

## Problem Statement

Delays in recognition, appropriate treatment, and timely escalation of care for obstetric patients with sepsis contribute to adverse outcomes, including severe sepsis, septic shock, and death

Focus Area  
Maternal Sepsis

Status  
Implementing

## Measures

State Surveillance - Cases Coded as Sepsis During the Birth Admission

## Key Interventions

### Patient Education

- ACOG Urgent Maternal Warning Signs handout added to postpartum discharge folders
- Education reviewed with patients prior to discharge

### Clinical Integration

- Handout embedded in the EMR and attached to discharge instructions via Clinical References

### Interdisciplinary Oversight

- OB representation added to the bi-monthly Hospital Sepsis Committee
- All obstetric sepsis fallouts reviewed collaboratively

## Results

No cases of maternal sepsis identified in 2025  
(0/1,117 births)

## What We'd Like To Learn

- Which additional early warning indicators best support timely recognition of maternal sepsis?
- How can escalation pathways be further streamlined across obstetric and critical care teams?
- What best practices from peer institutions can strengthen prevention and response efforts?