



AC³HIEVE

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: 3/8/24

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: EHR documentation_

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For identified issues above, fill in the following table:

Issue	Actions to Be Taken to Correct	Person Responsible for Follow-Up Action
Role Clarity- While there was situational awareness and quick decision making on the part of all team members. Once medication was verbally ordered by the Primary Provider it was unclear if the pharmacist would bring the medication or who was to pick up the medication from the pharmacist and administer it, which delayed medication administration.	In our severe hypertension recognition and response algorithm and policy we will clarify that the nurse will pick up the medication from the pharmacist, administer the medication and document administration.	The Nurse Manager will update the algorithm and policy and notify all staff of this update.
EHR Documentation- Once the medication was retrieved from the pharmacist, the MA administered the medication under the supervision of the Primary Provider; however, the MA did not know where to document the medication administration or what was to be included.	A request will be placed to have medication administration added to the EHR. While waiting for this change all staff will be informed to document medication administration in a progress note, being sure to document what medication was given, the route, the dosage and time of administration and that the correct patient was verified prior to administering the medication	The Medical Director will approve the requested change to the EHR and the Nurse Manager will follow up to be sure the request is received by IT. The Nurse Manager will also provide all staff with an update on how medication administration will be documented while awaiting changes to the EHR system.

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