

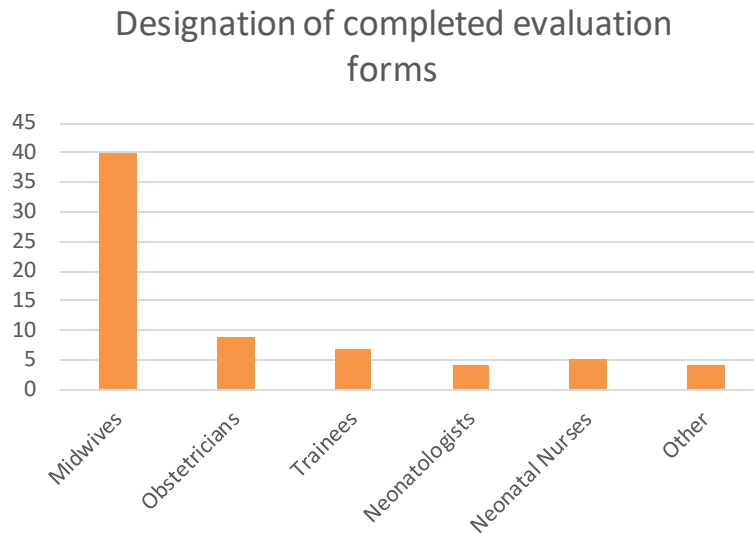
**Evaluation of
Maternal and Neonatal
Regional Shared Learning Event
26 February 2020**

Oxford

**Patient
Safety
Collaborative**

Maternal and Neonatal Safety
Improvement Programme

Who attended the event



- 93 delegates attended (107 booked via event brite)
- 69 evaluation forms completed = 74%

**Was it worth
attending the
event?**

Oxford

**Patient
Safety
Collaborative**

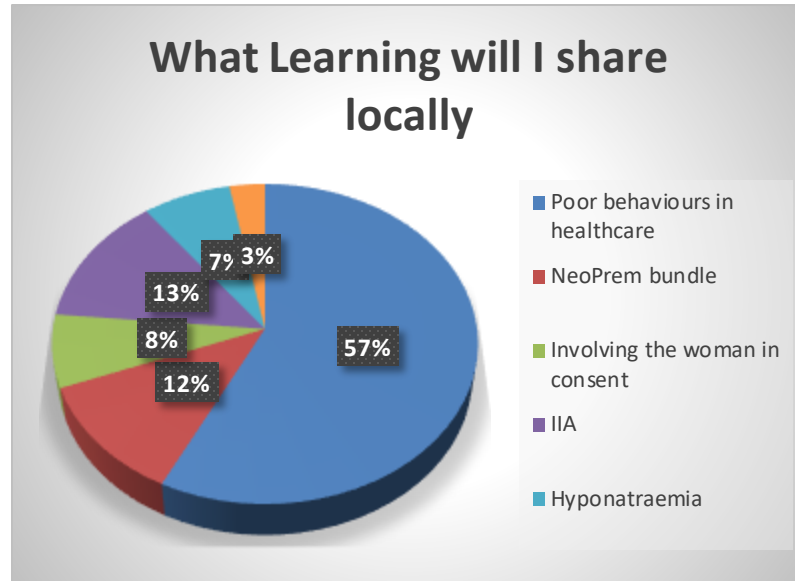
100%

YES 

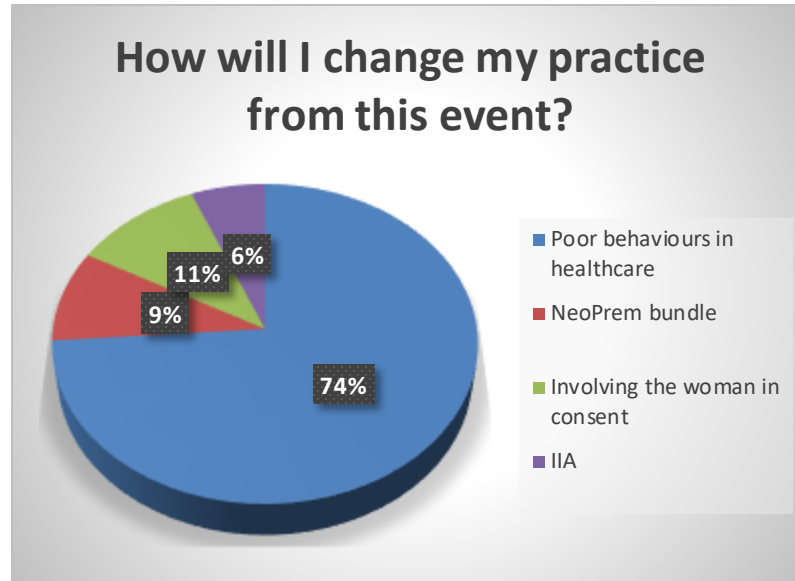
What Learning will I share locally

These included:

- Focusing on MDT de-briefing on incidents
- Delayed cord clamping
- Involving the woman in all decision making
- Ensure that I have received consent for procedures/students etc.
- Be kind – start with what went right not what went wrong
- Walk in someone else's shoes – do you know the role of everyone
- Intelligent Auscultation
- There is a regional governance group!



How will I change my practice from this event?



These included:

- Add delayed cord clamping to PROMPT
- Focus more on the positive
- Ensure MDT involvement in case reviews
- Continued reflection on patient experience
- Increased awareness of patient safety and regional working
- Shared decision making always involve women and families
- Challenge the negative culture
- Focus on team work
- Try to undertake a day of different roles e.g. domestic/porter/consultant/nurse

General comments



- "There was a great balance between national overview, general governance and case studies. These events are amazing and really useful."
- "Great to have regional colleagues in the room"
- "From today I need to be brave introducing what seem like impossible changes/projects/innovations"
- "A good mix of sharing and learning"
- "A clear central flow of patient safety"
- "Senior leaders demonstrating their own experiences with issues that have not gone as well as they hoped was invaluable"

