

Urgent Maternal Warning Signs Education Improvement

Women and Children's Services, Mount Nittany Health
PA PQC Maternal Sepsis Initiative – Patient Voice

Problem Statement

Maternal sepsis is a leading cause of maternal mortality in the US but is largely preventable with heightened awareness and timely intervention. Prior to project implementation, postpartum patient education regarding UMWS was not standardized or evaluated for effectiveness at MNH. Therefore, MNH was previously unable to determine whether UMWS education positively affected patient recognition and likely reporting of UMWS.

Goals

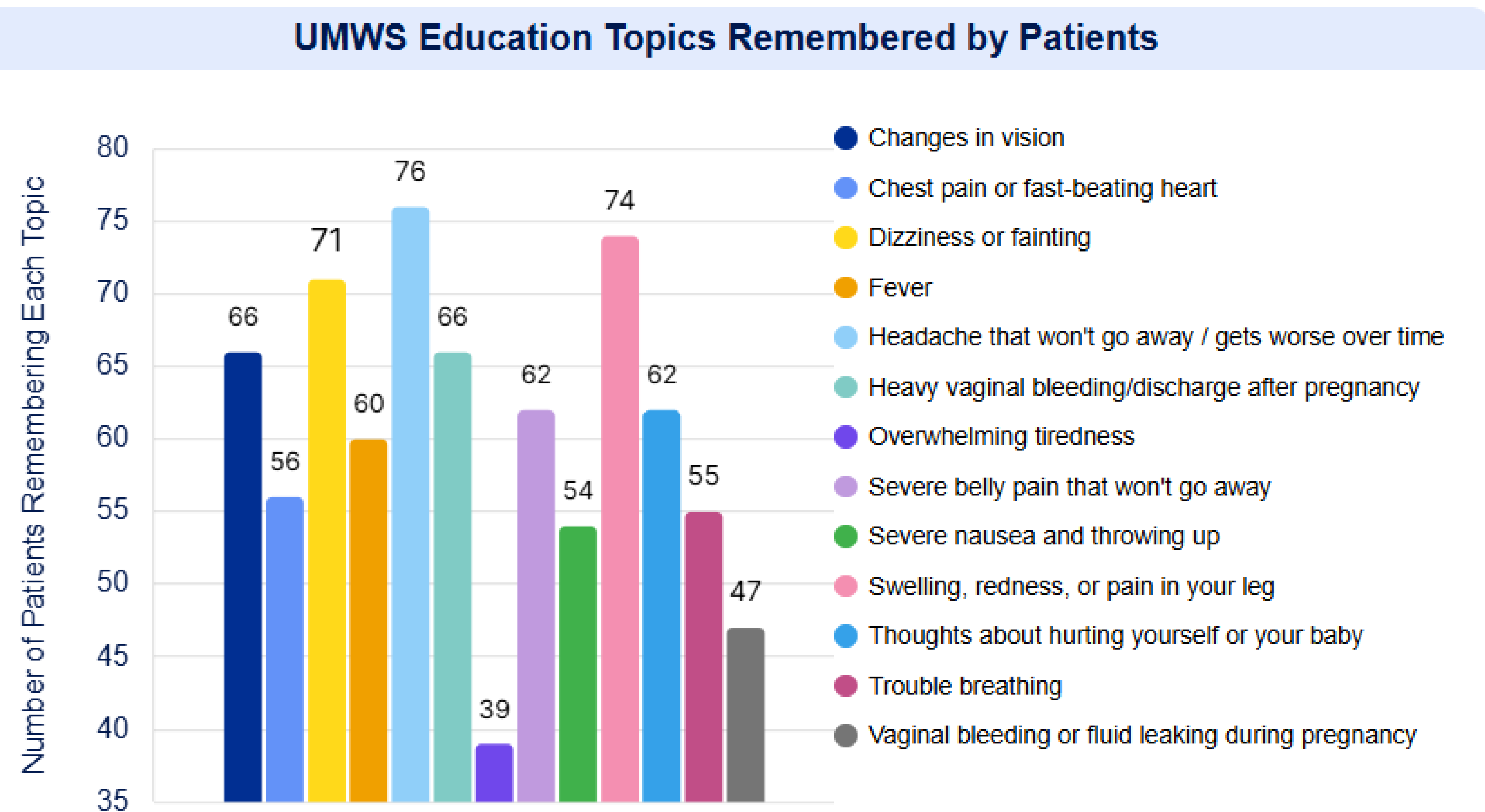
“By August 2025, questions specific to UMWS will be added to the existing department survey that is completed at discharge. The team will strive for a 50% completion goal of surveys from patients. The information from the survey will be collected and then guide changes to staff and patient education. By December 2025, new education will be created and implemented for both staff and patients. The patient surveys will continue to be collected and reviewed. In March 2026, a post-analysis of the data collected will be done to evaluate changes with patients' responses.”

Measures

In December 2025, questions regarding UMWS education were added to the existing postpartum patient survey. Questions assessed whether UMWS education was provided by staff and, if so, what UMWS topics were remembered by patients.

Results

Patient survey data collected in January, February, and March 2026:



UMWS education least remembered by patients (staff education target areas):

- Overwhelming tiredness
- Vaginal bleeding or fluid leaking during pregnancy
- Severe nausea and throwing up

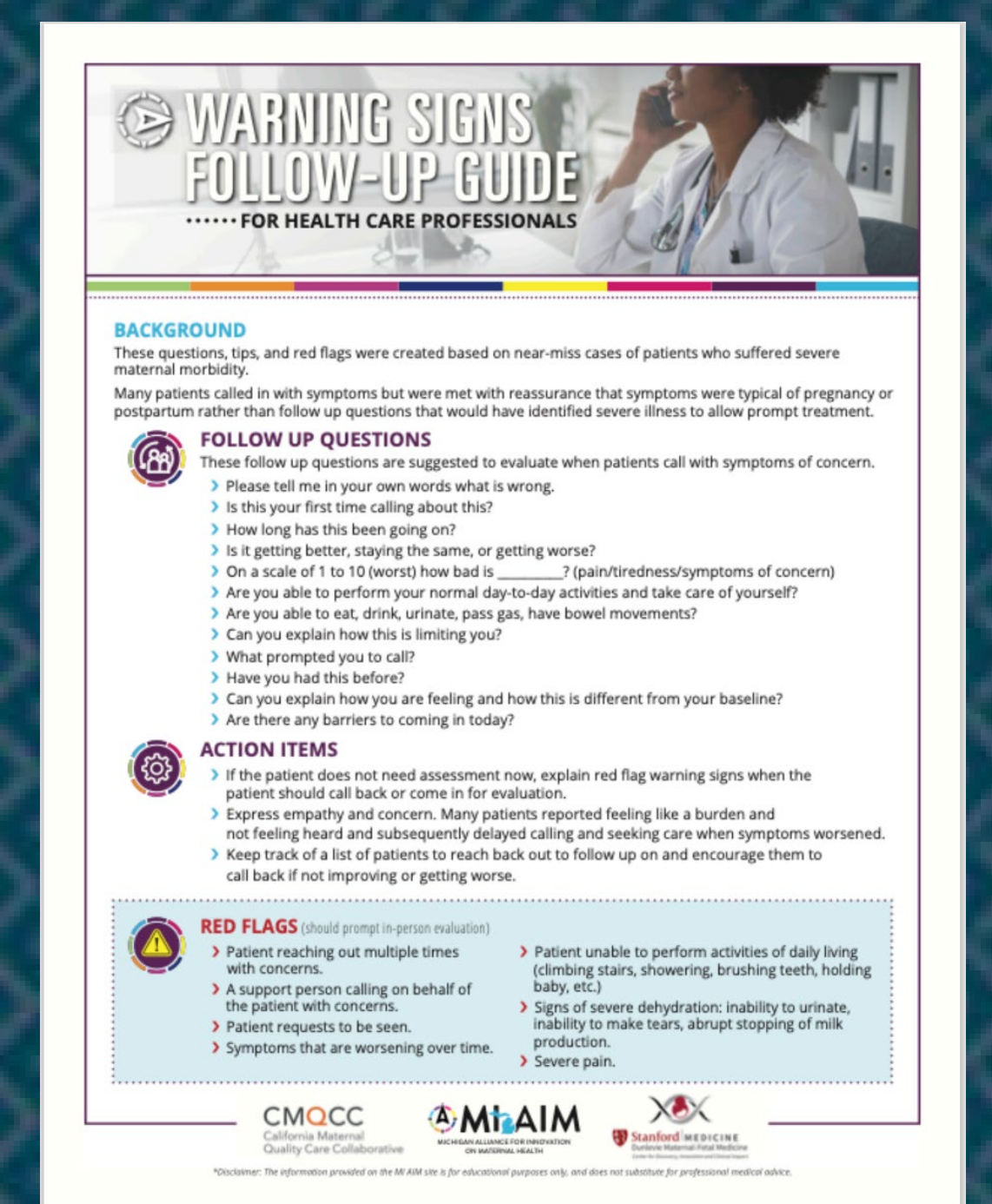
Key Interventions

The project team gathered data from January, February, and March 2026 surveys, and the team identified the three lowest scoring UMWS recalled by patients. The team designed education to teach staff about the three lowest scoring UMWS so that these topics could be better covered by staff in patient education.

The stand-alone ACOG UMWS handout was identified to supplement patient education. The project team implemented distributing this ACOG handout to outpatient L&D patients in addition to postpartum patients.

The CMQCC Warning Signs Follow-Up Guide for Healthcare Professionals was given to the outpatient OBGYN practice to use when triaging patients.

The project team developed a “Break-n-Learn” packet including the expanded version of the ACOG handout to teach staff about the three lowest scoring UMWS.



Outcomes, Implications, and Sustainment

By creating a process for evaluating patient education about UMWS, MNH now has a sustainable path forward to allow patients a voice to be involved in and improve their care. Our hope is that empowering patients with an avenue for feedback will help to improve patient outcomes related to the early recognition and treatment of UMWS.

***Note: With concurrent Epic training in progress throughout this project, we encountered barriers to meeting our goals on time; however, all goals were still met.

References

- Pennsylvania Perinatal Quality Collaborative - Maternal Sepsis
- Warning Signs Follow-Up Guide for Health Care Professionals (handout). MCQCC, MIAIM, Stanford Medicine.
- Urgent Maternal Warning Signs (handout). ACOG.