



This is a monthly report, specific to the hospital named below setting out a range of information on the safety of maternity services. (Version 4 – May 2020)

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Hospital Name	University Hospital Waterford Reporting Month July 2020				
	This Statement is used to inform local hospital and hospital Group management in carrying out their role in safety and quality improvement. The objective in publishing the Statement each month is to provide public assurance that maternity services are delivered in an environment that promotes open disclosure.				
t with	It is not intended that the monthly Statement be used as a comparator with other units that statements would be aggregated at hospital Group or national level. It assists in an early warning mechanism for issues that require local action and/ or escalation				
Purpose & Context	It is important to note tertiary and referral maternity centres will care for a higher complexity of patients (mothers and babies), therefore clinical activity in these centres will be higher and therefore no comparisons should be drawn with units that do not look after complex cases.				
	Maternity Safety Statements form part of the suite of key performance indicators for the maternity services. Hospitals must populate and publish on a monthly basis (2 months in arrears). Additionally the statements are discussed at the Hospital Group Maternity Network meetings with the National Women and Infants Health Programme as part of the quality and safety agenda.				

Headings		Information Areas	2020	
	Ref		July	Year to date
Hospital Activities	1	Total mothers delivered ≥ 500g (n)	128	961
	2	Multiple pregnancies (n)	2	16 (I set triplets)
	3	Total births ≥ 500g (n)	130	978
	4	Perinatal mortality rate ~ adjusted (per 1,000 total births)	0.0 Per 1,000	1.02 Per 1,000
	5	In utero transfer – admitted (n)	0	4
	6	In utero transfer – sent out (n)	0	3
Major Obstetric Events	7	Total combined rate (per 1,000 total mothers delivered) of major obstetric events for the following four obstetric metrics:  Eclampsia;  Uterine rupture;  Peripartum hysterectomy; and  Pulmonary embolism.	0.0 Per 1,000	0.0 Per 1,000

Ref	Information Areas	2020	
			Year to date
8	Rate of instrumental delivery per total mothers delivered (%)	16.4%	16.5%
9	Rate of nulliparas with instrumental delivery (%)	35.8%	33.8%
10	Rate of multiparas with instrumental delivery (%)	7.8%	7.5%
11	Rate of induction of labour per total mothers delivered (%)	40.6%	36.4%
12	Rate of nulliparas with induction of labour (%)	58.9%	45.7%
13	Rate of multiparas with induction of labour (%)	32.5%	31.6%
14	Rate of Caesarean section per total mothers delivered (%)	30.4%	27.2%
15	Rate of nulliparas with Caesarean section (%)	25.6%	28%
16	Rate of multiparas with Caesarean section (%)	32.5%	26.8%
17	Total number of clinical incidents for <b>Maternity Services</b> (reported monthly to NIMS) (n)	25	182
	8 9 10 11 12 13 14 15	8 Rate of instrumental delivery per total mothers delivered (%) 9 Rate of nulliparas with instrumental delivery (%) 10 Rate of multiparas with instrumental delivery (%) 11 Rate of induction of labour per total mothers delivered (%) 12 Rate of nulliparas with induction of labour (%) 13 Rate of multiparas with induction of labour (%) 14 Rate of Caesarean section per total mothers delivered (%) 15 Rate of nulliparas with Caesarean section (%) 16 Rate of multiparas with Caesarean section (%) 17 Total number of clinical incidents for Maternity Services (reported	Ref Information Areas  Rate of instrumental delivery per total mothers delivered (%)  Rate of nulliparas with instrumental delivery (%)  Rate of multiparas with instrumental delivery (%)  Rate of induction of labour per total mothers delivered (%)  Rate of nulliparas with induction of labour (%)  Rate of multiparas with induction of labour (%)  Rate of multiparas with induction of labour (%)  Rate of Caesarean section per total mothers delivered (%)  Rate of nulliparas with Caesarean section (%)  Rate of multiparas with Caesarean section (%)  Rate of multiparas with Caesarean section (%)  Total number of clinical incidents for Maternity Services (reported)

## **DEFINITIONS**

(n) = Number

Nulliparas = Women who have never had a previous pregnancy resulting in a live birth or stillbirth (≥ 500g)
Multiparas = Women who have had at least one previous pregnancy resulting in a live birth or stillbirth (≥ 500g)
N/A = Not available

The Maternity Safety Statement for University Hospital Waterford provides up to date information for management and clinicians who provide maternity services in relation to a range of patient safety issues for July 2020

The information in this Statement is a core element of clinical governance and management of maternity services within the above hospital and the SSWHG.

Hospital Group Clinical Director: JOHN R. HIGGINS

Signature:

Hospital Group CEO:

Gerry O'Dwye

Signature:

Date:

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