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Maternity staff's knowledge, practices and associated factors to enhance care to women following a primary postpartum haemorrhage



Imelda Fitzgerald, Dr Joye McKernan, Dr Rhona O'Connell, Professor Richard A Greene

ORIGINAL

Abstract

Introduction

Primary postpartum haemorrhage (PPH) is a leading cause of maternal morbidity and mortality globally. While clinical efforts often focus on the immediate physical management of PPH — such as controlling bleeding and stabilising vital signs — there is growing recognition of the broader spectrum of care that women require in the aftermath of such a traumatic event. Holistic recovery from PPH extends beyond physical stabilisation to include emotional support and the provision of clear, compassionate information, all of which are critical to a woman's overall wellbeing and long-term health.

Method

Taking a co-design approach, three focus group interviews were held with experienced midwives and consultant obstetricians, and a workshop with doctors in training (DIT), to collect data over a six-month period. Qualitative descriptive interviews were undertaken with subsequent content analysis. In total, 33 multidisciplinary team (MDT) staff from a large maternity hospital in the south of Ireland participated in the study, with a focus on care after a postpartum haemorrhage (PPH).

Results

Several suggested improvements of care were identified: individualised care to women regardless of volume of blood loss; all women to be provided with a debrief at different stages according to their needs; additional education for the MDT to provide woman-centred care; and the development of an information booklet for women with suggested advice on ways to care for themselves physically and emotionally.

Conclusion

This study has highlighted the importance of involving staff to gain perspective and professional suggestions for improving care in the maternity services. The findings from this study will be used to develop a care pathway for women following a PPH.

Keywords: Co-design; care pathway; primary PPH; woman-centred approach; multidisciplinary team.

Introduction

Primary postpartum haemorrhage (PPH) rates have continued to rise globally over the last two decades (Say et al 2014) and it is the leading contributor to maternal morbidity and mortality rates (Greene et al 2021). PPH can be defined as blood loss over 500mls within a 24-hour period following childbirth. It can be subcategorised into mild (500–999mls), moderate (1000mls–2000mls) and severe (over 2000mls) (Mavrides et al 2016).

In Ireland, the rate of PPH has quadrupled in the last 17 years (Fitzgerald et al 2024a). Obstetricians and midwives have a significant impact on the birthing experience of women, especially when medical care is required (Bäck et al 2017). Particularly important are the interactions with women and families in providing and coordinating person-centred care for preventive and acute maternity care needs. Quality in clinical practice relies on several issues, including: staff values; motivations; behaviours; and how decision makers involve staff for their insight and perspective to make systemic change (Farr & Cressey 2015, Shand et al 2021). Obtaining baseline information from clinical staff about current practice provides an opportunity for the health service to enhance person-centred and compassionate care (Engle et al 2021).

Women have particular needs — including physical, emotional and psychological — following a PPH. Failure to address these may result in significant complications for the women, in the short and long term (Thompson et al 2011, Dunning et al 2016, Briley et al 2021, Fitzgerald et al 2024b). A care pathway may help: this involves a structured intervention of agreed tasks for a specific group of people for a designated period of time (Schrijvers et al 2012). There are recognised benefits from implementing care pathways, including improved interpersonal teamwork, greater staff knowledge and standardised care for a designated group (Deneckere et al 2012, Seys et al 2017). There are currently no published care pathways for women who have experienced a PPH, therefore, to develop a pathway, it is important to understand the experience of women and the attitudes, knowledge and skills of staff providing care for women post a PPH. This will help identify potential improvements in clinical practice.

The experiences of women with a PPH have already been identified (Fitzgerald et al 2024b). This study aimed to gain insight on the current care being provided to women in the postnatal period from the staff who care for women following a PPH, and suggest improvements for enhancing care. It is important to gain insight and knowledge from midwives, obstetricians and DIT, as each discipline is different, as their code of conduct and scope of practice differ.

Methods

The research team was composed of an obstetrician, two experienced midwives and a research officer with experience in development and implementation of national clinical guidelines for management and treatment of primary PPH, clinical experience providing care to women in the postpartum period and insight into the needs of women following a primary PPH.

Design

A co-design qualitative descriptive study was conducted, comprising focus groups and a workshop. This design allowed the research team to gain perspective from the multidisciplinary team (MDT) involved in the care, treatment and clinical decision making related to PPH, in both the short and long term. Incorporating different approaches may lead to better insights and identify whether there are potential improvements to be made to clinical practice (Nassaji 2020).

Study setting

The study was conducted at a tertiary maternity hospital with a birth rate of over 6000 and 22 maternal obstetric haemorrhages (MOH) in 2022 (Ireland South Women and Infants Directorate 2023). It is a level four care facility for critically ill women who require invasive monitoring (HSE 2014). Ethical approval was obtained (reference number: ECM 4 (bb)) and permission for the study was provided by the local hospital management committee.

Study sample

A purposeful sample of nine midwives, four obstetricians and 20 DITs were recruited. It was important to ensure that the MDT involved in the decision making and care for women following a PPH had the opportunity to participate in the study.

Recruitment

The recruitment strategy included three approaches:

1. An information leaflet placed in clinical areas and word of mouth to midwives on the postnatal wards
2. A WhatsApp message of the leaflet sent to consultant obstetricians to advertise the study
3. The DIT were informed by emailing them the leaflet; during their weekly education session, the aims and objectives of the study was discussed by the research team.

The information leaflet included the rationale for the study and contact details for staff who wanted to participate.

Data collection

The triangulation approach (Palinkas et al 2015) of focus groups and the workshop took place in the maternity hospital between November 2023 and June 2024. There were three focus groups and one workshop, with a total of 33 participants. While the focus of each session was the same, there were different topic-guiding questions based on the participant group, as their knowledge, perspective, role and contributing factors varied.

Focus groups

Focus groups were arranged so that the disciplines remained with their peers, enabling participants the opportunity to feel comfortable and voice their views with colleagues and learn from the group (Maher et al 2018). Consent was signed by each participant before the focus group began. Each session was up to 60 minutes and was audio recorded using Microsoft Teams, which also transcribed the discussion. This was reviewed and edited by repeatedly listening to the audio recording. All identifying details were removed from the transcriptions and each participant was assigned a number (e.g. Midwife 1, Obstetrician 1, DIT 1).

Workshop

Following the capture of information and data saturation from the focus groups with midwives and obstetricians, DITs were then invited to participate in the study in a workshop. This was held following one of their weekly education sessions to build on the themes generated from the previous focus groups to add additional knowledge from their perspective. Twenty DITs attended the workshop and were divided into three groups. The groups all attended three themed 30-minute workstations: communication, perspective and future care. The workshop was not recorded but, at each workstation, a member of the research team facilitated the session asking pre-designed questions and documenting what was discussed. Following the workshop, the team met and shared the findings from each group. These were discussed, documented and transcribed by the lead researcher and included in the final data analysis.

Interview-guiding questions

There were separate questions for the focus groups and the workshop. Questions developed for cohort one (midwives); cohort two (consultant obstetricians); and cohort three (DITs), based on the design by Côté-Arsenault (2005).

The focus groups for midwives included an overview of the rates of PPH in Ireland over the last two decades. Questions were asked to establish the state of current care and the experience of women from previous research was provided (Fitzgerald et al 2024b). Following this, participants were asked their opinions on potential improvements in practice and the development of a care pathway was discussed. The obstetrician's focus group schedule followed the same format but, in addition, the midwives' experiences were shared with the obstetricians.

The questions for the focus groups ensured that the discussion remained on target with the objectives of the study while allowing the group to discuss topics openly and ask probing questions as appropriate.

For the workshop with the DITs, the research team read and discussed the immediate findings from the focus groups, organised into themes. A workstation with one theme from the focus group was developed and the 20 DITs were divided into three groups.

Rigour and reflexivity

Several methods were employed to ensure that rigour was maintained. Firstly, it was vital for the research team to maximise the interactions of learning modalities to ensure the analysis process was rigorous and productive (Health Information and Quality Authority (HIQA) 2018). The team met and discussed the aims and objectives for each cohort of the focus groups and workshop, and clarified the guiding questions that would be included. This was backed up by becoming familiar with the literature on conducting focus group interviews (Krueger 1998) and being open to adapting the questions to maximise learning for the different cohorts. All guiding questions were agreed by the research group. Next, various members of the research team were involved with the focus groups and workshop, capturing verbal and non-verbal interaction.

Before and after each focus group and workshop, the lead researcher wrote field notes to compare and contrast after each session for learning purposes, reflecting on the notes in case any adjustments needed to be made to future data collection. Lastly, the consolidated criteria for reporting qualitative research (COREQ) checklist was used to report the study (Tong et al 2007).

Data analysis

Data were analysed using content analysis guided by Graneheim & Ludman (2004) in five stages. Concurrent data collection and analysis were used. Each interview transcript was read and reread several times to identify meaningful words (units). Thirdly, the condensed meaningful words (units) were abstracted and labelled with codes. The codes were then classified into group categories and subcategories derived from comparisons of conceptual semantic similarities. Finally, after comparing categories together, themes were extracted from the analysis and interpretation of the qualitative data. This method involves collecting and analysing data without preconceived categories or theories to identify emerging patterns, themes and concepts (Andrews &

Jonathan 2006). The transcripts and summary report were analysed to identify repetition of codes used and these were grouped together. Following several analyses of the transcripts, 17 codes were identified, which were then grouped together into themes.

Findings

Three themes were identified: **communication**, **influence of team effectiveness**, and **improvements for clinical practice**, along with the 11 subcategories discussed below.

Communication

Communication was the most discussed issue among participants and subthemes were identified: staff communication, communication with the women, process of debrief and decision making.

Staff communication

Midwives stated that, during the transfer of care to the postnatal ward, a PPH was often referred to as '750ml blood loss' or measured blood loss (MBL) of 750ml. The midwives expressed concern, as aspects of the women's care may be missed. If PPH is not recognised, this may impact on her care in the short term, such as repeat blood tests or receiving a debrief, or, in the longer term, cause impacts such as recognition of previous PPH in subsequent pregnancy:

'Sometimes it's not clear when to take an FBC [full blood count] on the woman and it's often too late and her treatment is delayed and she's kept in longer.' Midwife 8

'It depends if she's private or public patient — if the woman is public there is very little to go on or that is documented for follow up. The private patients can sometimes have better documentation or you can call the consultant and a decision is made over the phone with one call. If the woman is public you are adding it to the list or a sticky note to review her and calling someone to review her and it can take hours to have a decision made or it could be the next day before she ends up getting blood (products).' Midwife 7

The DITs stated that a plan related to short-term care should be documented immediately following the PPH, including timing of appropriate blood tests, additional breastfeeding support and debrief. The DITs also reported lack of clarity when they were required to review a woman and decide if a follow-up appointment was needed:

'It can be hard sometimes to know what we can do or can't do in regards to making follow up appointments, if I make an appointment for the woman for the postnatal clinic in six weeks, will the consultant be happy to see her?' DIT 6

Communication with the woman

Obstetricians discussed how comments to women after a PPH can have a potential negative impact. They shared experiences in which comments such as *'you were so lucky'*, *'that doctor saved your life'* or *'you lost a lot of blood'* may result in the woman questioning her mortality, even though the PPH was most often managed effectively and there was no risk of danger to the woman. It was expressed that on multiple occasions the woman and birthing partner were often *'traumatised'* by these generalised statements rather than the event itself:

'*I was asked to review a woman because the staff thought she was upset. Actually, it turned out she was upset that somebody had said to her 'it was touch and go there'. So I think that our language around this is probably something that probably needs a bit of education*.' Obstetrician 13.

'*There are so many leaflets handed to the women for discharge (information), they are overwhelmed and do not take in the basics. I think we should change how information is provided with an app so it's accessible to the women*.' Midwife 8

'*The women shouldn't leave the hospital following medical intervention without a medical review. And unfortunately it still does happen*.' Obstetrician 2

'*Sometimes it can be hard to know which woman is going to be traumatised after a PPH, and we tend to focus on the severe bleeds, but a lot of the time, it is the women with the mild PPH I am asked to review and debrief. We need to be more aware because I think that is missed a lot*.' DIT 1

'*I will tell them what I know or what's written on the handover for open disclosure but I also want to be professional in that I don't say something that will upset the woman or get into trouble with a consultant*.' Midwife 1

Process of debrief

Discussion of the event with the woman and her partner should come from the perspective of the woman, leading the conversation, with the health care professional fully informed about what occurred during the PPH:

'The women want more information about breastfeeding or if they can go back running.' Midwife 2

'We have been trained to be task focused when debriefing, and this may not suit the woman. I think we could tailor debriefs to have more focus on what the woman in front of us needs.' DIT 1

There was a general consensus between the three cohorts that debrief should not take place during early morning daily review, as the woman is less likely to retain information or be prepared for an in-depth discussion, while the birthing partner is most likely to be absent. This time is inconvenient for the woman and her family, and thus time wasted for the DIT and obstetric consultant:

'It may not be feasible to debrief the following day but there should be at least one before discharge home, regardless of blood loss or if the woman was in the HDU.' Midwife 15

'Some women with a mild or moderate bleed (example of 600mls) can be more affected than a woman after a large bleed, so it needs to be individually assessed to see if debrief is needed but that the women after a lesser PPH may need the debrief more than others.' DIT 3

Decision making

Midwives stated that care for women following a PPH was dependent on many factors including volume of blood loss and pre-existing or comorbidities. There is no specific guidance for midwives on how best to facilitate the care women require following a PPH. Midwives provided examples of care where women with similar amounts of blood loss received different management and there was lack of clarity on approaches to tasks, time and support women received on the postnatal ward after a PPH. The DITs discussed that it was difficult to ensure women could be followed up by a particular DIT for debriefing, as there was no regular postnatal clinic for them to book women. The DITs gave examples of appointments made and, due to system error or unavailability of the woman, the debrief was often not scheduled with the DIT who had arranged the appointment:

'I currently have two patients in one room, one (woman) has an 860ml loss and the other woman had a PPH of 2 litres and they have both been managed similarly enough in that the doctor who attended the 2 litre PPH came up and reviewed them both.' Midwife 1

DIT 5 wanted more clarification from the lead consultant of the team on *'if it was the right thing to do'* or *'if there was an algorithm to follow'* when making a follow up appointment.

'I think at the moment it's very much the consultant actually needs to say (to the DIT), make an appointment. I actually try and organise a date with them (woman and partner) where I know when I'll be in clinic (OPD). Most of the time, I will know if a woman has been referred to the clinic for debrief but sometimes, I'm not told and she will arrive.' Obstetrician 2

Influence of team effectiveness

This theme represents the reflection from the MDT of the care required following the event, and how circumstances can affect care required, with sub-themes of documenting care and staffing levels.

Documenting care

There was discussion about the confusion around if and when to perform specific tasks because, at times, it was not always documented in the women's medical charts. Staff stated that if tasks were not documented, this could delay treatment and extend hospital inpatient stays. On occasion, information given to the woman during the debrief was not noted in the chart and this had implications during follow up visits, as an understanding of what had been discussed was unknown and could affect the woman's trust in the MDT:

'What ends up happening is that we don't have a checklist or we don't have a checklist to refer to for specific tasks to be done, and that can lead to delays because there's no clarity.' Midwife 1

'Documentation could be improved, I have been asked to review a woman and there is little or no documentation in the notes about the event and it's difficult to explain to the woman.' DIT 13

Staffing levels

At times, staff found it difficult to provide optimum care to women on the postnatal ward. The midwives expressed concerns regarding decision making and prioritising care. All midwives expressed their desire to *'do more'* for the woman, in particular for emotional support, additional time and breastfeeding support. Short staffing required them to prioritise care on a busy ward and it was often not feasible to provide the additional time and support the women required:

'It's hard when you are looking after 7, 8 or 9 women and infants and there are a lot of them who are high risk and they all need you and you have so many jobs to do.' (Midwife 9)

Improvements for clinical practice

There were several suggestions for improving maternity care in the postpartum period. The subthemes identified were: continuing education; structured approach; follow-up care; designated midwife; and information booklet.

Continuing education

Staff recognised they lacked specific education on how different amounts of blood loss could impact women physically and emotionally. They were aware of how a significant PPH/MOH could impact the woman in the short term. However, they expressed the need for more education on what additional information should be provided, such as dietary advice, rest, breastfeeding, wound healing, management of anaemia, secondary PPH and risk of venous thromboembolism (VTE). The DIT group expressed an interest in attending future education sessions on listening to the experiences of women who have had a PPH, so they could incorporate it into their practice. They all agreed '*a structured approach would be beneficial*'.

Structured approach

It was identified that care following a PPH, needs to be individualised to the woman. This should incorporate a structured approach to ensure that all women receive the most appropriate elements of care. This would reduce delays and omissions that can arise in daily care. The structured approach includes a schedule for debriefing, regardless of volume of blood lost, an information booklet and community follow up with a support midwife:

'Follow up whether it be a phone call or … like phone call clinic or something like that. Yeah, like I think that's a good time because you might also pick up in the perinatal mental health issues.' Midwife 2

The consultant obstetricians discussed what could be included in a booklet and suggested *'the physical, emotional and informational needs'* (Obstetrician 3) of women and that it should be *'structured for all women'* (Obstetrician 4). The booklet could also *'have empty sections for the woman to write in her story and questions'* (Obstetrician 2).

Follow-up care

The midwives identified that the practice of debriefing women had improved in the last few years but there were some women who still do not get a review prior to discharge. It was suggested by the consultant obstetricians that all women receive a debriefing after a PPH:

'A follow up call or debrief within 2 weeks (after discharge). And if the person who saw them in the hospital rang them it would be nice to have a familiar face and easier for the midwife to assess if the woman was coping at home as they are met and had a rapport.' Midwife 7

'I think we would definitely need to give consideration to the idea that we would put in place a phone call or video call to (all) women at six weeks. But that's an offer. If she said no, I'd prefer to come into the hospital. That's fine. But we're giving them an option and they can opt out … we'd normally give the woman the opportunity to come back in to talk to us in at three to six months.' Obstetrician 4

Optimal timing of when debrief should happen included immediately following the event, before discharge and at six–12 weeks postpartum. The six–12 week debrief could be conducted over the phone or face to face, at the choice of the woman. Following the discussion after the event and before discharge, the obstetricians suggested debrief in the long term for the woman and birthing partner of between six–12 months. They stated that some women are not ready to address what had occurred until they are considering another pregnancy. These longer follow-up meetings could be an opportunity to identify women who are experiencing mental health difficulties (anxiety, postnatal depression or post-traumatic stress disorder (PTSD)). The staff were conscious that non-verbal behaviour and providing the woman with the opportunity to lead the discussion were vital aspects for successful debriefing.

Designated midwife

The importance of continuity of care for women following a PPH was considered important. A support midwife or advanced midwife practitioner (AMP) could visit the woman on the postnatal ward and could be the person to discuss the information booklet. It was suggested a designated midwife could also follow up with the couple at two to six weeks postpartum to 'check in' with the woman and identify those women who require further support. There were also suggestions that the midwife could arrange a coffee-morning meet up with women who have experienced PPH to chat and be supports for each other. Others suggested a designated midwife could arrange the debrief in the postnatal clinic to ensure the DITs were available to meet with the woman. It was expressed that this service works in other maternity hospitals, is beneficial for the woman and reduces cost for the health service.

Comparing their current clinical practice to previous hospitals, the obstetric team is now:

'chasing a women for a suitable appointment as there have been missed appointments, in a previous hospital, there was a dedicated midwife to help with the supporting the women and ensuring appropriate appointments were arranged.' DIT 9

Information booklet

The majority of participants considered that an information booklet could be beneficial for the woman with following suggestions for content:

1) Support facilities for the woman in the immediate postnatal period, to reinforce the importance of the mother taking care of herself
2) Importance of rest and sleep, and suggested methods to apply this in the immediate postnatal period
3) To involve dieticians for clarity on dietary requirements and how to achieve requirements through recipes
4) Breastfeeding following a PPH and additional lactation team support for the woman
5) Risks and signs of secondary PPH
6) Risk of VTE
7) Suggested ideas and ways in which the birthing partner and family can support the woman after a PPH
8) An information booklet with blank sections for the woman to add relevant information that was discussed with her and questions she has that may come up. The booklet could be discussed with the woman by the midwife in the postnatal ward.

It was suggested the booklet '*could be a virtual platform for the woman and family members*' (DIT 11).

Discussion

Strengths and limitations

The main strength of this study is that it has MDTs as participants. PPH is managed and treated with a team approach and the care provided subsequent to the event needs to be structured to streamline what care is performed, when and by whom, to ensure all women receive high-quality care. Its second strength is its findings and contribution to the development of a care pathway. A limitation is that the focus groups and workshop were held in a large maternity hospital, so may not reflect the experience of maternity staff in other units, although the DITs in this study had previously worked in other maternity settings, and brought experience and insight to the study.

It is important for postnatal women to receive woman-centred care — particularly if they have had a traumatic birth experience — and to try to give them a positive experience in their postnatal care (Heiwe et al 2011, Floris et al 2023, Kim et al 2024). This study suggests several improvements that can be made, including structuring the care that is available with a pathway for staff and the women in the service. This correlates to international data suggesting that care pathways improve teamwork (Deneckere et al 2012), promote a collaborative approach (Scaria 2016), improve communication strategies (van Dijk-de Vries et al 2017) and boost staff morale if staff suggestions are heard (NCMW 2022). The participants reflected on occasions where suboptimal conveyance of information led to potential errors or a delay of treatment for the woman. A good handover can be a major influence on preventing patient harm and an important step in ensuring safe follow-on care (Raeisi et al 2019).

The participants reflected on clinical practice and described how, often, women following a mild PPH and women who did not experience a PPH had little difference in their physical, emotional or information needs, in contrast to women who had a severe PPH. However, there was a focus on only providing additional care if the woman had a significant volume of blood loss. The MDT have a responsibility to prevent and reduce provoking strong emotions when discussing the event with the woman. The effect of 'reassurance statements' whereby a comment is said with the aim of providing comfort, such as '*you were so lucky*' more often results in feelings of vulnerability and confusion. It can also result in harm by causing women to question their mortality, as has also been noted in trauma survivors (Muldoon et al 2019, Tanti et al 2024). Building staff confidence to communicate openly with the woman can reduce the likelihood of unhelpful reassurance statements. This can be incorporated into the formal debrief, and participants suggested rethinking the commonly used task-focused approach and simply deliver the facts about the event to the woman instead.

Baxter (2019) identified that women prefer to ask questions that might not be addressed using the formal framework; therefore, the MDT should discuss the birth events and refer to the maternity notes (Baxter 2019).

Another inhibitor of current care identified by the study was a lack of clarity in daily tasks and how this can impede their completion and cause delays. This has been reinforced as a common theme in health care in the international literature (Guenter et al 2014). There were several suggestions for improvements, including future education for staff on the physical, emotional and informational needs of women following a PPH, to add awareness of how to better communicate with women. This had previously been highlighted by Rosvig et al (2023).

Another important theme identified by the midwifery cohort was that, unless there are signs of anaemia, there is little to no difference in the care provided to the women with a mild PPH than to those women who did not experience it. The midwives were aware of increasing incidence of PPH and it was not something that '*shocked*' them. All agreed that additional care to meet women's needs should be offered, and that some women may be stable following the PPH but have additional emotional needs. The obstetric team stated that further education was needed to highlight an individual approach to care, perhaps through reviewing the measured blood loss in the context of weight of the woman. For example, in a woman with low BMI, the impact of blood loss of 1000mls could be considerably greater than the impact on a woman with a higher BMI (Kennedy et al 2022). Other topics for education included informing staff of the women's perspectives, an update on other methods to provide effective debrief and approaches to enhancing communication.

It was suggested by obstetricians and reinforced by both the other cohorts that all women should be offered debrief following a PPH, since they received medical intervention. Further suggested improvements included debriefing the woman and her birthing partner after the event but before discharge and between six–12 months postpartum. This was also recommended by Briley et al (2021).

The manner and words used during debrief were also important. The DIT staff recognised that their current approach to debriefing was based on their medical training and followed a format of providing medical information, whereas the women could have specific questions that this format would not answer. This is supported by a systematic review by Bastos et al (2015).

Development of a care pathway with the structured suggestions from the participants in this research could improve the approach and decision-making progress. Related studies have shown staff who have been involved in development and implementing care pathways have increased job satisfaction, better performance and positive attitude (Li et al 2024). Other recommendations from this study include a booklet with detailed information on how the woman can look after herself, physically and emotionally, and gain important advice. This could include what the women experienced, frequently asked questions, contact details for hospital and community support, breastfeeding needs, dietary information, and stories from other women who have experienced a PPH. This was correlated by Guillot & Keenan (2016).

It was also suggested a designated midwife role be created as a point of contact for women to enhance continuity of care and carer in the short and long term. This could reduce the number of follow-up reviews in the health service, reduce pressure on staff to provide the required information and time, and liaise with the MDT and the woman for suitable dates for follow-up appointments. The designated midwife could also provide a telephone service in the postpartum period, in case the women requires referral to other services. Providing continuity of care into the postpartum stage is associated with better mental and health in mothers, better physical health in babies, and longer duration of breastfeeding (Cibralic et al 2023).

Conclusion and implications for practice

This research has demonstrated the need for a designated care pathway to enhance care for women following a PPH; this requires a multifaceted approach that integrates physical, emotional and informational support. Maternity staff play a pivotal role in delivering this comprehensive care and their knowledge, clinical practices, and the factors influencing these are critical determinants of maternal outcomes. Addressing gaps in knowledge and standardising best practices can improve not only the immediate clinical management of PPH but also the emotional wellbeing and understanding of affected women.

Following this study, the lead midwife provided education sessions to staff in clinical and community settings on the needs of women following a PPH to enhance care in the short and long term. An algorithm for a care pathway following mild, moderate and severe PPH has been developed, alongside a booklet with suggestions for physical and emotional self-care. The research identified that enhancing the approach and context with communicating to women, offering a debrief appointment six to nine months after the event to address the women's needs and highlighted the need for further education of staff on updating their understanding of women's needs.

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For more information on this topic see MIC database Search Pack: PN29 Postpartum Haemorrhage.

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