

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 a	Hospital Name	Wexford General Hospital	Reporting Month	May 2016
delivered in an environment that promotes open disclosure. It is not intended that the monthly Statement be used as a comparator with other user that statements would be aggregated at hospital Group or national level. It assis in an early warning mechanism for issues that require local action and/or escalation and are 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 centwill be higher and therefore no comparisons should be drawn with units that do no 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 uses that require local acon the following reports: tal, Portlaoise Perinatal ony Holohan, Chief Metion into the Safety, Quate to patients in the Midleral maternity centres wishies), 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, ill care for a higher activity in these centres

			2016	
Headings	Ref	Information Areas	May	Year to date
Hospital Activities	1	Total mothers delivered ≥ 500g (n)	152	734
	2	Multiple pregnancies (n)	1	2
	3	Total births ≥ 500g (n)	153	736
	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)	7	24
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	1.36 Per 1,000

	Ref	Information Areas	2016	
Headings			May	Year to date
Delivery Metrics	8	Rate of instrumental delivery per total mothers delivered (%)	17.8%	17.2%
	9	Rate of nulliparas with instrumental delivery (%)	39.2%	36.8%
	10	Rate of multiparas with instrumental delivery (%)	7.1%	5.9%
	11	Rate of induction of labour per total mothers delivered (%)	23%	24.5%
	12	Rate of nulliparas with induction of labour (%)	25.5%	29.1%
	13	Rate of multiparas with induction of labour (%)	22.2%	22.1%
	14	Rate of Caesarean section per total mothers delivered (%)	24%	26.5%
	15	Rate of nulliparas with Caesarean section (%)	27.5%	29.1%
	16	Rate of multiparas with Caesarean section (%)	22.2%	25.1%
Maternity Services Total Clinical Incidents	17	Total number of clinical incidents for Maternity Services (reported monthly to NIMS) (n)	21	124

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 Wexford General Hospital provides up to date information for management and clinicians who provide maternity services in relation to a range of patient safety issues for May 2016.

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

21/7/16

Hospital Group Clinical Director: Mr Kevin O'Malley

Signature:

Hospital Group CEO: Mary Day

Signature:

Date: