

## 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.

Regional Hospital Wullingar Reporting Worth FEBRUARY 20	Hospital Name	Regional Hospital Mullingar	Reporting Month	FEBRUARY 2016
This Statement is used to inform local hospital and hospital Group management carrying out their role in safety and quality improvement. The objective in publish 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 as 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 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 or will be higher and therefore no comparisons should be drawn with units that do relook after complex cases.	Purpose & Context	carrying out their role in safety and que the Statement each month is to provide delivered in an environment that prond that is not intended that the monthly Statements would be aggregated in an early warning mechanism for isself that the monthly Statements would be aggregated in an early warning mechanism for isself that the monthly Statements would be aggregated in an early warning mechanism for isself that the monthly Statements in an early warning mechanism for isself that the monthly statements in an early warning mechanism for isself that the monthly statements in an early warning mechanism for isself that the monthly statements in an early warning mechanism for isself that the monthly statements in an early warning mechanism for isself that the monthly statements in an early warning mechanism for isself that the monthly statements in an early warning mechanism for isself that the monthly statements would be aggregated in an early warning mechanism for isself that the monthly statements would be aggregated in an early warning mechanism for isself that the monthly statements would be aggregated in an early warning mechanism for isself that the monthly statements would be aggregated in an early warning mechanism for isself that the monthly statements would be aggregated in an early warning mechanism for isself that the monthly statements would be aggregated in an early warning mechanism for isself that the monthly statements would be aggregated in an early warning mechanism for isself that the monthly statements would be aggregated in an early warning mechanism for isself that the monthly statements would be aggregated in an early warning mechanism for isself that the monthly statements would be aggregated in an early warning mechanism for isself that the monthly statements would be aggregated in an early warning mechanism for isself that the monthly statements would be aggregated in an early warning mechanism for isself that the monthly statements would be aggregated in an early warning mechanism for issel	pality improvement. The de public assurance that notes open disclosure. Itement be used as a cored at hospital Group or sues that require local action the following reports: pital, Portlaoise Perinatal Tony Holohan, Chief Meation into the Safety, Quater at maternity centres whabies), therefore clinical	objective in publishing a maternity services are imparator with other units national level. It assists ction and/ or escalation.  I Deaths, Report to the dical Officer, 24  ality and Standards of land Regional Hospital,  ill care for a higher I activity in these centres

		Information Areas	2016	
Headings	Ref		FEBRUARY	Year to date
Hospital Activities	1	Total mothers delivered ≥ 500g (n)	167	329
	2	Multiple pregnancies (n)	2	3
	3	Total births ≥ 500g (n)	169	332
	4	Perinatal mortality rate – adjusted (per 1,000 total births)	0.0 Per 1,000	0.0 Per 1,000
	5	In utero transfer – admitted (n)	0	0
	6	In utero transfer – sent out (n)	1	4
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	2016	
Headings			FEBRUARY	Year to date
Delivery Metrics	8	Rate of instrumental delivery per total mothers delivered (%)	12.42 %	11.77 %
	9	Rate of nulliparas with instrumental delivery (%)	29.31 %	27.02 %
	10	Rate of multiparas with instrumental delivery (%)	3.66 %	4.12 %
	11	Rate of induction of labour per total mothers delivered (%)	26.03 %	26.74 %
	12	Rate of nulliparas with induction of labour (%)	32.75 %	31.53 %
	13	Rate of multiparas with induction of labour (%)	22.93 %	23.39 %
	14	Rate of Caesarean section per total mothers delivered (%)	38.46 %	38.92 %
	15	Rate of nulliparas with Caesarean section (%)	44.82 %	46.84 %
	16	Rate of multiparas with Caesarean section (%)	35.77 %	34.86 %
Maternity Services Total Clinical Incidents	17	Total number of clinical incidents for <b>Maternity Services</b> (reported monthly to NIMS) (n)	38	59

## **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 February 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.

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

Signature:

Hospital Group CEO:

Signature:

28/4/16 Date: