

Implementation of a local postpartum haemorrhage (PPH) care bundle: A Quality Improvement Project (QIP)

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Introduction

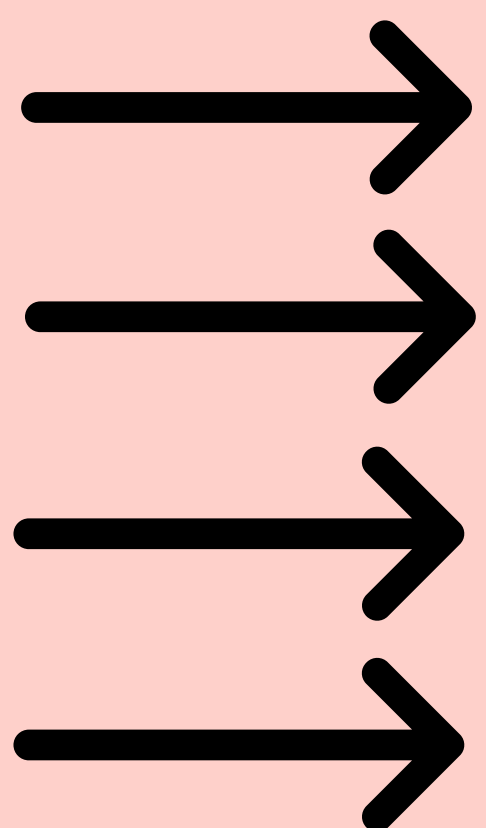
Obstetric haemorrhage is one of the five areas of focus in the newly published national maternal care bundle for reducing maternal mortality and morbidity. This guidance closely relates to the successful OBS Cymru care bundle and the ongoing multi-centre OBS UK trial. At Bradford Teaching Hospitals NHS Trust, we are aligning our practice with national guidance, outside of a funded trial programme.

Methods



Creation of project group. A multidisciplinary team (MDT) PPH Quality Improvement (QI) project group was established with peer review from senior clinicians. Cycle leads were allocated within midwifery, obstetrics and anaesthetics.

Local data audit completed. A local retrospective audit was completed to include data between August 2023 and July 2024. MEaCC data was used for regional comparison.



PPH risk assessment

Contemporaneous blood loss measurement

Thromboelastography

Escalation to seniors

Results

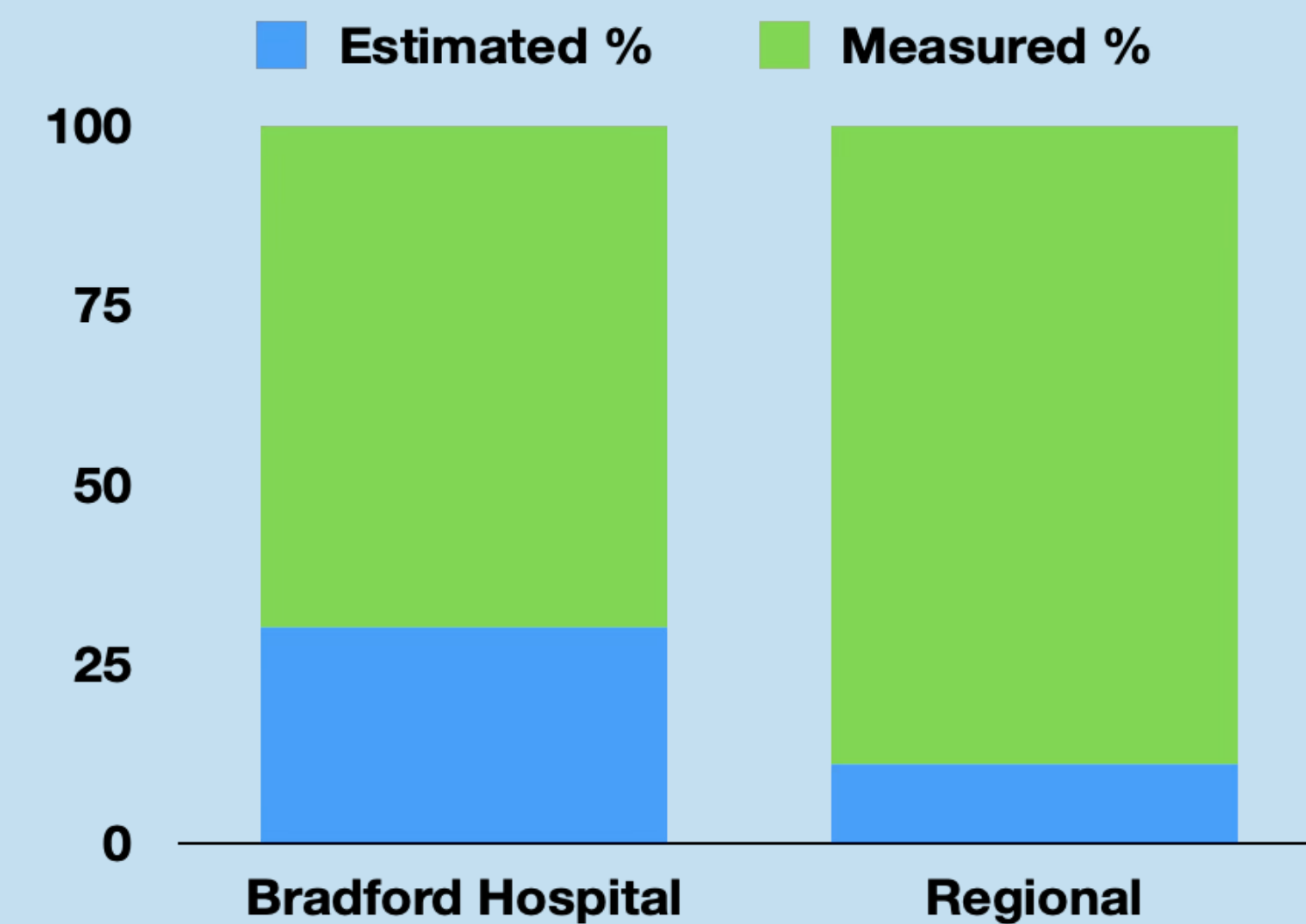


Figure 1: Comparison of blood loss measured or estimated locally and regionally. 30% of haemorrhages recorded over 1.5L were estimated losses compared to 10.9% regionally.

