



**AC<sup>3</sup>HIEVE**

Advancing Community and Clinical Care for Childbirth-related Hypertension:  
Implementation, Engagement, and Valuing Equity

## Severe Hypertension Event Debriefing Form

**Remember: Debriefing is meant to be a learning experience and a way to address both human factors and systems issues to improve the response for next time. There is no blaming/finger-pointing.**

Date of Event: \_\_\_\_\_

### Members of Team Present (check all that apply)

- Nurse
- Nurse Manager
- MA or CNA
- Primary Provider (MD, NP/CNM or PA)
- Attending Physician
- Medical Director or Lead Provider
- Pharmacist
- Front Desk Staff
- Other: \_\_\_\_\_

#### Identify what went well: (Check if yes)

- Communication
- Role clarity (leader/supporting roles identified and assigned)
- Teamwork
- Situational awareness
- Decision-making
- Other: \_\_\_\_\_

#### Identify opportunities for improvement: “human factors” (Check if yes)

- Communication
- Role clarity (leader/supporting roles identified and assigned)
- Teamwork
- Situational awareness
- Decision-making
- Other: \_\_\_\_\_

#### Identify opportunities for improvement: “systems issue” (Check if yes)

- Equipment
- Medication availability
- Inadequate training or awareness of policies
- Delays in transporting patient
- Other: \_\_\_\_\_

# Severe Hypertension Event Debriefing Form

For identified issues above, fill in the following table:

Issue	Actions to Be Taken to Correct	Person Responsible for Follow-Up Action

*\*Adapted from ACOG District II, Safe Motherhood Initiative, Phelan Obstetric Debriefing Form <http://unmobgyn.pbworks.com/w/file/attach/115267570/Phelan%20-%20Obstetric%20Team%20Debriefing%20Form.pdf>*