

Improving communication during a Major Obstetric Haemorrhage: a second cycle Quality Improvement Project

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Introduction

In the spring of 2021, we introduced the use of Major Obstetric Haemorrhage (MOH) communication whiteboards in the obstetric theatres of St Mary’s Hospital, Manchester. This was aimed at improving communication during MOH as guided by the 2020 MBRRACE report (1). Now, 5 years later, we have re-evaluated the use of our MOH boards and re-surveyed MDT opinion to try and make significant changes to the current content and use of them. Our changes are aimed at reflecting updates in clinical practice that have arisen since their introduction, improving MDT engagement, and adhering to most recent MBRRACE recommendations (2).

Methods

We surveyed anaesthetists, obstetricians, theatre staff and nurses at the beginning of our project to evaluate current usage of the board and asked for constructive feedback. We took on board these comments to re-invent an improved and more useable version of our existing initiative. We also liaised with both the anaesthetic and obstetric teams regarding recent changes in practice when it comes to MOH to ensure these were accurately reflected in our update. Finally, we looked further afield to the use of whiteboards in trauma to see if any lessons could be learnt there- specifically with regard to the inclusion of sit-reps.

MAJOR OBSTETRIC HAEMORRHAGE
CALL 2222

PRE-OPERATIVE CHECKLIST

DISTRICT NO		STARTING HB	
WEIGHT		PLACENTAL SITE	
EBL PRIOR TO THEATRE		PRODUCTS AVAILABLE	

DRUG	TICK	SURGICAL STEPS	TIME
CARBETOCIN or OXYTOCIN		BAKRI BALLOON	
OXYTOCIN INFUSION		VAGINAL PACK	
TXA		B LYNCH SUTURE	
ERGOMETRINE/ SYNTOMETRINE		HYSTERECTOMY	
CARBOPROST (HAEMABATE)	Time: 1. 2. 3. 4. 5. 6.		
MISOPROSTOL			

EBL		TICK	
EBL PRIOR TO THEATRE		TEG 6	
SWABS		CELL SALVAGE	
SUCTION	LIQUOR BLOOD	BLOOD PRODUCTS GIVEN	NUMBER
SURROUNDS		UNITS OF RBC	
TOTAL EBL		UNITS OF FPP	
		UNITS OF CRYO	
		UNITS OF PLATELETS	
		FIBRINOGEN	

	30 min	60 min	90 min	120min
MDT SIT-REP				

The board gives a good mental exercise or flow of thoughts that is needed when MOH happens

In situation of stress, we look at the board to get an update of bleeding and measures to contain it.

They were not mentioned on the obstetric mandatory SIM days - may be helpful to incorporate them into SIM if they being used.

Results

Our initial survey found that 81.8% of the MDT were aware of the MOH boards in theatres, and 59.1% had used them. Of those that had used them, 93.8% found them useful in the management of MOH. By far the most common theme highlighted as helpful was that the boards act as an aid memoir or quick reference for drugs, timings and products given. In terms of suggestions for improvement- most comments were concerned with position (and therefore useability) of the boards in theatre, the omission of carbetocin and TEG6, and the fact that the boards aren’t signposted in induction for rotational doctors.

Discussion

Based on the above, we worked to improve awareness and engagement with our boards based on the survey. We updated our boards to reflect the department's introduction of carbetocin as a first line uterotonic, and we also included the use of our new TEG6 machine. We learnt from the use of communication boards in trauma by turning the static laminated posters into more durable, moveable whiteboards on wheels, and also included prompts for regular MDT sit-reps. In terms of increasing awareness -we ensured signposting of the boards at rotational doctor’s induction, as well as included their use in departmental simulation teaching. We are confident that all of these changes will improve useability and reflect current practice more accurately.

References

1. MBRRACE (2020), *Saving Lives, Improving Mothers’ Care: Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2016-18*. Available at: https://www.npeu.ox.ac.uk/assets/downloads/mbrrace-uk/reports/maternal-report-2020/MBRRACE-UK_Maternal_Report_Dec_2020_v10_ONLINE_VERSION_1404.pdf. Accessed 09/01/26.

2. MBRRACE (2025)*Saving Lives, Improving Mothers’ Care: Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2021-23*. <https://www.npeu.ox.ac.uk/assets/downloads/mbrrace-uk/reports/maternal-report-2025/MBRRACE-UK%20Maternal%20Report%202025%20-%20Main%20ONLINE%20v1.0.pdf> Accessed 09/01/26