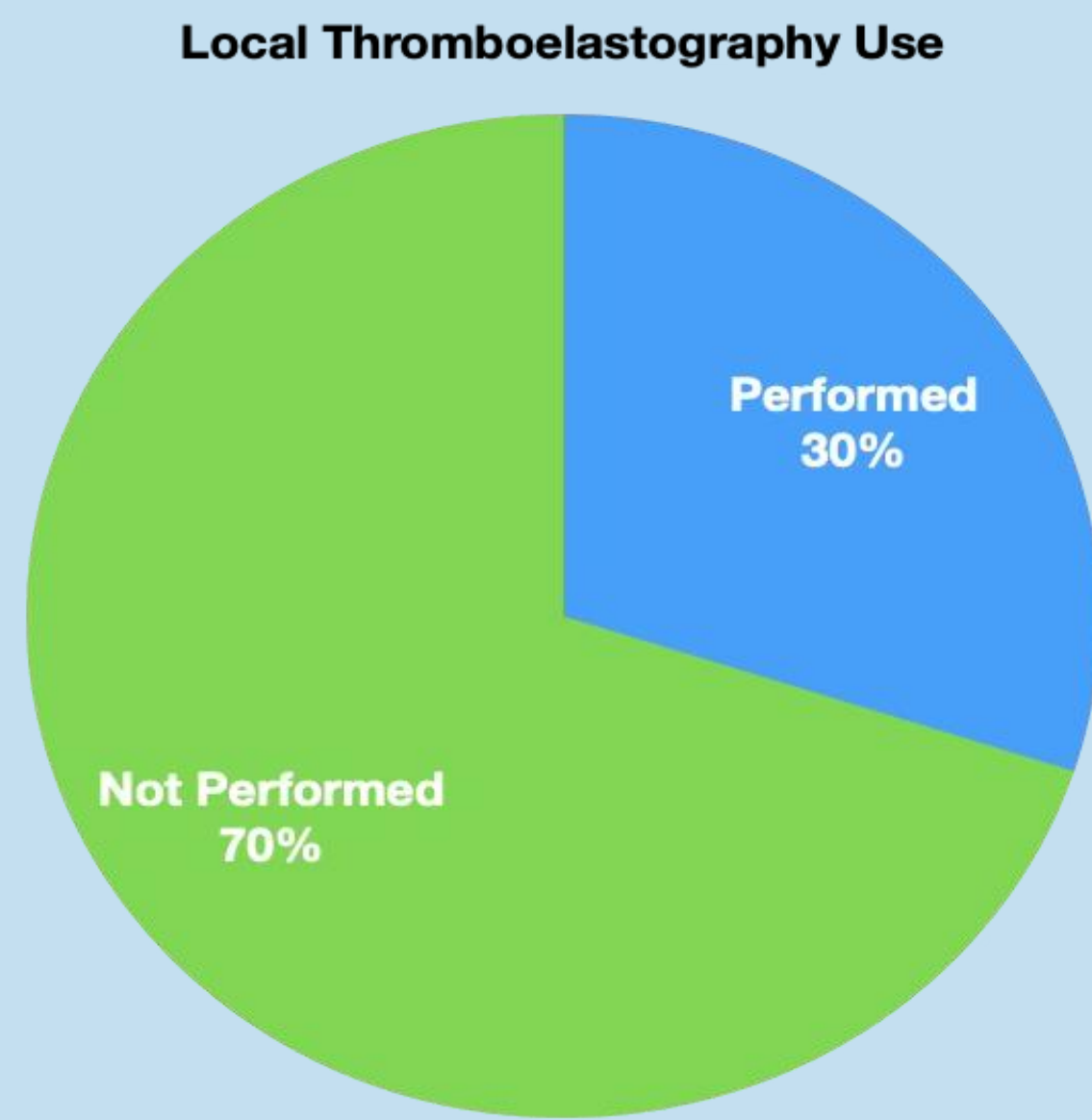


Figure 2: Local rates of thromboelastography use in PPH greater than 1.5L. Of the 30% where TEG was used, eight cases had clotting products given. The regional variation in point of care testing made comparison inappropriate.

