

Maternity Patient Safety Statement Feidhmeannacht na Seirbhíse Sláinte Health Service Executive

This is a monthly report, specific to the hospital named below setting out a range of information on the safety of maternity services.

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	Hospital Name	Midland Regional Hospital Portlaoise	Reporting Month	March 2016
 delivered in an environment that promotes open disclosure. It is not intended that the monthly Statement be used as a comparator with other unit or 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. It forms part of the recommendations in the following reports: HSE Midland Regional Hospital, Portlaoise Perinatal Deaths, Report to the Minister for Health from Dr. Tony Holohan, Chief Medical Officer, 24 February 2014; and HIQA Report of the Investigation into the Safety, Quality and Standards of Services Provided by the HSE to patients in the Midland Regional Hospital, Portlaoise, 8 May 2015. 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 centre will be higher and therefore no comparisons should be drawn with units that do not look after complex cases. 	Purpose & Context	 carrying out their role in safety and quathe Statement each month is to provid delivered in an environment that promulate in an environment that promulate or that statements would be aggregate in an early warning mechanism for issues it forms part of the recommendations in the instead of the	ality improvement. The e public assurance that otes open disclosure. ement be used as a con- ed at hospital Group or ues that require local ac n the following reports: tal, Portlaoise Perinatal ony Holohan, Chief Me tion into the Safety, Qua E to patients in the Midl rral maternity centres w abies), therefore clinical	objective in publishing maternity services are mparator with other units national level. It assists ction and/ or escalation. Deaths, Report to the dical Officer, 24 ality and Standards of and Regional Hospital, ill care for a higher activity in these centres

			2016	
Headings	Ref	Information Areas	March 2016	Year to date
Hospital Activities	1	Total mothers delivered ≥ 500g (n)	129	335
	2	Multiple pregnancies (n)	0	2
	3	Total births ≥ 500g (n)	129	337
	4	Perinatal mortality rate – adjusted (per 1,000 total births)	0.0	0.0
	5	In utero transfer – admitted (n)	3	4
	6	In utero transfer – sent out (n)	3	8
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

	Ref I	Information Areas	2016	
Headings			March 2016	Year to date
Delivery Metrics	8	Rate of instrumental delivery per total mothers delivered (%)	15.5%	14.9%
	9	Rate of nulliparas with instrumental delivery (%)	23.%	27.5%
	10	Rate of multiparas with instrumental delivery (%)	12.2%	10.48%
	11	Rate of induction of labour per total mothers delivered (%)	32.55%	29.5%
	12	Rate of nulliparas with induction of labour (%)	46.15%	37.98%
	13	Rate of multiparas with induction of labour (%)	26.6%	26.66%
	14	Rate of Caesarean section per total mothers delivered (%)	34.1%	26.5%
	15	Rate of nulliparas with Caesarean section (%)	35.89%	28.73%
	16	Rate of multiparas with Caesarean section (%)	33.33%	25.8%
Maternity Services Total Clinical Incidents	17	Total number of clinical incidents for Maternity Services (reported monthly to NIMS) (n)	47	93

DEFINITIONS

(n) = Number

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

The Maternity Patient Safety Statement for Dublin Midlands Hospital Group provides up to date information for management and clinicians who provide maternity services in relation to a range of patient safety issues for March 2016.

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

Hospital Group Clinical Director:

Mr Martin Feeley

Dr Susan O Reilly

Signature:

Hospital Group CEO:

Jusan O'Reille

Signature:

Date:

31.05.2016