

Maternity Patient Safety Statement

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 is	Hospital Name	Regional Hospital Mullingar	Reporting Month	October 2016
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 delivered in an environment that promotes open disclosure. It is not intended that the monthly Statement be used as a comparator with other or that statements would be aggregated at hospital Group or national level. It ass in an early warning mechanism for issues that require local action and/ or escalar lit forms part of the recommendations in the following reports: • HSE Midland Regional Hospital, Portlaoise Perinatal Deaths, Report to 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 Services Provided by the HSE to patients in the Midland Regional Hosp 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 ce will be higher and therefore no comparisons should be drawn with units that do n look after complex cases.	Purpose & Context	carrying out their role in safety and qualithe Statement each month is to provid delivered in an environment that prome. It is not intended that the monthly State or that statements would be aggregated in an early warning mechanism for issuit forms part of the recommendations in HSE Midland Regional Hospi Minister for Health from Dr. To February 2014; and HIQA Report of the Investigate Services Provided by the HSI Portlaoise, 8 May 2015. It is important to note tertiary and refere complexity of patients (mothers and baseful will be higher and therefore no companion.	ality improvement. The e public assurance that otes open disclosure. ement be used as a cored at hospital Group or rues that require local acon the following reports: tal, Portlaoise Perinatal ony Holohan, Chief Mettion into the Safety, Quality to patients in the Midlerral maternity centres with abies), therefore clinical	maternity services are mparator with other units national level. It assists ation and/ or escalation. Deaths, Report to the dical Officer, 24 ality and Standards of and Regional Hospital, Il care for a higher activity in these centres

			2016	
Headings	Ref	Information Areas	October	Year to date
Hospital Activities	1	Total mothers delivered ≥ 500g (n)	155	1752
	2	Multiple pregnancies (n)	3	21
	3	Total births ≥ 500g (n)	158	1773
	4	Perinatal mortality rate – adjusted (per 1,000 total births)	0 Per 1,000	1.12 Per 1,000
	5	In utero transfer – admitted (n)	0	0
	6	In utero transfer – sent out (n)	2	27
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 Per 1,000	0.56 Per 1,000

	Ref	Information Areas	2016	
Headings			October	Year to date
Delivery Metrics	8	Rate of instrumental delivery per total mothers delivered (%)	10.32 %	10.73 %
	9	Rate of nulliparas with instrumental delivery (%)	12.96%	22.05%
	10	Rate of multiparas with instrumental delivery (%)	8.91%	4.92 %
	11	Rate of induction of labour per total mothers delivered (%)	29.67 %	28.82 %
	12	Rate of nulliparas with induction of labour (%)	31.48 %	34.84%
	13	Rate of multiparas with induction of labour (%)	28.71 %	25.73 %
	14	Rate of Caesarean section per total mothers delivered (%)	37.42%	38.64%
	15	Rate of nulliparas with Caesarean section (%)	46.29 %	44.27 %
	16	Rate of multiparas with Caesarean section (%)	32.67 %	35.75 %
Maternity Services Total Clinical Incidents	17	Total number of clinical incidents for Maternity Services (reported monthly to NIMS) (n)	29	292

Please note that the activity data published above is based on the information available when the report was compiled.

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 Patient Safety Statement for Regional Hospital Mullingar provides up to date information for management and clinicians who provide maternity services in relation to a range of patient safety issues for October 2016.

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

W. Smilly.

Hospital Group Clinical Director: Kevin O'Malley/Risteard O'Laoide

Signature:

Mary Day Hospital Group CEO:

20th December 2016 Date:

Signature: