

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 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. It is not intended that the monthly Statement be used as a comparator with other units 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 centres	Hospital Name	Regional Hospital Mullingar	Reporting Month	MARCH 2016
will be higher and therefore no comparisons should be drawn with units that do not look after complex cases.		This Statement is used to inform local carrying out their role in safety and quathe Statement each month is to provid delivered in an environment that promet it is not intended that the monthly State or that statements would be aggregated in an early warning mechanism for issult forms part of the recommendations i 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 bas will be higher and therefore no companion.)	hospital and hospital Gality improvement. The epublic assurance that otes open disclosure. The ement be used as a constant the following reports: tal, Portlaoise Perinatal ony Holohan, Chief Medical into the Safety, Quality to patients in the Midle and maternity centres with the solution into the safety in the Midle and maternity centres with the safety, therefore clinical safety, therefore clinical safety, therefore clinical safety, the safety in the safety in the safety, the safety is the safety in the safety in the safety, the safety is the safety in t	roup management in objective in publishing maternity services are imparator with other units national level. It assists stion 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

	Ref	Information Areas	2016	
Headings			MARCH 2016	Year to date
Hospital Activities	1	Total mothers delivered ≥ 500g (n)	179	508
Addivides	2	Multiple pregnancies (n)	1	4
	3	Total births ≥ 500g (n)	180	512
	4	Perinatal mortality rate – adjusted (per 1,000 total births)	5.55 Per 1,000	1.95 Per 1,000
	5	In utero transfer – admitted (n)	0	0
	6	In utero transfer – sent out (n)	1	5
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

Headings	Ref	Information Areas	2016	
			MARCH 2016	Year to date
Delivery Metrics	8	Rate of instrumental delivery per total mothers delivered (%)	9.49%	11.0%
	9	Rate of nulliparas with instrumental delivery (%)	11.86%	21.76%
	10	Rate of multiparas with instrumental delivery (%)	8.33%	5.62%
	11	Rate of induction of labour per total mothers delivered (%)	30.16%	27.56%
	12	Rate of nulliparas with induction of labour (%)	35.59%	32.94%
	13	Rate of multiparas with induction of labour (%)	27.5 %	24.85%
	14	Rate of Caesarean section per total mothers delivered (%)	39.66%	39.17%
	15	Rate of nulliparas with Caesarean section (%)	49.15 %	47.64%
	16	Rate of multiparas with Caesarean section (%)	35.1%	34.9%
Maternity Services Total Clinical Incidents	17	Total number of clinical incidents for Maternity Services (reported monthly to NIMS) (n)	31	90

DEFINITIONS

(n) = Number

Signature:

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 March 2016.

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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

W. Smily. Signature: Mary Day

Hospital Group CEO:

30th May 2016 Date: