

## Problem Statement

**Maternal sepsis remains a leading cause of maternal mortality worldwide, with an estimated 261,000 annual deaths.**

*Globally, maternal sepsis is estimated at 5.7 million cases each year.*

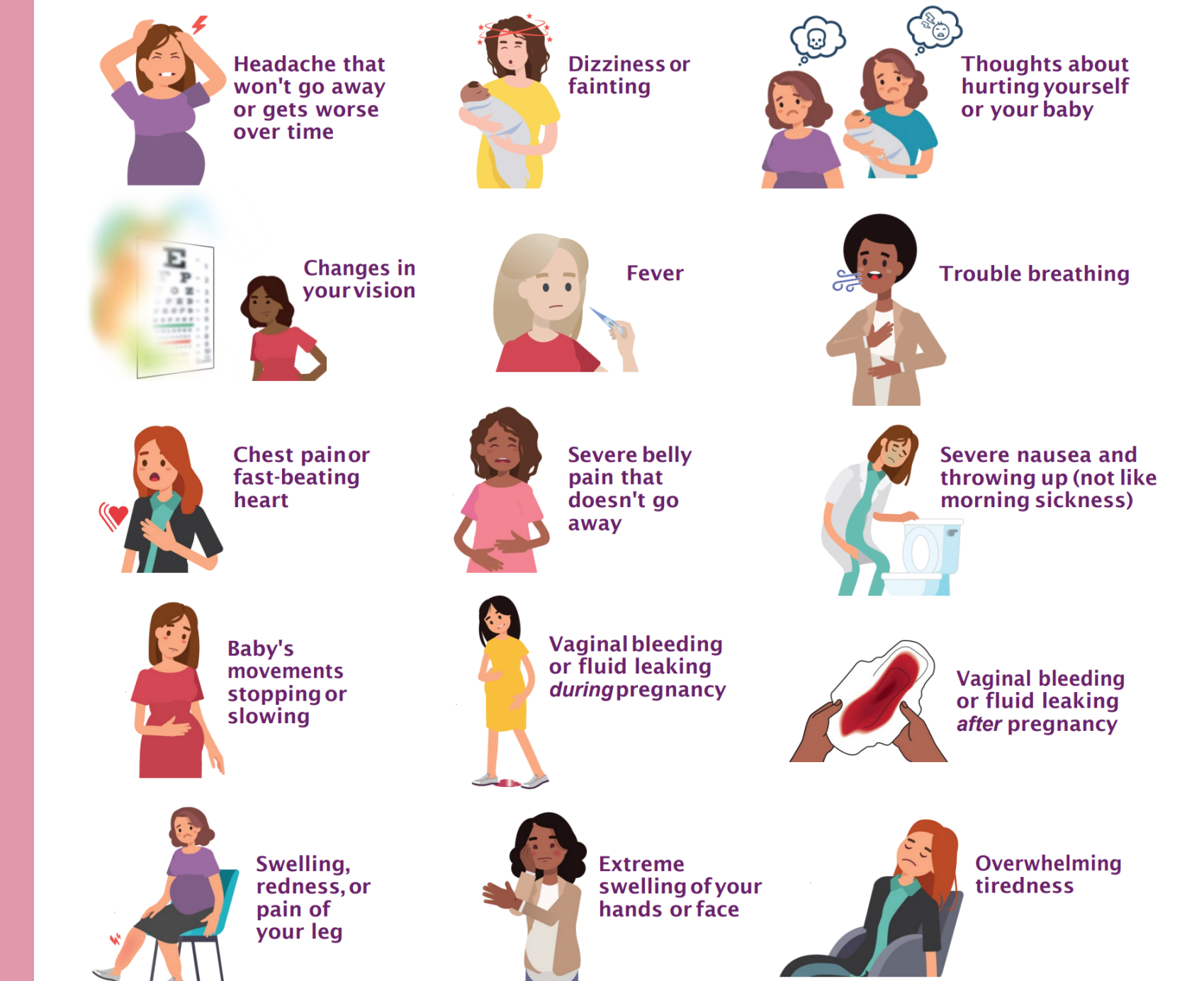
- ❑ 63% of maternal deaths from sepsis had a **strong chance to have been preventable**
- ❑ For each maternal death, there are 50 women/birthing people who experience life-threatening morbidity from sepsis
- ❑ Black and Hispanic patients have a higher incidence (1.1-1.7 times higher) of severe sepsis as compared to white patients

## Key Interventions

At Geisinger Wyoming Valley our focus is on initial recognition and timely treatment. Our goal of this initiative is to:

- Provide education to our providers and nursing staff to recognize signs and symptoms of maternal sepsis with a focus on healthcare inequity
- Utilizing an interdisciplinary simulation environment to identify and treat a maternal sepsis case
- Collaborate with Emergency Department to provide education on maternal sepsis.
- Provide Post Birth Warning Sign printout and QR code to all patients upon discharge.
- Identify and implement a Maternal Early Warning Trigger to alert in the EPIC EMR, as we understand there are physiological differences within the pregnant and post partum population
- Aid in earlier recognition of maternal sepsis by an addition of a visible indicator on EHR for a pregnancy within the last year

### URGENT MATERNAL WARNING SIGNS



**If you have any of these symptoms during or after pregnancy, contact your health care provider and get help right away.**

If you can't reach your provider, go to the emergency room. Remember to say that you're pregnant or have been pregnant within the last year.

Learn more: <https://saferbirth.org/aim-resources/aim-cornerstones/urgent-maternal-warning-signs/>



Take a photo to learn more

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## “On this topic, our team would like to learn from our peers”

- *Maternal sepsis triggers within the EHR that would “fire” if abnormal vitals/lab results occur. Do any institutions currently have this in place?*
- *How to better include Emergency Department for early sepsis signs?*

## Focus Area:

*We will maintain sepsis knowledge with the OB nurses and providers with continuing education and strive to collaborate with the Emergency Department.*

## Measures/Results

*We had 99% of OB staff completed Lippincott modules*

*48% of staff completed maternal/neonatal sepsis and health equity simulations and case studies*

*46% of providers completed Lippincott modules*

*Limited ED staff were able to complete any education related to competing priorities within their department*

## References:

Society of Critical Care Medicine: FCCS Obstetrics Sepsis Lecture: 2022  
[NIH Funding to Identify and Address Barriers and Strategies in the care of Maternal Sepsis \(two s...](#) Dr. Melissa E Bauer, D.O Duke University  
[Racial Equity in Sepsis Care Matters | Sepsis Alliance](#)  
CMQCC  
[Sepsis | California Maternal Quality Care Collaborative](#)