, BP

Normal

Normal Assessment
(No abnormal triggers)
STOP here and continue to monitor

MEWT

2 Moderate Triggers Present

Temperature	≤36.0
O_2 Saturation	90-94%
Maternal HR	110-130 or 40-49
Respiratory Rate	24-30
Systolic BP	>=160 or <80
Diastolic BP	>=105 or <45
Fetal Heart Rate	>160 (infection pathway only)

1 Severe Trigger Present

Temperature	≥39.0
O_2 Saturation	<90%
Maternal Heart Rate	>130 or <40
Respiratory Rate	>30 or <10
Other	Nurse clinically uncomfortable with patient

MEWT

Confirmed
(Sustained for 20min):
ACTION: REQUEST BEDSIDE PROVIDER EVALUATION*

x 8.50 in

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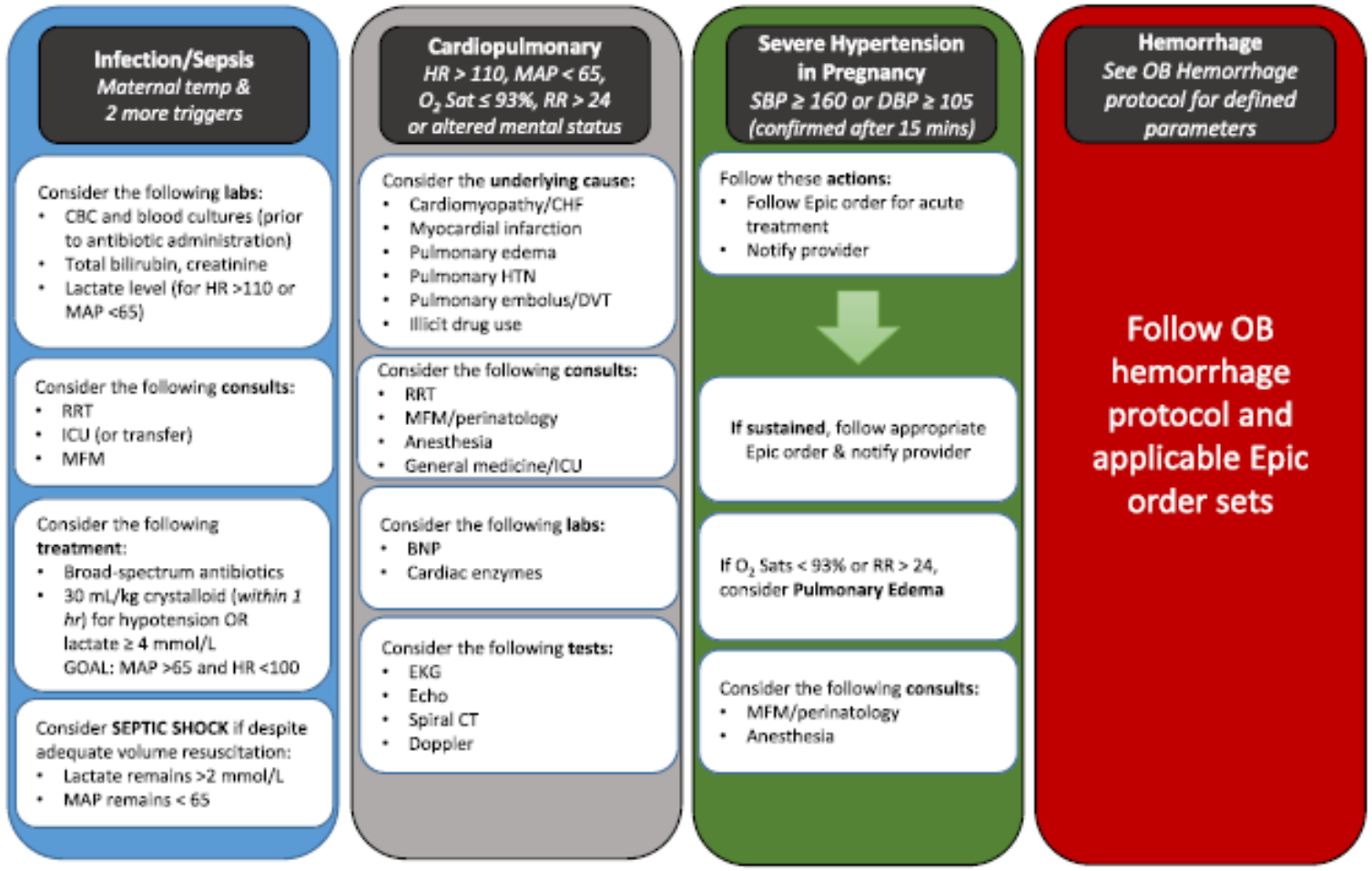
Step 2:
Review triggers and consider below clinical pathways (consider overlap)



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Current PDSA…Post event debriefs

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- Establish a culture of huddles for high risk patients and post-event debriefs to identify successes and opportunities

PDSA 1

- Plan
  - √ Create Critical Debrief Form
  - √ Educate Charge Nurses about the form
  - √ Create binders with forms and instructions
  - √ Collect forms for 30 days
  - √ Use information to make immediate changes

- Do
  - √ Convene 4 bedside nurses to evaluate the incidents and select 2-3 for presentation
  - √ Hold quarterly M & M on selected cases
- Study/Act
  - – Pending

Completed by: _____

Date of Incident: _____

Time of Incident: _____

Unit where the event occurred:___ _____

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Patient Sticker

****Not Part of the Medical Record****

** Protected by AS 18.23.030 & AS 18.23.070(5)**

Type of Incident (check all that apply)		Staff Involved/Role
Neonatal Resuscitation	☐	
Post Partum Hemmorhage	☐	
HTN Emergency	☐	
Transfer to Higher Level of Care	☐	
Delivery Complication	☐	
Prolonged second stage of labor	☐	
Other_____	☐	

Event Description - Include as much detail as you can. If you need more space for writing, you can attach a blank piece of paper with written descripti

What Went Well	Yes	No	What Could Have Gone Better
Communication with Providers	☐	☐	
Communication with other Departments	☐	☐	
Communication with Staff	☐	☐	
Equipment/ Supplies	☐	☐	
Staffing	☐	☐	
Policies and Protocals	☐	☐	
Epic Documentation	☐	☐	
Medications	☐	☐	
Other_____			

Suggestions for Improvement

UOR	☐
Notify the Manager on Call (if needed)	☐
Debrief completed	☐

Place Completed form in binder at Charge Nurse Station

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Future PDSA

- Emergency Department Protocols
- OB Triage Nurse Initiated Orders