

## **Maternity 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.

Hospital Name	Mayo University Hospital	Reporting Month	March 2025			
	<ul> <li>This Statement is used to in management in carrying out The objective in publishing t assurance that maternity se promotes open disclosure.</li> </ul>	their role in safety and he Statement each mo	quality improvement.  nth is to provide public			
Purpose & Context	other units or that statement national level. It assists in a require local action and/ or e	<ul> <li>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:</li> </ul>				
	higher complexity of patient activity in these centres will	<ul> <li>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.</li> </ul>				
		This statement does not contain the entire suite of metrics used to measure safety in our maternity services				

Headings	100	Ref Information Areas	2025	
	Ref		March	Year to date
Hospital Activities	1	Total mothers delivered ≥ 400g (n)	96	317
	2	Multiple pregnancies (n)	1	2
	3	Total births ≥ 400g (n)or ≥ 23weeks(n)	95	317
	4	Perinatal mortality rate – adjusted (per 1,000 total births)	0.0 Per 1,000	3.2 Per 1,000
	5	In utero transfer – admitted (n)	0	0
	6	In utero transfer – sent out (n)	0	1
Major Obstetric Events	major obstetric events for the following four obstetric metrics:  • Fclampsia:		0.0 Per 1,000	3.2 Per 1,000

Headings	Ref	Information Areas	2025	
			March	Year to date
Delivery Metrics	8	Rate of instrumental delivery per total mothers delivered (%)	9.4%	10.7%
	9	Rate of nulliparas with instrumental delivery (%)	20.0%	22.9%
	10	Rate of multiparas with instrumental delivery (%)	3.3%	3.5%
	11	Rate of induction of labour per total mothers delivered (%)	41.7%	36.6%
	12	Rate of nulliparas with induction of labour (%)	57.1%	47.5%
	13	Rate of multiparas with induction of labour (%)	32.8%	30.2%
	14	Rate of Caesarean section per total mothers delivered (%)	43.8%	42.0%
	15	Rate of nulliparas with Caesarean section (%)	60.0%	48.3%
	16	Rate of multiparas with Caesarean section (%)	34.4%	38.2%
Maternity Services Total Clinical Incidents	ervices (reported monthly to NIMS) (n) otal Clinical		56	174

## **DEFINITIONS**

(n) = Number

Nulliparas = Women who have never had a previous pregnancy resulting in a live birth or stillbirth (≥ 400g) Multiparas = Women who have had at least one previous pregnancy resulting in a live birth or stillbirth (≥ 400g) 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 March and year 2025.

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

REO/ Designated IHA Manager:

Mr. Tony Canavan

Signature:

Maternity Network CD

Dr. John Morrison

Signature: