RECOMMENDATIONS

- Professional interpreters should always be used for women who have been identified as requiring interpreting skills [2,6]

- Next of kin should always be documented in the notes and confirmed on every admission.

- The Situation Background Assessment Recommendation (SBAR) or similar communication tool should always be used especially when there are a number of clinicians and specialties involved in a woman's care.

- A postnatal plan of care must always be documented for women with blood loss >1 litre.

- All staff should participate in multidisciplinary skills and drills sessions for the management of major obstetric haemorrhage (at least once/year). This should be organised as a core component of mandatory training and include training in quantitative measurement of blood loss.

- The obstetric department should review their maternal haemorrhage guidelines against the Maternity SCN toolkit[12]

- All women l should have their observations consistently recorded on a Modified Early Obstetric Warning Score (MEOWs) chart. This should be analysed by a registered health professional not a health care assistant

- Use of the MEOWS charts in all maternity areas should be audited every 3-6 months to demonstrate improvement

- The Surviving Sepsis care bundle[11] should be used in cases of suspected sepsis.

- Training to recognise sepsis should be undertaken by all clinical staff

- Women with abnormal observations (eg tachycardia, temperature or tachypnoea) in the post natal period should be reviewed every day by the obstetric medical team, with early consultant involvement if the woman is deteriorating or needs to return to theatre. *The panel has received an update from the Trust that a daily consultant postnatal ward round has already been implemented*.

- Women with ongoing sepsis should be discussed with (and reviewed by) the microbiologist.

- Consultants in the Trust should review the decision making process for performing a hysterectomy in the context of haemorrhage or sepsis

- The organisation must ensure compliance with correct use of the WHO safer surgery check list"

- The Trust should review its pathways for the care of vulnerable women

- Supervisor of midwives to be represented at maternal death investigations