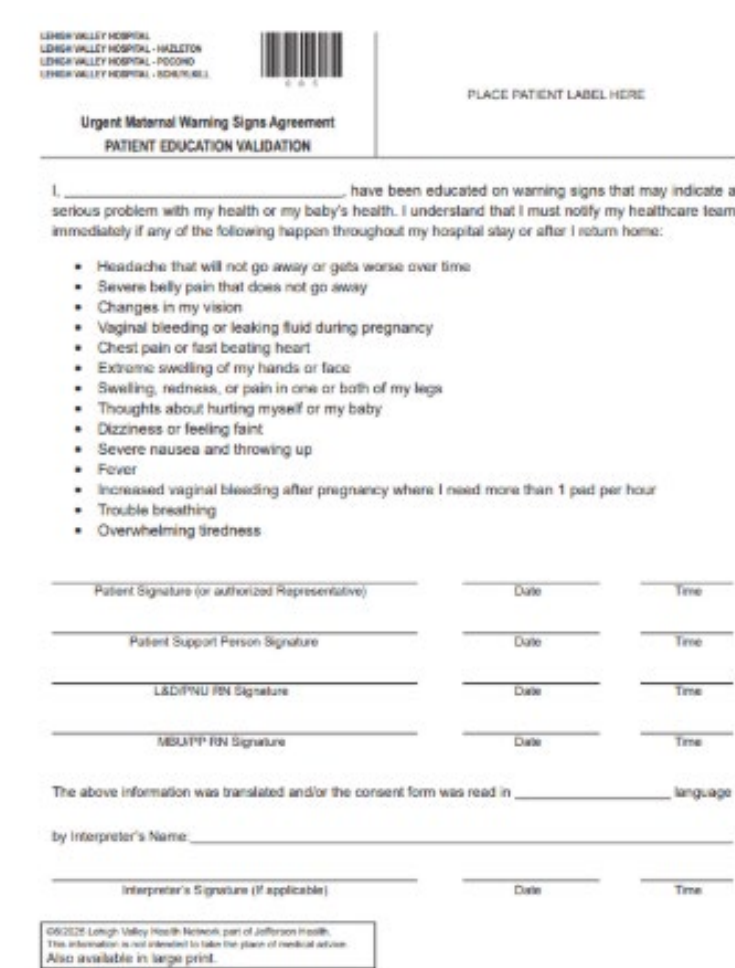
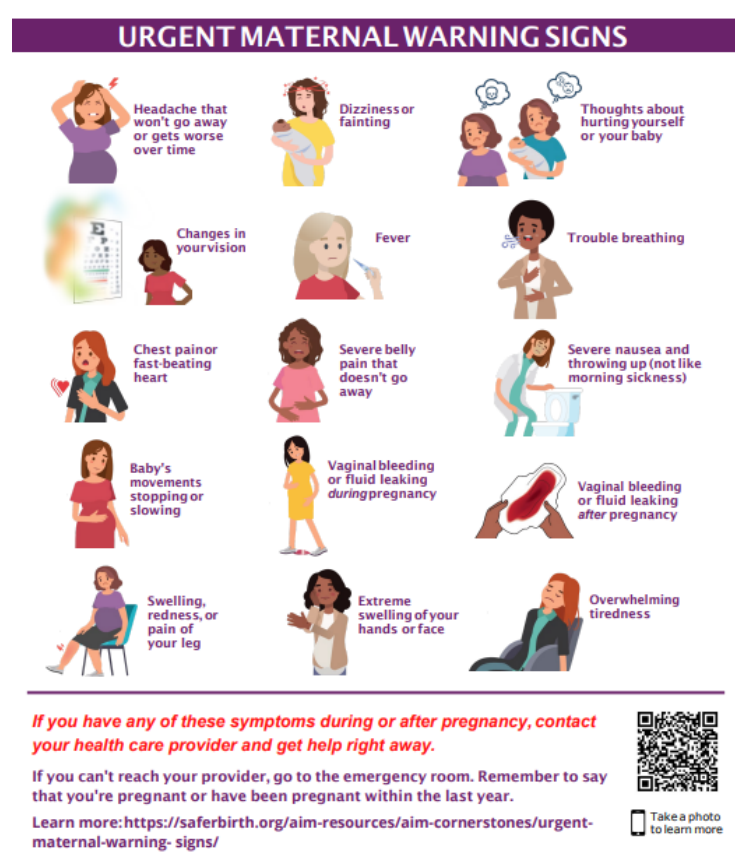


Problem Statement

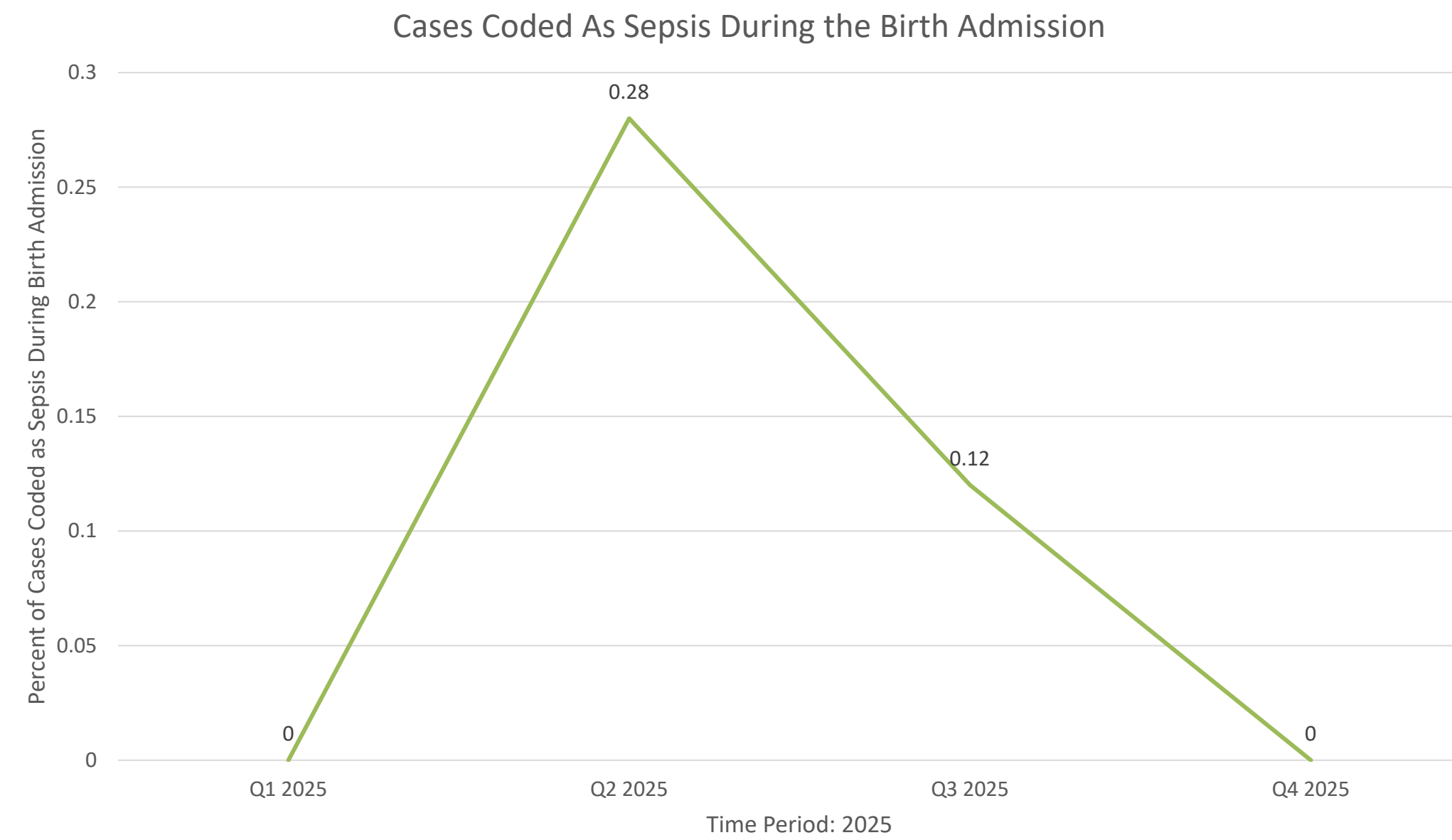
- Lack of differentiation between sepsis and obstetrical sepsis protocols/interventions
- Inconsistent patient education regarding urgent maternal warning signs

Focus Area and Key Interventions

- Education provided to patients in outpatient and inpatient environments
 - Written hand out during prenatal care
 - AIM Poster regarding urgent maternal warning signs in all inpatient rooms
 - Written patient hand out on admission to intrapartum and antepartum units
 - AIM urgent maternal warning signs added to discharge summary for all patients discharged from antepartum and postpartum units



Measures and Results



Patient Voice

- Patient survey implemented at discharge to determine if education is meeting the needs of the patient population
 - 90 responses received
 - 100% know when it is appropriate to seek emergency care for a maternal health crisis; 94% know who to contact if they experienced any of the urgent maternal warning signs; 84% felt extremely confident in recognizing urgent maternal warning signs.
 - 1% identified as American Indian or Alaskan Native, 4% Asian, 11% Black, 1% Native Hawaiian, 64% Caucasian, and 11% wished not to disclose. 36% identified as Hispanic or Latino, 60% identified as not Hispanic or Latino, and 4% wished not to disclose.

Health Equity

- Reviewed social determinants of health and patient demographics for 100% sepsis cases from April 2025-January 2026
 - Decrease in sepsis cases by 50% from previous year
 - No significant findings related to SDOH or demographics

Status and Next Steps

- Reinforce staff education with Obstetric Sepsis module
- Working with providers for obstetric sepsis bundle

On this topic, we would like to learn from our peers...

- What do your obstetric protocols, order sets, or bundles include?