

Feedback of Major Obstetric Haemorrhage Simulation Training

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Introduction

Following an incidence at our hospital site, we developed a simulation programme in managing major obstetric haemorrhage (MOH) as a multi - disciplinary team. Obtaining feedback was essential for identifying the effectiveness of training and areas of improvement for future sessions and for the service of the trust.

Methods

Training was delivered during the COVID-19 pandemic in July - September 2020. Anaesthetists, obstetricians, midwives, theatre nurses, clinical support staff and students were involved in managing a clinical scenario. Feedback was obtained post -simulation in a questionnaire adapted from the Joint Royal College of Physicians Training Board evaluation form. 87 feedback forms were completed, which equates to 74.35% response rate.

Results

Not all members were aware of trust MOH protocols nor how to access guidelines. On a five-point scale (very poor, poor, satisfactory, good and excellent), over 90% of staff thought the simulation training was 'good' or 'excellent' in the following categories: teaching environment (n=84); learning objectives were met (n=84); delivery of teaching was clear and effective (n=79); candidates had learnt something today (n=83); and the usefulness of the session (n=83). Only 68 (78%) of staff knew how to access the local trust guidelines, however following this training 84 (97%) felt more confident in calling a MOH.

General comments include greater appreciation of other team members' roles, whilst developing better communication and team-working skills.

Through general feedback and discussion we have also identified the staff members' concerns which were not highlighted previously.

We found due to recent changes in theatre facilities and staff role, O negative blood was no longer readily available within the theatre complex and required delivery from a separate hospital building (which would take around 15 min). This was investigated, only to find that the blood fridge was non - functional and had no direct internet connection (for remote site monitoring).

These concerns were highlighted leading to:

(1) reinstatement of an accessible and functional fridge;
(2) establishment of wired internet access for remote site monitoring of fridge temperature;
(3) negotiation with biomedical scientists and transfusion practitioner to expand role in monitoring fridge by direct checks; and
(4) training of local staff within the maternity department to monitor and maintain fridge conditions.

Discussion

Having alleviated our staff concerns, improved their confidence and knowledge in managing a frequent obstetric complication as well as allowing better access to crucial blood products, we hope this reflects as an improvement in service provision by auditing in the future. We hope to replicate this activity over at our cross -site hospital with the intention of enhancing staff training, inter-departmental relationships and again identification of concerns which can be rectified to improve patient safety.

References

Joint Royal Colleges of Physicians Training Board, Evaluation form for teaching and presentations. https://www.jrcptb.org.uk/documents/evaluation-form-teaching-andpresentations