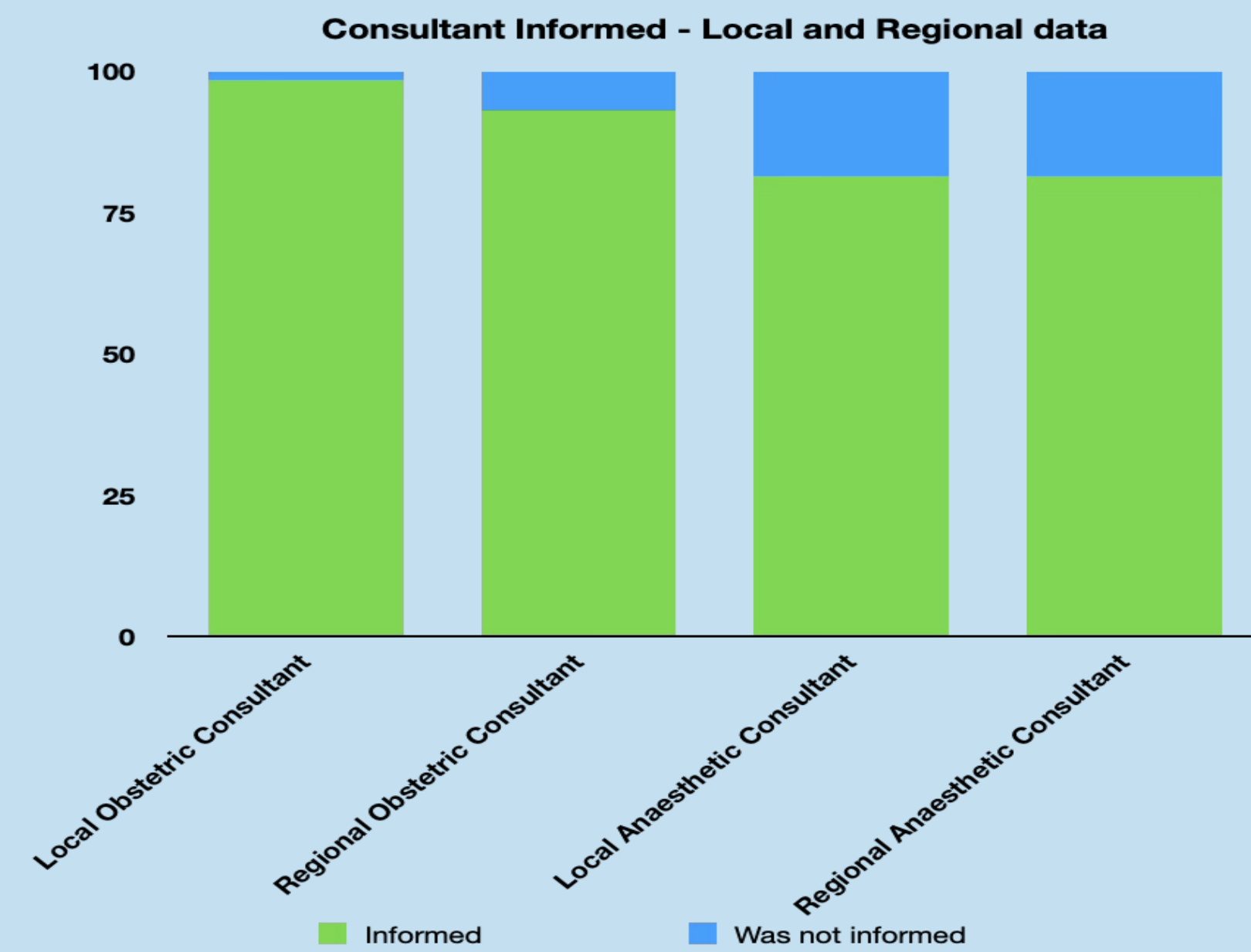


Figure 3: Local and regional rates of the consultants being informed in blood losses greater than 1.5L. Locally the obstetric consultant was informed in 98.4% of cases and the anaesthetic consultant was informed in 81.5% of cases. This compared to regional data was 93% and 81.5% respectively.

Between August 2023 and July 2024 there were 5273 deliveries of which 93 were PPH cases where blood loss exceeded 1.5L. Development of a risk assessment tool, accurate measurement of blood loss, consistent use of TEG and clear escalation thresholds were highlighted as areas which could be improved. Local audit data was gathered and is presented here. This was compared to regional data acquired from MEaCC data sets.

Discussion

A PPH risk assessment was devised using the OBS CYMRU stage 0, audit data and MDT consensus. Local PPH guidance was reviewed by Multi Disciplinary Team (MDT) stakeholders. PPH categorisation was changed from minor/major, to three stages based on MBL. Senior escalation and thromboelastography thresholds were revised. Lessons learned, shared by regional centres in the OBS UK trial, allowed us to anticipate barriers to local implementation. Equipment for real-time MBL was sourced including scales, drapes, calculators, documentation and aide-memoires. A focused implementation phase with regular MDT project updates, a real-time documentation tool, shift in language from ‘estimated’ to ‘measured’ blood loss, tea-trolley teaching, PROMPT, and haemorrhage awareness week is underway with full implementation projected by April 2026.

Conclusions

Data shown here contributed to the update of local guidelines in accordance with new National Maternal Care Bundle guidance.

References

1. NHS England, The Maternal Care Bundle: A care bundle for reducing maternal mortality and morbidity. <https://www.england.nhs.uk/long-read/the-maternal-care-bundle/>, 2026 (accessed 19 January 2026).
2. A. Corp, B. Wilkinson, S. Hickey, V. Dolby, D. Horner, 2024. Maternal Enhanced and Critical Care (MEaCC) in Yorkshire and the Humber: regional implementation of an enhanced maternal care pathway and data collection. International Journal of Obstetric Anesthesia, Volume 57, 103934. <https://doi.org/10.1016/j.ijoa.2023.103934>.

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