READINESS

The Readiness section provides strategies to improve readiness to treat severe hypertension in pregnancy or postpartum to prevent delays in identifying and treating severe hypertension in every unit. The goal is to implement critical clinical pathways on every unit, and have early warning signs, diagnostic criteria, monitoring and rapid access to treatment of severe preeclampsia and eclampsia.

Key elements in readiness include the identification of early warning signs, diagnostic criteria, monitoring, and treatment including order sets and algorithms.

Early warning signs establish when a patient will be evaluated by a provider at the bedside. We will provide a standard for Early Warning, diagnostic criteria for severe hypertension, and preeclampsia, and algorithms for monitoring and treatment. Second is team training, drills and debriefs. Thirdly, a process for timely triage and evaluation of pregnant and postpartum women in the ED or urgent care center. Fourth, establish rapid access to medication used for severe hypertension, preeclampsia, and eclampsia. And finally, all units should have a system plan for escalation, obtaining consultation.

- Ambulatory Readiness Assessment
  https://www.in.gov/health/laboroflove/files/Ambulatory-Readiness-Assessment.pdf
- Emergency Department Readiness Assessment
  https://www.in.gov/health/laboroflove/files/Emergency-Department-Readiness-Assessment.pdf
- Inpatient Readiness Assessment
  https://www.in.gov/health/laboroflove/files/Inpatient-Readiness-Assessment.pdf
- Manual Blood Pressure Competency Checklist
  https://www.in.gov/health/laboroflove/files/Manual-Blood-Pressure-Competency-Checklist.pdf

Hypertension in Pregnancy-Ambulatory Readiness Assessment

Requirements-Every Unit	In Place-Consistently Executed	In Place-Not Working	Not In Place	Comments
Standards for early warning signs, diagnostic criteria, monitoring of preeclampsia.				
Office team education reinforced by regular office drills/scenario.				
Process for a timely triage and evaluation of pregnant and postpartum women with hypertension outpatient areas.				
Rapid access to inpatient/OB triage unit for treatment.				
System plan for escalation, obtaining appropriate consultation and maternal transport, as needed.				

For each requirement that is not in place and consistently executed, complete an Action Plan

Fast Five Triage for Ambulatory:

- How have you been feeling sense your last prenatal appointment?
- Any visual changes, unexplained weight gain, HA not relieved by acetaminophen, swelling not relieved by elevation…etc.?
- Any new condition onsets that concern you?
- Are you currently on blood pressure medication? If so, what medication, dosage, and the last time you have taken the medication?
- Do you have a log of your blood pressures?

Hypertension in Pregnancy-Emergency Department Readiness Assessment

Requirements-Every Unit	In Place-Consistently Executed	In Place-Not Working	Not In Place	Comments
Standards for early warning signs, diagnostic criteria, monitoring and treatment of severe preeclampsia/ eclampsia (include order sets and algorithms).				
Unit team education, reinforced by regular multi-department (L&D and PP) drills with debriefing.				
Process for a timely triage and evaluation of pregnant and postpartum women with hypertension upon arrival to Emergency Department.				
Rapid access to medications used for severe hypertension/eclampsia: Medications should be stocked and immediately available in the ED. Include brief guide for administration and dosage.				
System plan for escalation and maternal transport to appropriate setting for further evaluation and treatment.				

For each requirement that is not in place and consistently executed, complete an Action Plan

Fast Five Triage for ED:

- Are you pregnant?
- Have you had a baby within the last six (6) months?
- Any complications with previous/during current pregnancy?
- What symptoms brought her to ER? (headache, shortness of breath, chest pain, distorted vision)
- Do you have a history of elevated blood pressure?

Hypertension in Pregnancy-Inpatient Readiness Assessment

Requirements-Every Unit	In Place-Consistently Executed	In Place- Not Working	Not In Place	Comments
Standards for early warning signs, diagnostic criteria, monitoring and treatment of severe preeclampsia/ eclampsia (include order sets and algorithms).				
Unit team education, reinforced by regular unit-based drills with debriefs.				
Process for a timely triage and evaluation of pregnant and postpartum women with hypertension.				
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.				

For each requirement that is not in place and consistently executed, complete an Action Plan

Fast Five Triage for Inpatient:

- How far along in this pregnancy are you or have you recently delivered within the last six (6) months?
- Any visual changes, unexplained weight gain, HA not relieved by acetaminophen, swelling not relieved by elevation…etc.?
- Are you currently on blood pressure medication? If so, what medication, dosage, and the last time you have taken the medication?
- Any recent labs drawn in prenatal office related to your blood pressures?
- Any additional history of blood pressure complications outside of pregnancy, during this pregnancy, or in previous pregnancies?

BLOOD PRESSURE COMPETENCY CHECKLIST

DATE:____________________________________

Attempt: 1 2 3

Competency: Obtains both systolic and diastolic blood pressure readings.

Behaviors: 1. Chooses correct size blood pressure cuff.
2. Demonstrates correct procedure for obtaining accurate blood pressure measurement.

Classification: **RN**

Steps:

Steps	RATING SCALE: MEETS	RATING SCALE: DOES NOT MEET
1. Identify patient.		
2. Assist patient to Semi-Fowler's or sitting position with back supported and allow to rest for 5 minutes prior to obtaining blood pressure.		
3. If sitting, patient's feet should be flat, not dangling from exam table or bed, and her legs uncrossed.		
4. Assess for any consumption of caffeine or nicotine within previous 30 minutes.		
5. Instruct patient on need to obtain blood pressure.		
6. Position patient with back supported and arm at heart level with palm turned up.		
7. Bare upper arm of any restrictive clothing.		
8. Select appropriate size cuff (width of bladder 40% of circumference and encircle 80% of arm).		
9. Palpate brachial artery		
10. Position cuff 1" above site of brachial pulsation (antecubital space). Center bladder of cuff above artery.		
11. Assess for proper fit of blood pressure cuff.		
12. Verbalizes that if proper fit is not obtained may use forearm for B/P measurement.		
13. Instruct patient not to talk during B/P measurement		
14. Obtain blood pressure reading using automated or manual method		
15. Document B/P, patient position, and arm in which taken.		
16. Verbalizes that if B/P in severe range (≥ 160/110), recheck B/P in 15 minutes		
TOTAL SCORE		
REQUIRED TO MEET	80%	

* Essential Elements

MEETS ☐ DOES NOT MEET ☐

Verifier Signature____

Employee Signature__________________________________

Adapted with permission from Community Hospital Network