Abstract

Maternal sepsis is the fourth leading cause of maternal death in the US. The majority of deaths due to maternal sepsis are related to a delay in identification and treatment of sepsis. The goal of this maternal sepsis project was to develop a policy where all patients in the perinatal units at the site hospital are being screened for sepsis and if sepsis is identified, then the patient is treated according to best practice. The Surviving Sepsis Campaign (SSC) has guidelines for treatment of sepsis, but these guidelines were not being followed at the site hospital. Nurse's knowledge was assessed in regards to maternal sepsis in a pre and posttest during an educational class on maternal sepsis and the new policy. A electronic medical record (EMR) maternal sepsis screening assessment was implemented and required by nurses to fill out on every patient. The assessment notifies nurses if the patient screens positive for sepsis so that the physician can be notified and order the recommeneded treatment protocol. The results of the project show that nurses did increase their knowledge on maternal sepsis after the required educational class. The audits of the maternal sepsis assessment showed that proper and timely treatment of maternal sepsis occurred in four out of the five positive cases one month after implementation. In the one fall-out case, the antibiotics were delayed by thirteen minutes.

Keywords: maternal sepsis, obstetric sepsis, sepsis in the pregnant patient