FPQC
Florida Perinatal Quality Collaborative

Hypertension in Pregnancy (HIP) Initiative

August 2016 Learning Session:

Emergency Departments

Partnering to Improve Health Care Quality
for Mothers and Babies

Welcome!

- **Please join by telephone to enter your Audio PIN on your phone or we will be unable to un-mute you for discussion.**
- If you have a question, please enter it in the Question box or Raise your hand to be un-muted.
- This webinar is being recorded.
- Please provide feedback on our post-webinar survey.

Agenda
August 18, 2016

- **HIP Initiative Announcements**
- Hospital Perspectives
  - Randy Katz and Jean Miles, Memorial Healthcare
  - Vida Miller, Broward Health
  - Robin Piaggione, Lee Memorial
- **Q&A**

Announcements: Resources

- Website with archived webinars: http://health.usf.edu/publichealth/chiles/fpqc/hip
- Toolbox: http://health.usf.edu/publichealth/chiles/fpqc/hip_toolbox
  - Newly added: Emergency Department Statement
- Site Visit with or without a Grand Rounds presentation
- Clinical Questions/Technical Assistance – send us your questions any time fpqc@health.usf.edu

New! French/Creole Tear Pads!

English/Spanish Tear Pads *and* Posters

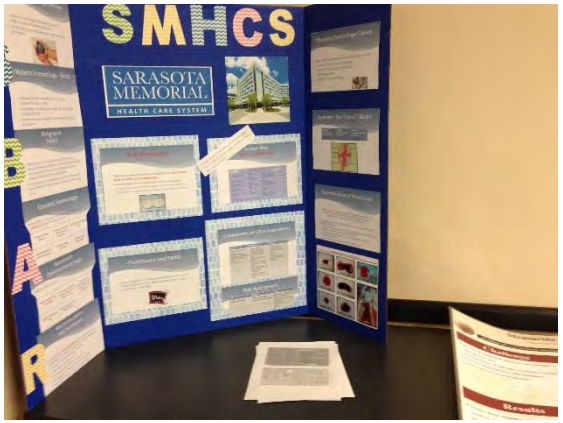
Limited number per hospital at no cost!

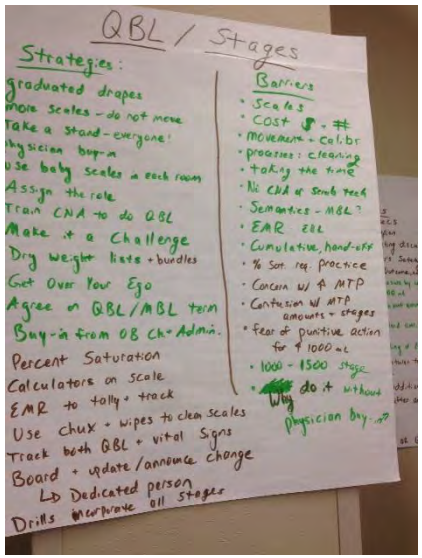
Contact

FPQC@health.usf.edu

Save the Date!
HIP Initiative Mid-Project Meeting
November 10, 2016

Our OHI Mid-Project Meeting was a hit!





Jean Miles, MD

Chief of Obstetric Anesthesia

Randy Katz, DO, FACEP

Chairman, Department of Emergency Medicine

Hypertension in Pregnancy Maternal Safety Bundle Implementation in the Emergency Department

Randy Katz, DO, FACEP
Chief, Emergency Department
Memorial Healthcare System,
Hollywood, Fl
TeamHealth

Jean Miles, MD
Regional Director for
Obstetric Anesthesiology
Memorial Healthcare
System, Hollywood, Fl
Sheridan Healthcare

Memorial Healthcare System

Key Points

- Maternal safety bundles: 4 R's and the Emergency Department's role
- Facility wide standardized care process and Emergency Department
- MHS experience and challenges

Maternal Mortality: tip of the iceberg

- 87 Maternal deaths 1999-2012 in Florida
- “50-100” women who experience “near-miss” or significant morbidity
- The numbers: 4,350- 8, 8700 women with significant medical complications

FPQC Partnering to Improve Health Care Quality for Mothers and Babies

Preeclampsia/Eclampsia Hypertension in Pregnancy

- Incidence 3%-5% of pregnancies
- (12,000 deliveries/year in the MHS system)
- ED major portal for diagnosis and treatment
- Tremendous prevention opportunities

The 4 R's-"every unit"

- Readiness
- Recognition
- Response
- Reporting

COUNCIL ON PATIENT SAFETY
IN WOMEN'S HEALTH CARE
safe health care for every woman

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

COUNCIL ON PATIENT SAFETY IN WOMEN'S HEALTH CARE
safe health care for every woman

READINESS

- Timely Triage
- Rapid access to medications
- Plan for escalation, consultation

READINESS

Diagnostic Criteria: Severe Hypertension

- Severe hypertension that is accurately measured using standard techniques and is persistent for > 15 minutes is considered a ***hypertensive emergency***.

Severe hypertension is defined as:
systolic blood pressure ≥ 160 mm Hg or
diastolic blood pressure ≥ 110 mm Hg

- Severe hypertension can occur during the antepartum, intrapartum, or postpartum period.

COUNCIL ON PATIENT SAFETY IN WOMEN'S HEALTH CARE
safe health care for every woman

FPQC Recommendations

- Administration of antihypertensive medication within one hour of a single or sustained blood pressure measuring:
  - 155 – 160 mm Hg, systolic ***OR***
  - 105 – 110 mm Hg, diastolic

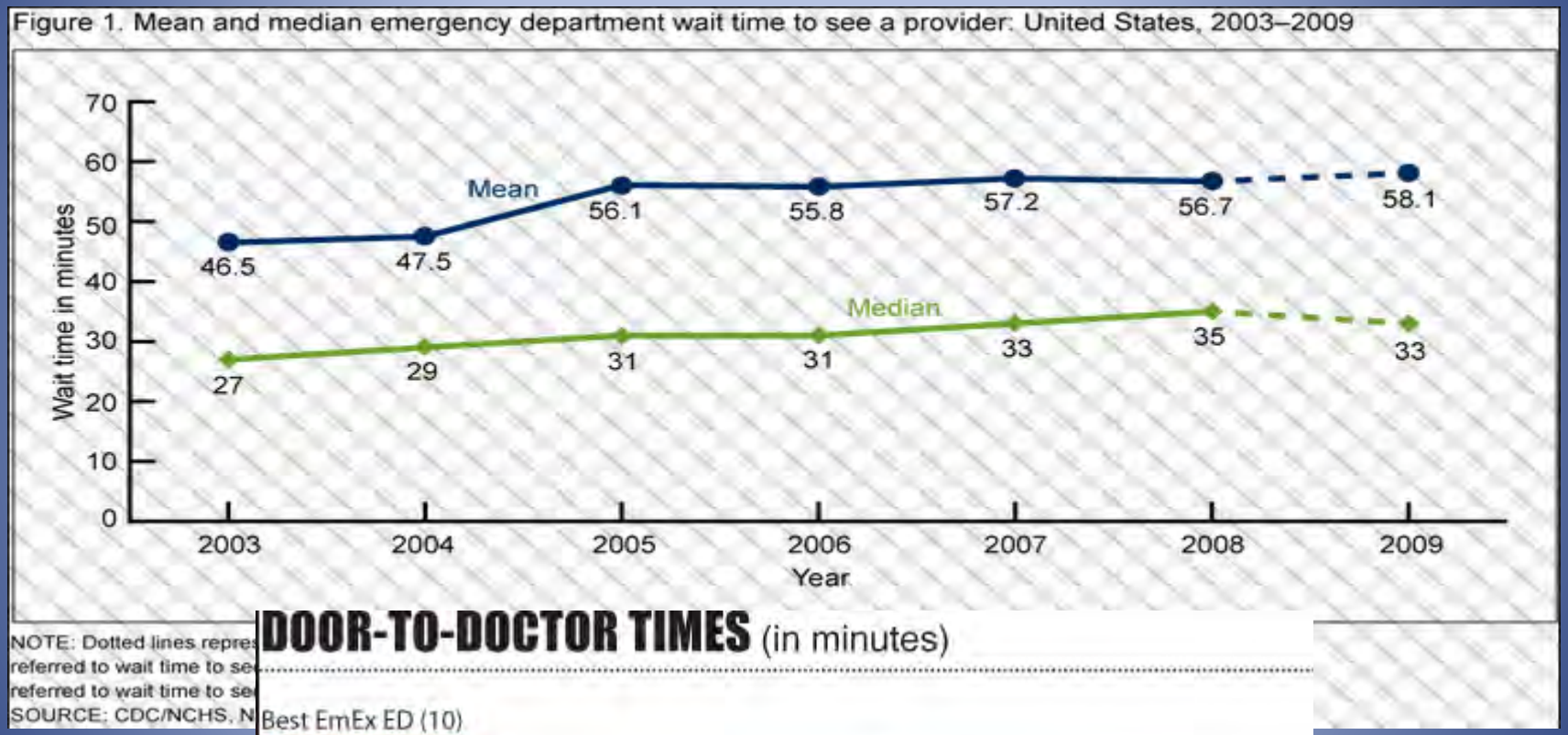
- Decrease blood pressure by no more than 10 – 15% first hour

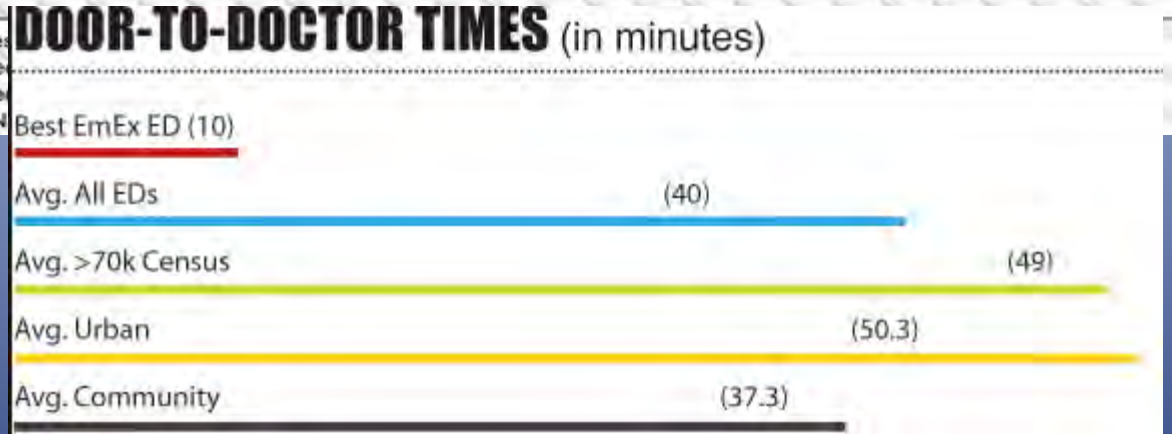
FPQC
Partnering to Improve Health Care Quality for Mothers and Babies

ED specific challenges to one hour treatment

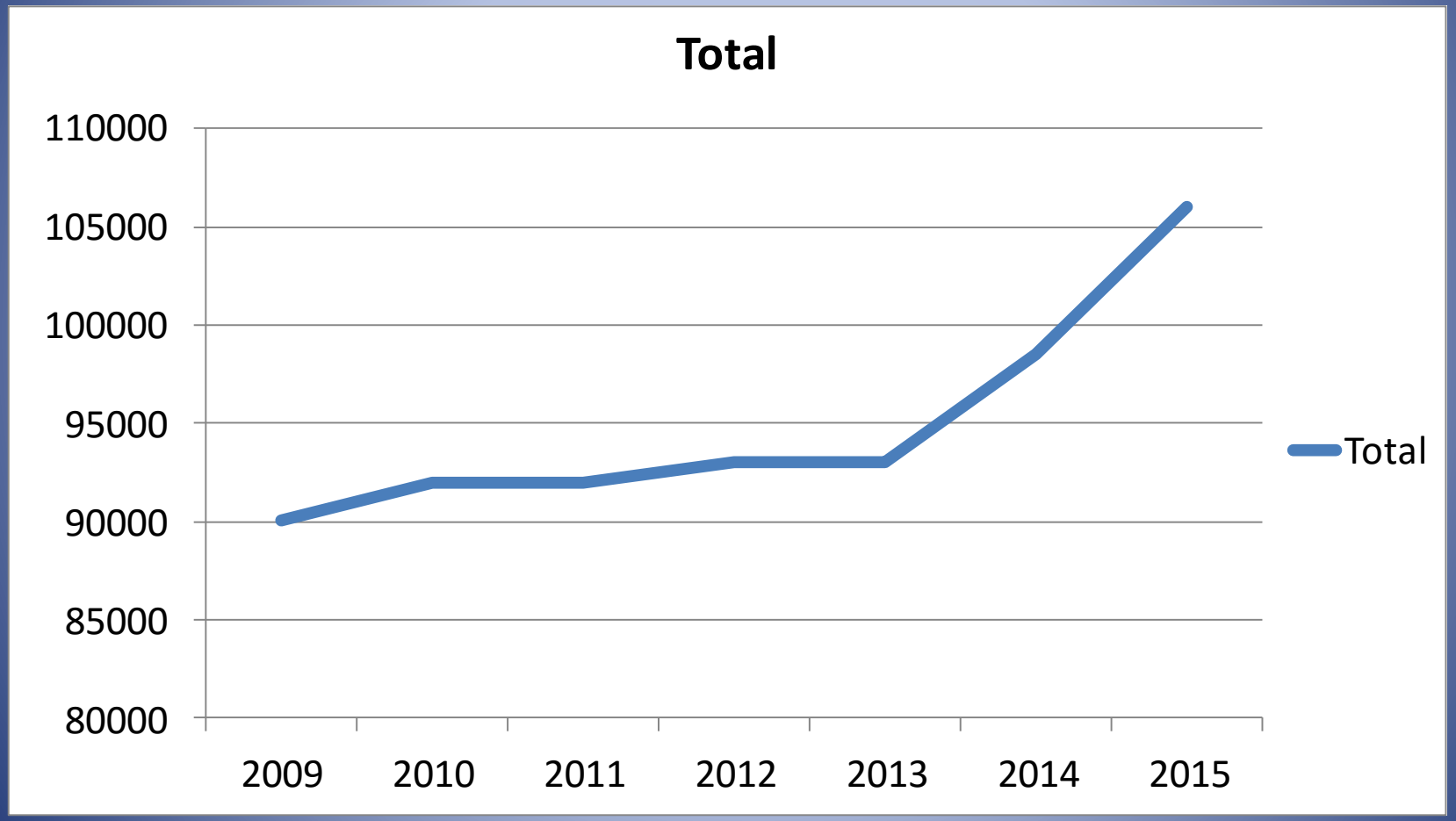
- Lack of recognition by triage staff (education)
- Standard BP parameters that lead to consistent response
- L&D triage vs ED triage
- Inconsistent threshold for treatment
- Wait times and boarding/ED capacity
- Inconsistent response from consulting OB's
- Alert fatigue (stroke, trauma, sepsis, cardiac)

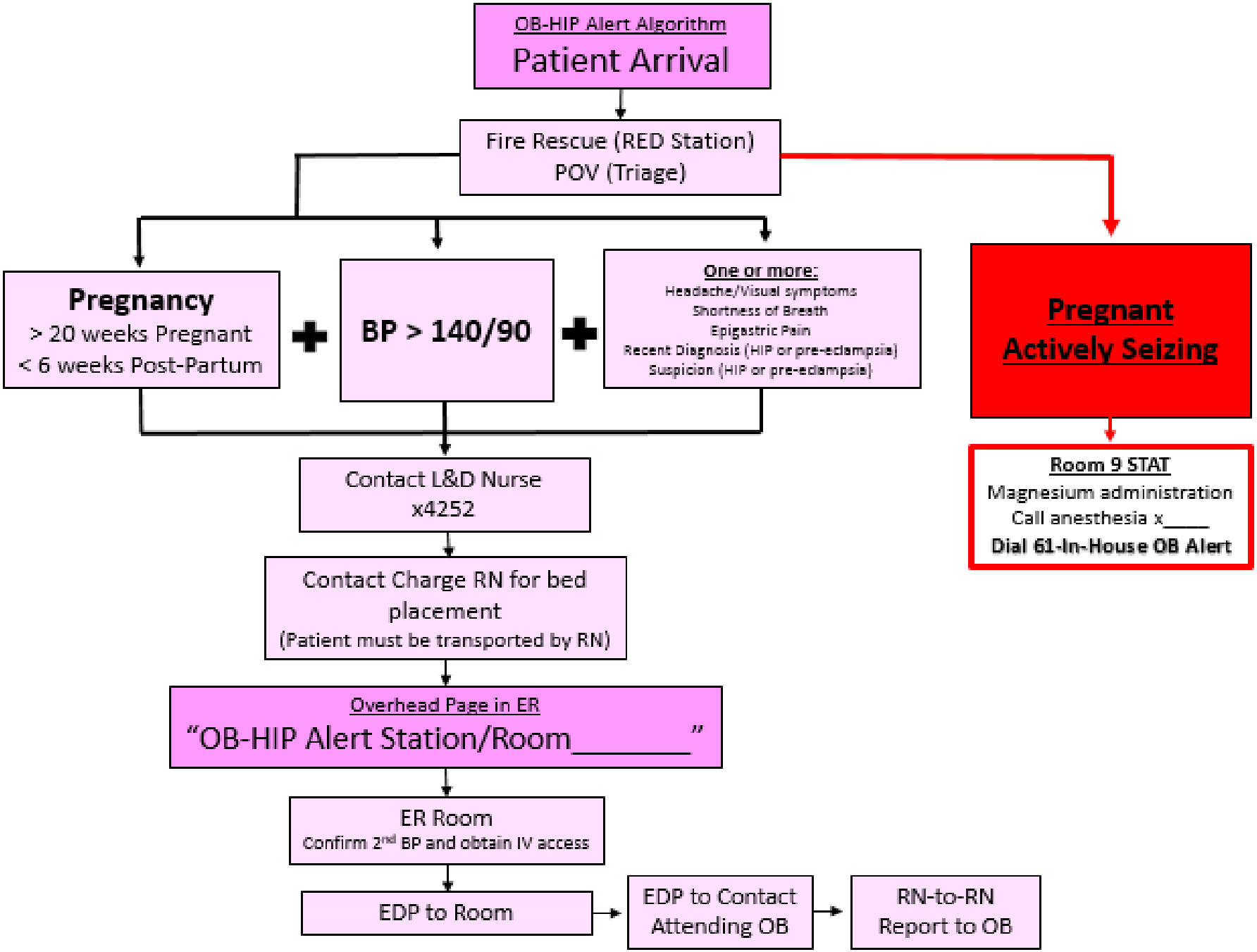
ED specific challenges to one hour treatment





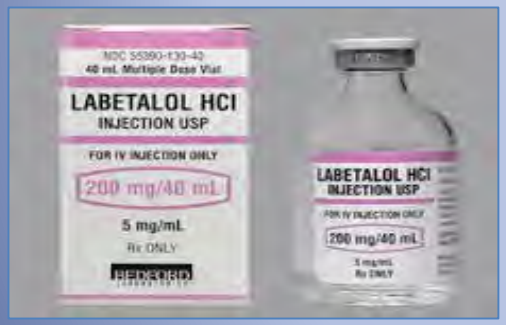
MRH ED VOLUME (2009-2015)




OB-HIP Alert Algorithm
Patient Arrival
Fire Rescue (RED Station)
POV (Triage)
Pregnancy
> 20 weeks Pregnant
< 6 weeks Post-Partum
BP > 140/90
One or more:
Headache/Visual symptoms
Shortness of Breath
Epigastric Pain
Recent Diagnosis (HIP or pre-eclampsia)
Suspicion (HIP or pre-eclampsia)
Pregnant Actively Seizing
Room 9 STAT
Magnesium administration
Call anesthesia x____
Dial 61-In-House OB Alert
Contact L&D Nurse
x4252
Contact Charge RN for bed placement
(Patient must be transported by RN)
Overhead Page in ER
"OB-HIP Alert Station/Room_____"
ER Room
Confirm 2nd BP and obtain IV access
EDP to Room
EDP to Contact Attending OB
RN-to-RN Report to OB

READINESS

First line treatment for hypertensive emergency



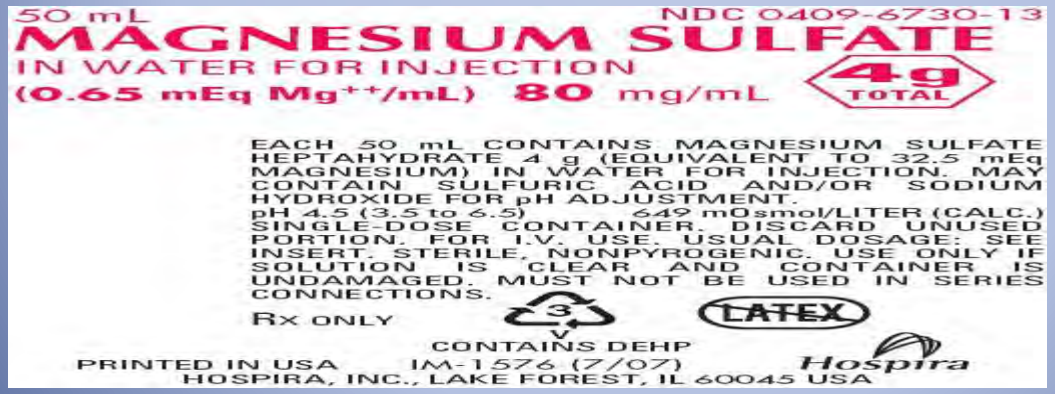
Labetalol IV OR Hydralazine IV

READINESS

First line treatment for hypertensive emergency

MAGNESIUM SULFATE IV

Magnesium 4 gram bolus IV over 20 min followed by Magnesium 1-2 gram/hour continuous infusion



Anti-seizure

Magnesium is NOT an antihypertensive

READINESS

- Know where antihypertensive and magnesium medications are stored
- Know doses, infusion pump libraries/pharmacy involvement
- Obtain appropriate consult

MHS Emergency Department Order Set for HIP

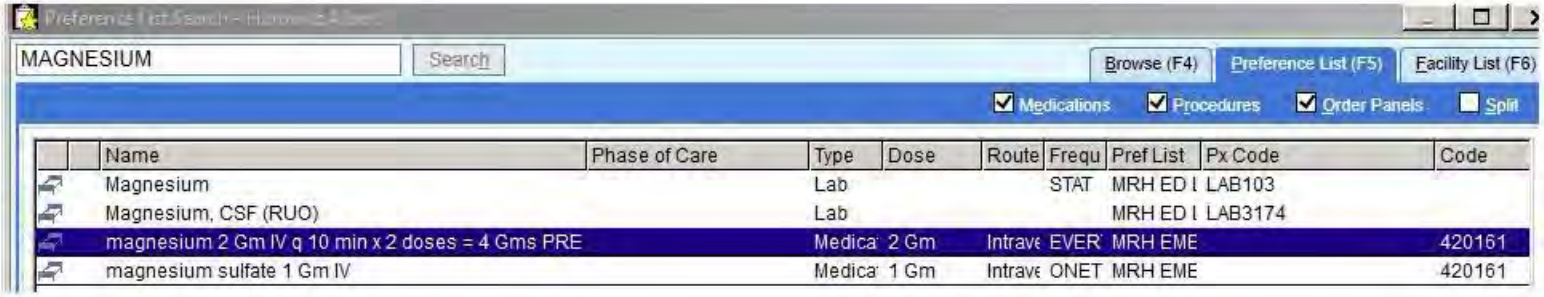
- Improves efficiency
- Consistent choice of medication
- Consistent dosing of medications
- Nursing orders consistent
- Includes nursing orders, diagnostics and medications

EHR order sets

Good afternoon,

We now have a Magnesium 4g bolus order specific for Preeclampsia in EPIC (see highlighted below). The order will populate in the Pyxis and the nurse will give two 2g Boluses c
post partum patients (up to 6 weeks). Going forward please use this order for Magnesium bolus in Preeclampsia.

We will be working on creating an ED order set for Preeclampsia that includes all of the diagnostic and treatment orders as well as an improved transfer algorithm with L&D.



Randy S. Katz, D.O., FACEP
Chairman, Department of Emergency Medicine
Memorial Regional Hospital
Hollywood, Florida
Medical Director
Hollywood Fire Rescue
Medics Ambulance Service
Office: 954-265-3063
Cell: 786-325-4860

RECOGNITION & PREVENTION

Postpartum Preeclampsia/Eclampsia

- Incidence difficult to obtain - 0.3% of all post partum ED admissions due to hypertension and preeclampsia
- Symptomatology for days prior to presentation

Emergency department use during the postpartum period: implications for current management of the puerperium

Steven L. Clark, MD, Michael A. Belfort, MD, PhD, Gary A. Dildy, MD, Jane Englebright, PhD, Laura Meints, MD, Janet A. Meyers, RN, Donna K. Frye, RN, Jonathan A. Perlin, MD, PhD
Hospital Corporation of America, Nashville, TN

RECOGNITION & PREVENTION

- Have you been pregnant with in the last 6 weeks?
- Contribution of Non-steroidal medications to increase blood pressure
- Most common complaint: Headache

COUNCIL ON PATIENT SAFETY IN WOMEN'S HEALTH CARE
safe health care for every woman

DDX: Postpartum headache

- Tension headache 39%
- Migraine 11-34%
- Musculoskeletal 11-15 %
- Preeclampsia/Eclampsia 8-24 %
- Post-dural puncture Headache 5-16%
- Cortical vein thrombosis 3%
- Subarachnoid Hemorrhage 1 %
- PRES
- Brain tumor
- Subdural hematoma
- Cerebral infarction
- Pseudotumor cerebri
- Sinusitis
- Meningitis
- Pneumocephalus
- Caffeine withdrawl
- Lactation headache

RESPONSE

ED peripartum checklist:

If BP > 160/110 or 140/90 with:

— Unremitting headaches

— Visual disturbance

— Epigastric pain

Begin stabilization
Call for Obstetric consult immediately

Labs should include:

— CBC

— PT

— PTT

— Fibrinogen

— CMP

— Uric Acid

— Hepatic function panel — Type and Screen

Initiate Intravenous Access

RESPONSE

ED peripartum checklist:

[ ] Assess neurologic status
- LOC/arousal/orientation/behavior
- Deep tendon reflexes
- Speech

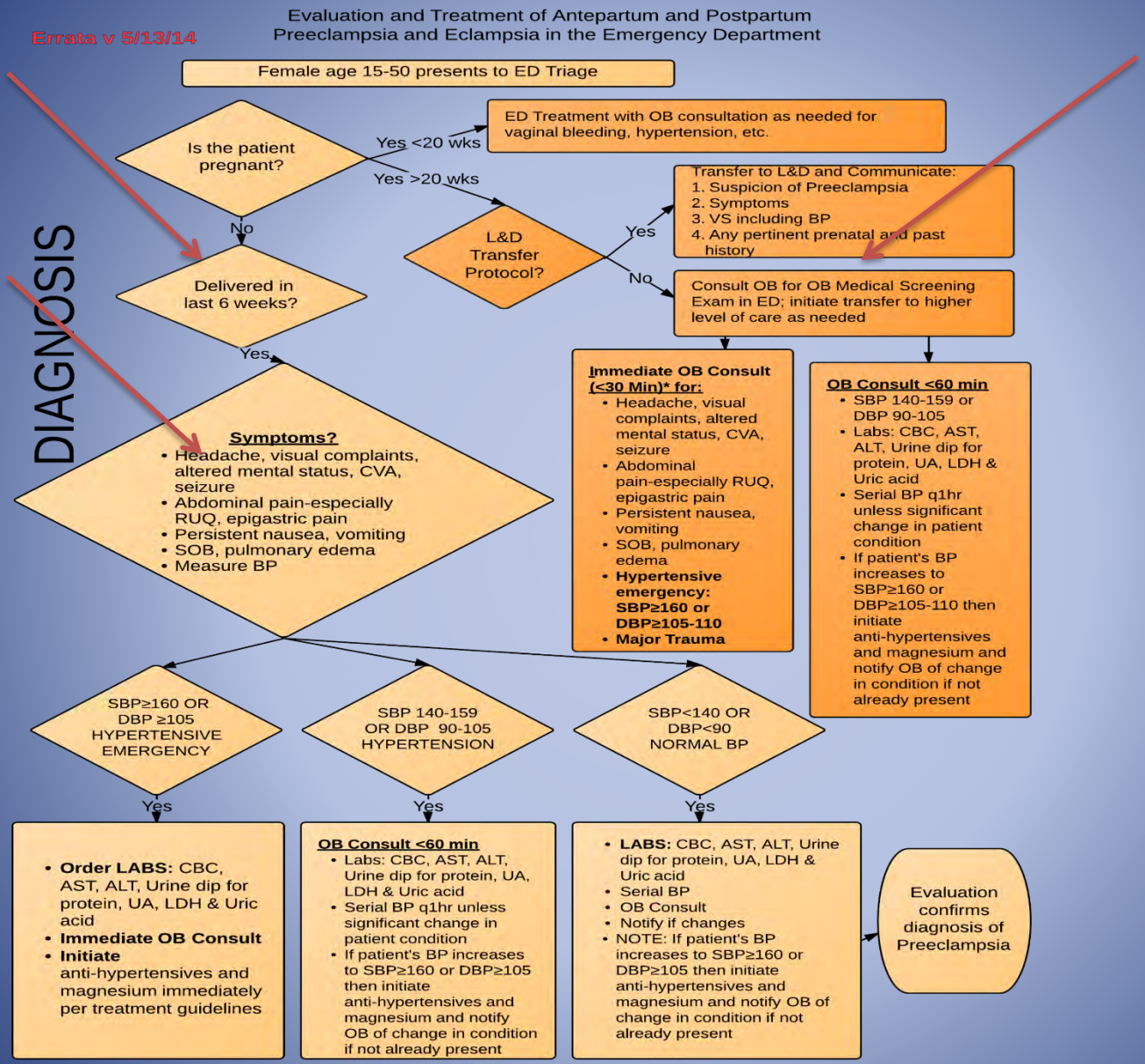
[ ] Assess vital signs including oxygen saturation

