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.

Hospital Name	Mayo University Hospital	Reporting Month	October 2016
Purpose & Context	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 will be higher and therefore no comparisons should be drawn with units that do not look after complex cases.		

Headings	Ref	Information Areas	2016	
			October	Year to date
Hospital Activities	1	Total mothers delivered ≥ 500g (n)*	126	1325
	2	Multiple pregnancies (n)	2	25
	3	Total births ≥ 500g (n)*	128	1350
	4	Perinatal mortality rate – adjusted (per 1,000 total births)	0 Per 1,000	0 Per 1,000
	5	In utero transfer – admitted (n)	0	1
	6	In utero transfer – sent out (n)	2	12
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	1.5 Per 1,000

Headings	Ref	Information Areas	2016	
			October	Year to date
Delivery Metrics	8	Rate of instrumental delivery per total mothers delivered (%)*	12.7%	12.0%
	9	Rate of nulliparas with instrumental delivery (%)* / **	30.3%	25.7%
	10	Rate of multiparas with instrumental delivery (%)* / **	6.5%	5.0%
	11	Rate of induction of labour per total mothers delivered (%)*	16.7%	22.8%
	12	Rate of nulliparas with induction of labour (%)*	18.2%	32.6%
	13	Rate of multiparas with induction of labour (%)*	16.1%	17.8%
	14	Rate of Caesarean section per total mothers delivered (%)*	35.7%	32.5%
	15	Rate of nulliparas with Caesarean section (%)*	30.3%	35.7%
	16	Rate of multiparas with Caesarean section (%)*	37.6%	30.9%
Maternity Services Total Clinical Incidents	17	Total number of clinical incidents for **Maternity Services** (reported monthly to NIMS) (n)	18	122

*Amended 28/02/17. **Amended 03/10/17.

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 Mayo University Hospital provides up to date information for management and clinicians who provide maternity services in relation to a range of patient safety issues for the month of October and year 2016.

The information in this Statement is a core element of clinical governance and management of maternity services within the above hospital and the Saolta University Health Care Group.

Hospital Group Clinical Director: Dr. Pat Nash

Signature: 17/10/17

Hospital Group CEO: Mr. Maurice Power

Signature: 19/10/17

Date: