Tip Sheet for Ongoing Monitoring of Recognition and Response to Severe HTN

Huddles, Debriefs and Action Planning

- Huddles occur in two contexts:
    1. As a daily process at a designated time to proactively communicate and plan for patient care of those patients being seen that day and/or clinic session. Successes, concerns, safety risks, updates on patient safety initiatives or announcements may also be shared.
    2. As a brief, ad hoc meetings among staff members when there is a change in patient status that requires team awareness and planning. Improving Patient Safety and Team Communication through Daily Huddles | PSNet (ahrq.gov)
- When appropriate, patients and their designated support team should be included in the huddle. 12-FINAL_AIM_OERRK_ReportingSystemsLearning.pdf (saferbirth.org)
- **EXAMPLE**: HuddleExampleDocument.docx

- Debriefs following an event in the clinical setting are structured, brief conversations that can help to build a shared understanding of the team's ability to effectively respond to emergencies. Debriefs should:
    1. include all individuals who were involved or provided care in the event,
    2. review the timeline and summarize major events, and
    3. identify successes, barriers, and opportunities that can be changed to address future events more effectively.
- Debriefs should always be conducted in the spirit of collaboration and should not assign blame to specific individuals. The goal is to identify opportunities both among "human factors" and among "systems issues"
- 12-FINAL_AIM_OERRK_ReportingSystemsLearning.pdf (saferbirth.org)
- **EXAMPLE**: SevereHTNEventDebriefingForm_ACHIEVE

Multidisciplinary Reviews of Obstetric Care and Emergencies

- Multidisciplinary reviews provide more insight into how systems and structure contribute to positive and negative outcomes and should include various stakeholders with different perspectives. These are to be used for ongoing quality improvement.
- These reviews can inform process improvements and provide important insight into health disparities and/or trends in social determinants of health for the community that the clinic serves.

- A Just Culture approach should be used to produce constructive solutions to systemic factors and address accountability while preventing blame culture for any one or multiple individuals at fault. (Microsoft Word - Just CultureToolkit_ Final (ashp.org))
- To engage in multidisciplinary reviews, an organization must establish:
    - Foundation: multidisciplinary membership, meeting frequency, peer review process
    - Process: clinical indicator trigger in place (which charts are looked at), source of chart identification, case abstractor(s) and presenters
    - Recommendations (including who is responsible for): implementation, dissemination and education, follow-up monitoring (guide-to-integrating-severe-maternal-morbidity-case-review.pdf (nyc.gov)
- Whenever possible, multidisciplinary reviews should include social determinants of health including patient race/ethnicity, employment status, marital status, occupation, documented evidence of social or emotional stress, adherence to care barriers (transportation access, family obligations, difficulty accessing medications), and screenings for mental health conditions/substance abuse.
    - Follow up items after these reviews may be in response to unmet needs for social determinants of health, especially if observed as a trend among patients in a clinic population. Clinics are encouraged to partner with existing community-based organizations to leverage support and collaborate on new goals.
- **EXAMPLE**: MomBaby Debrief Sample Form Examples.docx (sharepoint.com)