[ ] Assess complaints and report; unremitting headaches, epigastric pain, visual disturbances, speech difficulties, lateralizing neuro signs

[ ] Place Foley catheter

[ ] Strict I&O report output less than *30 ml/hr for 2 hours*

[ ] Plan brain imaging studies if:
- Unremitting headache
- Focal signs and symptoms
- Uncontrolled high blood pressure
- Lethargy
- Confusion
- Seizures
- Abnormal neurologic examination



PATIENT SAFETY BUNDLE

Hypertension

REPORTING/SYSTEMS LEARNING

- QI opportunities: treatment with in one hour of hypertensive crisis
- Data collection drives improvement
- Formal meeting to identify any systems issues or breakdowns in outcome events
- Multidisciplinary review of all severe hypertension/eclampsia cases admitted to the ICU

Patient Education

Pre Eclampsia hand outs and posters available through www. preeclampsia.org

PREECLAMPSIA foundation

Summary of Safety Bundle

- ED has tremendous import in patient treatment and “near miss” intervention
- Hypertension treatment within one hour
- High Index of suspicion for postpartum hypertension up to 6 weeks post delivery
- Standardization of process and reduction in variation can improve outcomes

Vida Miller, BSN, RNC

Clinical Specialist

Broward Health Medical Center

“HIP” in the ED

Vida Miller, RN, BSN, RNC
Perinatal Clinical Specialist

BROWARD HEALTH

Care Warriors

BROWARD HEALTH
MEDICAL CENTER
Maternity Place

HIP in the ED

- Meeting to discuss vision
  - Understanding the current ED workflow
  - Proper screening to recognizing patients at risk in ED triage
  - Appropriate area for assessment and treatment
  - Collaboration with ED pharmacy for medication availability
  - Develop workflow for staff
- Development of Algorithm
- Development of ED care set for HIP patients
- Staff and Physician education

ALGORITHM

Triggers:

Are you pregnant?

or

Have you recently given birth within the last 6 weeks?

If yes

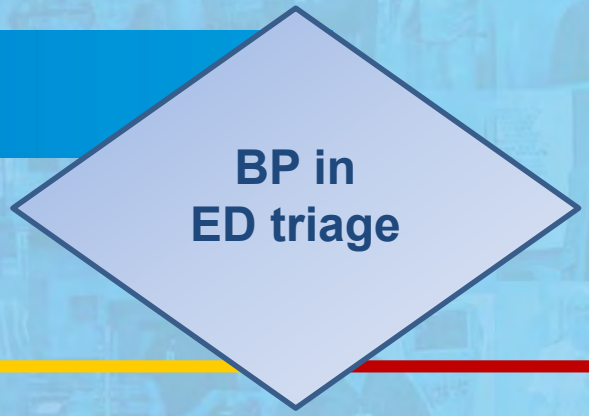
Do you have any of the following symptoms present?

- Headache
- Blurred vision, spots
- Altered mental status
- Seizures
- Abdominal pain
  - RUQ
  - Epigastric pain
- Persistent nausea, vomiting
- Pitting edema
- Swollen face, hands, & feet
- Muscle twitching
- Shortness of breath

YES

Measure BP in ED triage

ALGORITHM



BP ≥ 140/90

- Notify ED MD
- Transfer to ED-yellow
- Orders for CBC, AST, ALT, UA, LDH, Uric Acid
- Serial BP q 1 hour
- Consult OB
- If BP increases to >160/110, initiate severe preeclamspia treatment within 30 minutes

BP ≥ 160/110
X 2- 15 minutes apart

- Notify ED MD STAT
- Initiate HIP ED Care Set Orders: Procardia, Magnesium, CBC, AST, ALT, UA, LDH, Uric Acid
- Ensure IV access
- OB consult
- Prepare for admission
- **Initiate severe preeclampsia treatment within 30 minutes**

ED HIP CARE SET

OBGYN Pregnancy Induced Hypertension
LABORATORY

- ☑ CBC w/Auto Diff
  STAT, T;N, Blood
- ☑ PT INR
  STAT, T;N, Blood
- ☑ PTT
  STAT, T;N, Blood
- ☑ CMP
  STAT, T;N, Blood
- ☑ Fibrinogen Level
  STAT, T;N, Blood
- ☑ Uric Acid
  STAT, T;N, Blood
- ☑ Urinalysis
  STAT, T;N, Urine

CONSULTS

- ☑ Notify (Notify/Call)
  T;N, STAT, private OBGYN or on-call OBGYN, *ONCE*

MEDICATIONS
For blood pressure *equal to or greater than 160 mmHg SBP or 110 mmHg DBP (NOTE)**

Antihypertensives: Check a drug from each steps 1-4 below(NOTE)*
*Oral Nifedipine protocol (must check one order from each step 1-4 below)(NOTE)**

STEP 1:(NOTE)*

- ☐ NIFEdipine 10 mg oral capsule
  10 mg, PO, CAP, ONCE, STEP 1. Give if SBP is > 160 mmHg or DBP > 110 mmHg. Reassess BP after 20 minutes and proceed to STEP 2 if needed.

STEP 2:(NOTE)*

- ☐ NIFEdipine 10 mg oral capsule
  20 mg, PO, CAP, ONCE, STEP 2. Give 20 minutes after STEP 1 if SBP is > 160 mmHg or DBP > 110 mmHg. Reassess BP 20 minutes after last dose and proceed to STEP 3 if needed.

STEP 3:(NOTE)*

- ☐ NIFEdipine 10 mg oral capsule
  20 mg, PO, CAP, ONCE, STEP 3. Give 20 minutes after STEP 2 if SBP is > 160 mmHg or DBP > 110 mmHg. Reassess BP 20 minutes after last dose and proceed to STEP 4 if needed.

STEP 4: IV Labetalol will be given if BP threshold is exceeded and patient is unresponsive to oral Nifedipine.(NOTE)*

- ☐ Normodyne (labetalol)
  40 mg, IVP, INJ, ONCE, PRN Hypertension, STEP 4. Give 20 minutes after STEP 3 if SBP is still > 160 mmHg or DBP is still >110 mmHg. Reassess BP 10 minutes after giving; if BP still exceeds threshold, contact physician for additional order.
  Comments: IV Push over 2 minutes

ED HIP CARE SET

Seizure Prophylaxis (BP equal or greater than 160 SBP or 110 mmHg DBP)(NOTE)*

*Magnesium Protocol for Gestational Hypertension:(NOTE)**

Magnesium Loading dose

☐ magnesium sulfate 4 gm/100 mL SWFI Premix IVPB

4 gm = 100 mL, IV, IVPB, ONCE, Infuse: 200 mL/hr, Infuse Over 30 min(s), Loading Dose.

Comments: Call pharmacy for dose

IV Solutions(NOTE)*

☐ Sodium Chloride 0.9%

1,000 mL, IV, IV SOLN, Rate: 100 mL/hr

☐ Dextrose 5% with 0.45% NaCl

1,000 mL, IV, IV SOLN, Rate: 100 mL/hr

PATIENT CARE

☐ Vital Signs

Routine,

Comments: Repeat BP Q 20 minutes. Additional BP monitoring as per prescriber.

☐ Vital Signs

Routine, For Gestational Hypertension Treatment (BP equal or greater than 160 SBP or 110 mmHg DBP)

Comments: Repeat BP 20 minutes after each Nifedipine dose and 10 minutes after each Labetalol dose. Once BP threshold achieved (SBP < 160 mmHg and DBP < 110 mmHg), repeat BP every 10 minutes x 1 hour, then every 15 minutes x 1 hour, then every 30 minutes x 1 hour, and then hourly x 4 hours. Additional BP monitoring as per prescriber.


BROWARD HEALTH®
A Team of Care ~~Workers~~
Warriors

Robin Piaggione

MSN, RNC-OB,C-EFM, CBC

OB Educator

Lee Memorial Health System

Lee Memorial Health System

Robin Piaggione, MSN, RNC- OB, C-EFM, CBC

Who we are

6-hospital system in SW FL

- 3 hospitals perform OB services
- Perform ~1400, 1600, 3500 deliveries per year
- I RIPCC center
- Level II And III nursery

Step 1:
Policy Development

HYPERTENSION/PREECLAMPSIA CARE GUIDELINES IN PREGNANCY

PURPOSE:

To provide guidelines for measurement of blood pressure and the management of preeclampsia/eclampsia

Timing is Everything!

I was asked to participate in the ER Skills Fair

Precipitous Delivery

Or

Opportunity!!

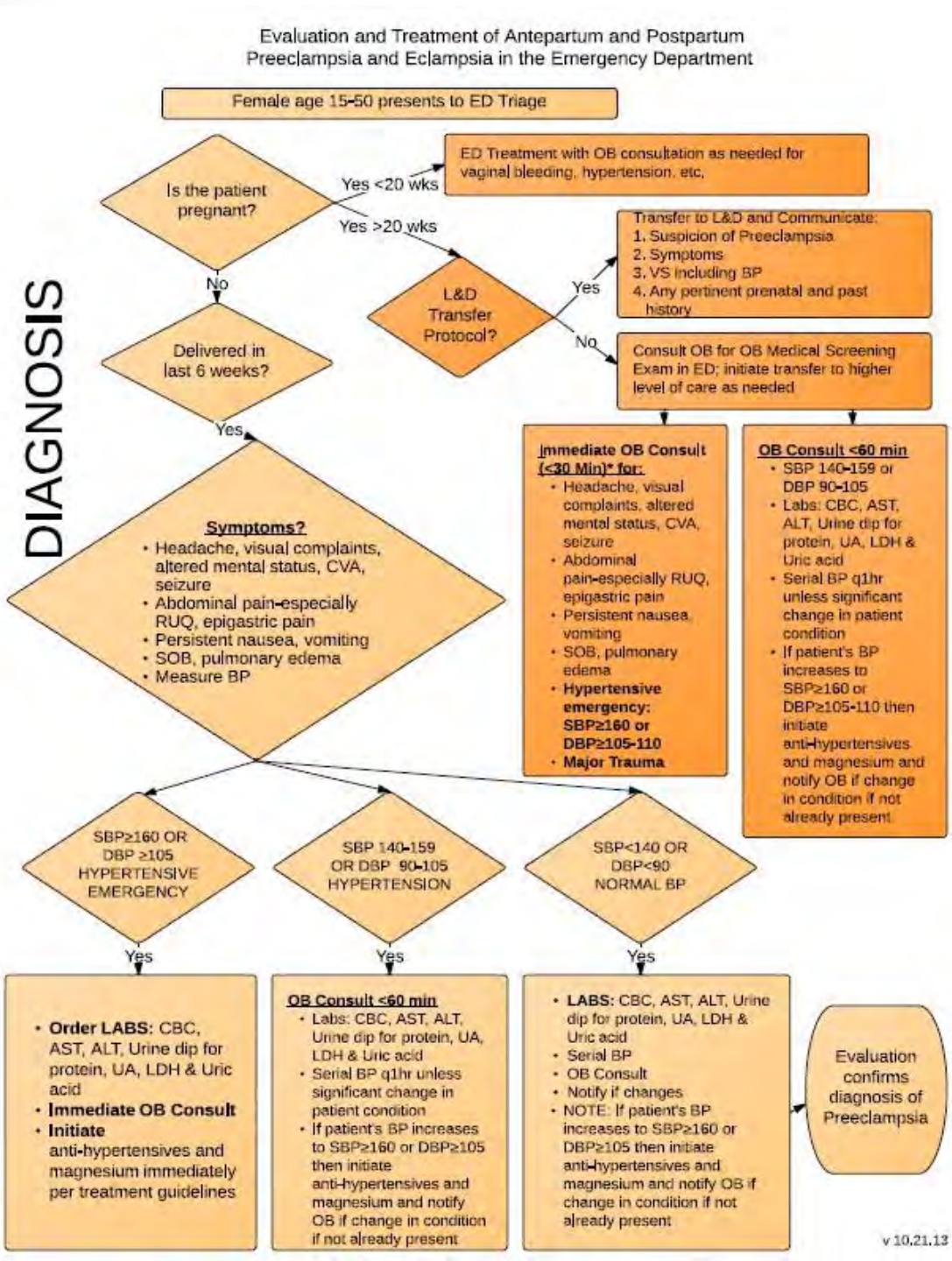
Obstetrical Emergencies

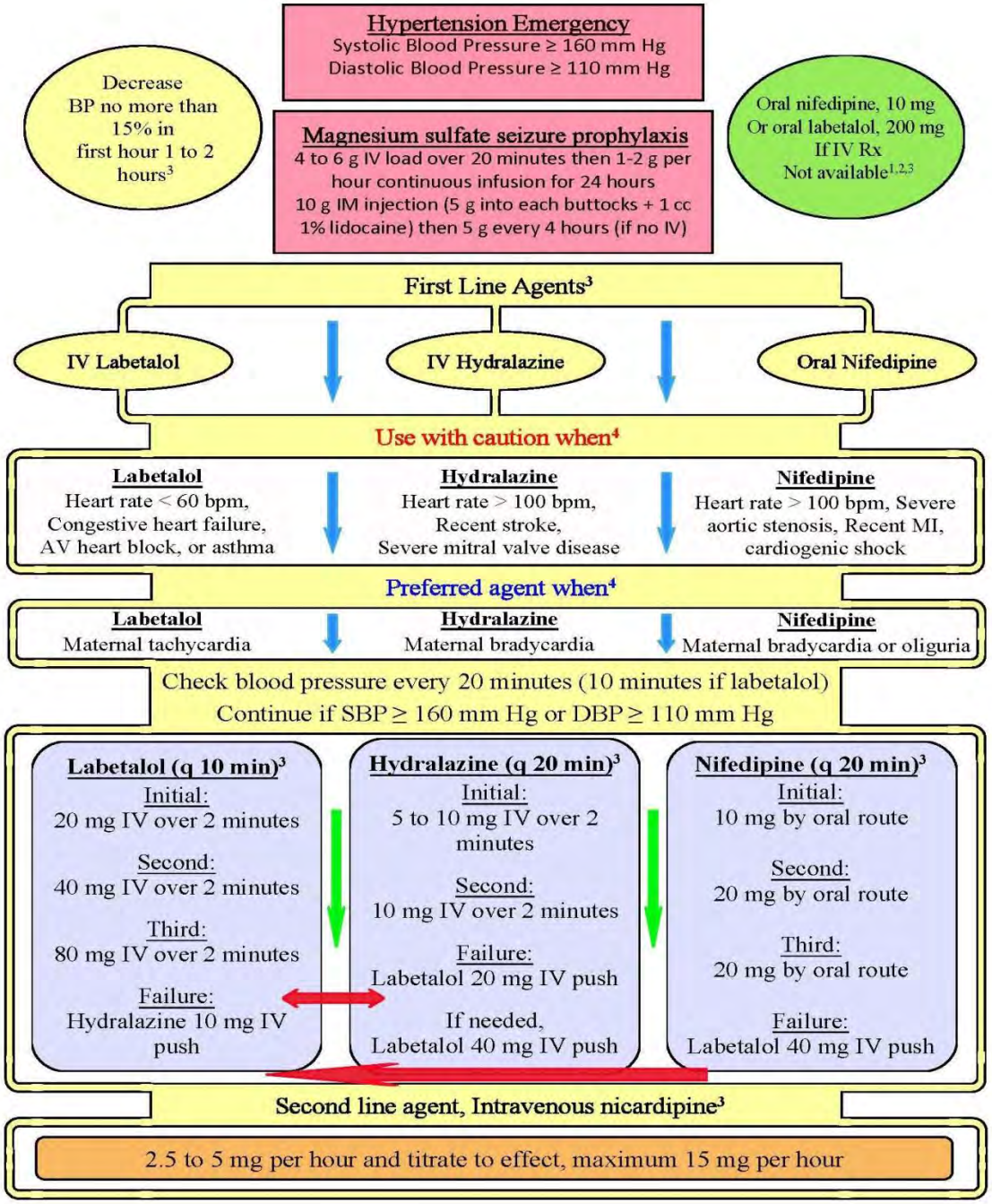
- Cord Prolapse
- Shoulder dystocia
- Breech presentation
- Placenta Previa
- Placenta Abruption
- **Preeclampsia/Eclampsia**

Preeclampsia/Eclampsia

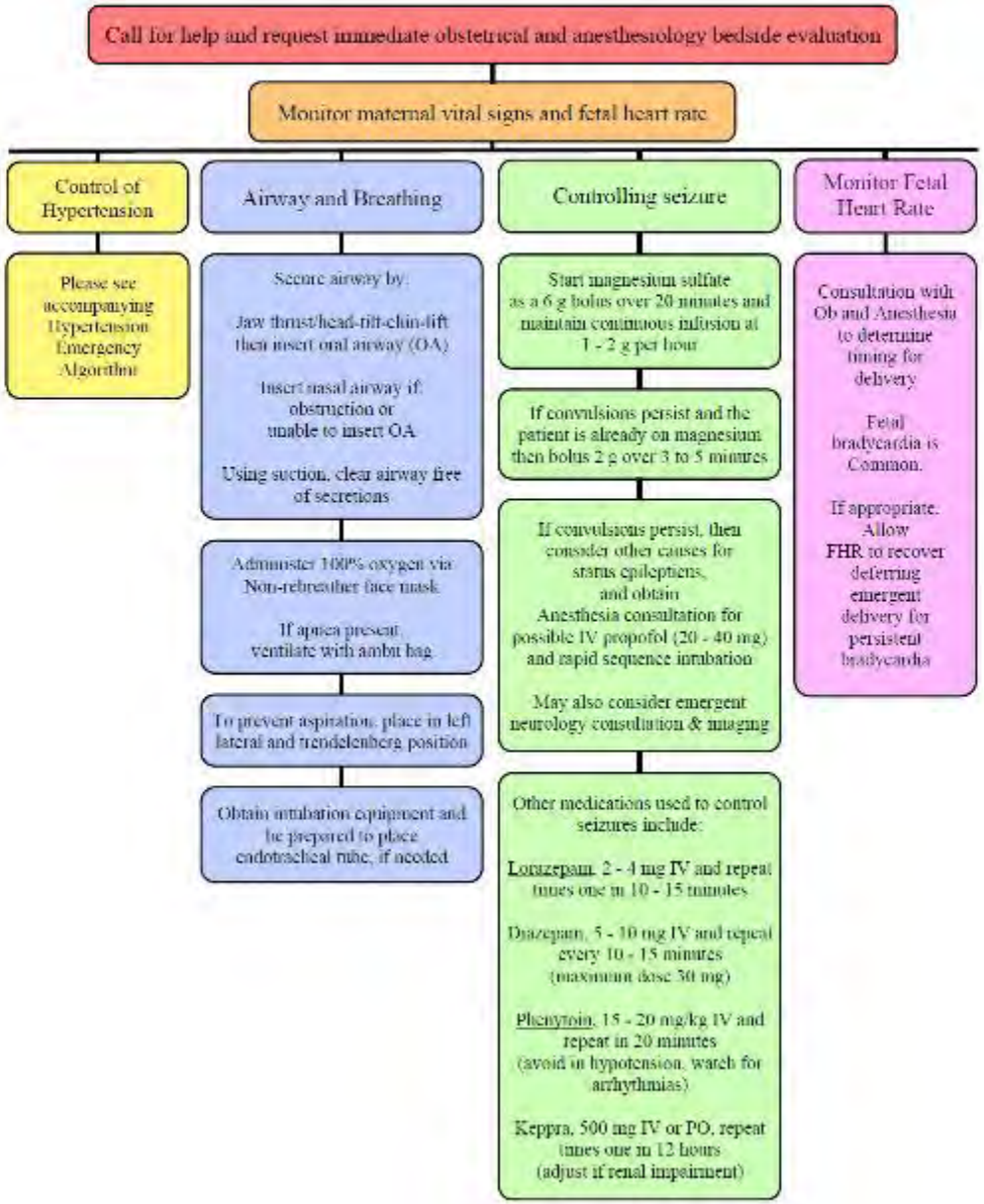
Definition of Preeclampsia with Severe Features

- Systolic blood pressure greater than 160 mm Hg or diastolic blood pressure greater than 105-110 mm Hg (*check blood pressure within 15 minutes to confirm since persistent elevation greater 160 mm Hg or 110 mm Hg is a hypertensive emergency- do not change position*)
- CNS symptoms (headache or visual disturbances)
- Pulmonary edema
- Platelet count less than 100,000/microliter
- Elevation serum transaminases more than 2 times over baseline or ALT greater than 70
- Serum creatinine level greater than 1.1 mg/dL or doubling of serum creatinine
- HELLP syndrome
- Generalized tonic clonic seizure = Eclampsia


Evaluation and Treatment of Antepartum and Postpartum Preeclampsia and Eclampsia in the Emergency Department
DIAGNOSIS
Female age 15-50 presents to ED Triage
Is the patient pregnant?
Yes <20 wks
ED Treatment with OB consultation as needed for vaginal bleeding, hypertension, etc.
Yes >20 wks
No
L&D Transfer Protocol?
Yes
Transfer to L&D and Communicate:
1. Suspicion of Preeclampsia
2. Symptoms
3. VS including BP
4. Any pertinent prenatal and past history
No
Consult OB for OB Medical Screening Exam in ED; initiate transfer to higher level of care as needed
Delivered in last 6 weeks?
Yes
Symptoms?
• Headache, visual complaints, altered mental status, CVA, seizure
• Abdominal pain-especially RUQ, epigastric pain
• Persistent nausea, vomiting
• SOB, pulmonary edema
• Measure BP
Immediate OB Consult (<30 Min)* for:
• Headache, visual complaints, altered mental status, CVA, seizure
• Abdominal pain-especially RUQ, epigastric pain
• Persistent nausea, vomiting
• SOB, pulmonary edema
• Hypertensive emergency: SBP≥160 or DBP≥105-110
• Major Trauma
OB Consult <60 min
• SBP 140-159 or DBP 90-105
• Labs: CBC, AST, ALT, Urine dip for protein, UA, LDH & Uric acid
• Serial BP q1hr unless significant change in patient condition
• If patient's BP increases to SBP≥160 or DBP≥105-110 then initiate anti-hypertensives and magnesium and notify OB if change in condition if not already present
SBP≥160 OR DBP ≥105 HYPERTENSIVE EMERGENCY
SBP 140-159 OR DBP 90-105 HYPERTENSION
SBP<140 OR DBP<90 NORMAL BP
Yes
Yes
Yes
• Order LABS: CBC, AST, ALT, Urine dip for protein, UA, LDH & Uric acid
• Immediate OB Consult
• Initiate anti-hypertensives and magnesium immediately per treatment guidelines
OB Consult <60 min
• Labs: CBC, AST, ALT, Urine dip for protein, UA, LDH & Uric acid
• Serial BP q1hr unless significant change in patient condition
• If patient's BP increases to SBP≥160 or DBP≥105 then initiate anti-hypertensives and magnesium and notify OB if change in condition if not already present
• LABS: CBC, AST, ALT, Urine dip for protein, UA, LDH & Uric acid
• Serial BP
• OB Consult
• Notify if changes
• NOTE: If patient's BP increases to SBP≥160 or DBP≥105 then initiate anti-hypertensives and magnesium and notify OB if change in condition if not already present
Evaluation confirms diagnosis of Preeclampsia
v 10.21.13


Hypertension Emergency
Systolic Blood Pressure ≥ 160 mm Hg
Diastolic Blood Pressure ≥ 110 mm Hg
Decrease BP no more than 15% in first hour 1 to 2 hours[3]
Magnesium sulfate seizure prophylaxis
4 to 6 g IV load over 20 minutes then 1-2 g per hour continuous infusion for 24 hours
10 g IM injection (5 g into each buttocks + 1 cc 1% lidocaine) then 5 g every 4 hours (if no IV)
Oral nifedipine, 10 mg
Or oral labetalol, 200 mg
If IV Rx Not available[1,2,3]
First Line Agents[3]
IV Labetalol
IV Hydralazine
Oral Nifedipine
Use with caution when[4]
Labetalol
Heart rate < 60 bpm, Congestive heart failure, AV heart block, or asthma
Hydralazine
Heart rate > 100 bpm, Recent stroke, Severe mitral valve disease
Nifedipine
Heart rate > 100 bpm, Severe aortic stenosis, Recent MI, cardiogenic shock
Preferred agent when[4]
Labetalol
Maternal tachycardia
Hydralazine
Maternal bradycardia
Nifedipine
Maternal bradycardia or oliguria
Check blood pressure every 20 minutes (10 minutes if labetalol)
Continue if SBP ≥ 160 mm Hg or DBP ≥ 110 mm Hg
Labetalol (q 10 min)[3]
Initial: 20 mg IV over 2 minutes
Second: 40 mg IV over 2 minutes
Third: 80 mg IV over 2 minutes
Failure: Hydralazine 10 mg IV push
Hydralazine (q 20 min)[3]
Initial: 5 to 10 mg IV over 2 minutes
Second: 10 mg IV over 2 minutes
Failure: Labetalol 20 mg IV push
If needed, Labetalol 40 mg IV push
Nifedipine (q 20 min)[3]
Initial: 10 mg by oral route
Second: 20 mg by oral route
Third: 20 mg by oral route
Failure: Labetalol 40 mg IV push
Second line agent, Intravenous nicardipine[3]
2.5 to 5 mg per hour and titrate to effect, maximum 15 mg per hour

Management of Eclampsia Algorithm




The End

New Emergency Department Statement

Florida Perinatal Quality Collaborative

Hypertension in Pregnancy (HIP) Initiative
Emergency Department Guidance

The Florida Perinatal Quality Collaborative (FPQC) and its partners have implemented an initiative focused on prevention of severe maternal morbidity and mortality related to Hypertension in Pregnancy (HIP). The initiative follows national recommendations developed by the Council on Patient Safety in Women's Health Care. One of the challenges of the initiative is the broad range of touch points for pregnant women: from the prenatal through the postpartum period there are many community partners and hospital departments who may encounter a woman experiencing hypertension in pregnancy. The Emergency Department is a key player in assessing and managing these women.

The following information, excerpted from the FPQC HIP Toolkit, provides a succinct statement of needed interventions and coordination with EDs. Emergency Departments are urged to coordinate with the Obstetrics Departments and providers in their area to assure that policies and protocols are in place to standardize responses. Obstetric providers need to know when postpartum emergencies occur and be a part of management of these patients.

EMERGENCY DEPARTMENT RECOGNITION AND TREATMENT

Focus on Recognition of Hypertensive Disorders in Pregnancy and Delayed Postpartum Preeclampsia

- In Florida, hypertensive disorders accounted for 15.5% of pregnancy-related deaths from 1999-2012, representing one of the leading causes of maternal death.
- Intracerebral hemorrhage is the leading cause of death attributed to hypertensive related emergencies during pregnancy and the postpartum period. Because gravid and recently gravid patients have a lower ability to autoregulate blood pressure within the central nervous system, they are more likely to suffer a hemorrhagic stroke when the systolic blood pressure exceeds 160 mm Hg and/or when the diastolic blood pressures exceed 110 mm Hg. Administration of escalating antihypertensive medication within one hour of these confirmed blood pressure thresholds can decrease the risk for hemorrhagic stroke and death.
- Up to 26% of eclamptic seizures occur beyond 48 hours and as late as 4-6 weeks postpartum, therefore it is not uncommon for these patients to present to the Emergency Department (ED).
- Proper assessment and identification of preeclampsia is essential. Women of childbearing age that present with common symptoms of preeclampsia should be questioned about a current or recent pregnancy.
- It is imperative that Emergency Department personnel be comfortable with diagnosis of and initial management of these cases and prompt obstetric consultation is always necessary.
- Systolic BP >160 or diastolic BP >110 in pregnant or postpartum women is considered a hypertensive emergency. Delays in aggressive management of hypertensive emergency is associated with stroke and other adverse outcomes. All emergency department personnel should be aware of this association and initiate the Diagnosis Algorithm for Emergency Departments.

FPQC
Florida Perinatal Quality Collaborative

FPQC
Florida Perinatal Quality Collaborative

Partnering to Improve Health Care Quality
for Mothers and Babies

DISCUSSION

If you have a question, please enter it in the Question box or Raise your hand to be un-muted.

We can only unmute you if you have dialed your Audio PIN (shown on the GoToWebinar side bar).