University Hospital Galway
Ospidéal na hOllscoile, Gaillimh
GALWAY UNIVERSITY HOSPITALS

Portiuncula University Hospital


Mayo University Hospital

Sligo University Hospital
The Mall, Sligo. F91 H684 Tel: 071 917 1111 Fax: 071 917 4648


Letterkenny University Hospital

Saolta
*Grúpa Ollscoile Cúram Sláinte*
*University Health Care Group*

# Women's & Children's Managed Clinical & Academic Network

University Hospital Galway
Portiuncula University Hospital
Mayo University Hospital
Sligo University Hospital
Letterkenny University Hospital

## Annual Clinical Report 2019

# Contents

# *Women's & Children's Managed Clinical & Academic Network - Annual Clinical Report – 2019*

Clinical Director Professor John Morrison

This Annual Clinical Report serves to outline the clinical activity and statistics related to Womens and Childrens services in the Saolta Healthcare Group of hospitals, namely Galway University Hospital, Letterkenny University Hospital, Mayo University Hospital, Castlebar, Sligo University Hospital and Portiuncula University Hospital Ballinasloe, pertaining to 2019. These five hospitals provide services in Obstetrics & Gynaecology, and in Paediatrics and Neonatology, over a large geographical area of the West/North West region of Ireland. In an era when clinical accountability is paramount, and in an environment of finite resources, it is fitting that Saolta in 2019 developed an integrated network for delivery of these services across the entire group, namely the Womens and Childrens Managed Clinical and Academic Network (MCAN). The ethos of this integrated approach is based on sound evidence that such a network introduces the opportunity for a high quality clinical service across our Group hospitals, alongside consistent standards, sound governance, integration of care, and the configuration of services to make optimal use of resources. It also provides for academic opportunities in terms of undergraduate and postgraduate education, and research, with our partner institution National University of Ireland Galway. From a governance perspective the Womens and Childrens MCAN works closely with the multidisciplinary team on each site, and also with the Saolta Executive Team.

From an obstetric perspective there was a marginal decline in the number of infants delivered in Saolta Group hospitals during 2019 (n=8921) compared to 2018 (n=9039), which is consistent with a national trend. The demographic features, mode of delivery, and obstetric parameters, are outlined for all of the individual hospitals. During 2019 it is encouraging that more hospital sites have developed low risk midwifery services in compliance with the supported care pathway of the national maternity strategy. For specialist services in fetal medicine, and high risk obstetric care, University Hospital Galway serves as the referral centre. In relation to Gynaecology, there are two trends apparent which are consistent with current practice in general. Firstly, a greater number of procedures are being performed laparoscopically. Secondly, the development of ambulatory gynaecology services, with the facility for one outpatient visit to 'see and treat', is ongoing, and remains a strategy for the network in all sites. Specialist services in Gynaecological Oncology are provided at University Hospital Galway, with well established referral pathways and multi-disciplinary team meetings. Similar services are available for the specialties of Reproductive Medicine and Urogynaecology.

Much attention was paid during 2019 to development of the neonatal services within the Saolta Healthcare Hospital Group. The NICU at University Hospital Galway serves as a Level 2 neonatal unit for provision of specialist services from 27 weeks gestation onwards. In 2019, separation of the neonatal and paediatric consultant rotas was achieved, with 24-hour neonatal cover on site, in order to facilitate the referral pathway from other hospitals within our network. I want to thank of the nursing and medical staff in neonatology who worked hard to achieve this aim. It is a work in progress and remains our goal to further develop this service. There are well developed general Paediatric Units on all of our 5 hospital sites, with a greater proportion of specialty clinical services on the University Hospital Galway site. The infrastructure available for paediatric care on some of our sites is a challenge we need to address in the coming years. It is a time of great change in Paediatric care nationally, with the development of the National Children's Hospital, and the associated hub and spoke model. It is imperative that we in Saolta are in a position to meet these demands as a regional hub, in compliance with the Paediatric National Clinical Care Programme.

There were other challenges and controversies during 2019 that are worthy of mention. The controversy over the National Cervical Check programme highlighted the important concept of quality assurance in screening programmes. The issue of open disclosure to service users was also to the forefront. There are four colposcopy units within our Saolta Hospital Group, and significant effort was made in all units in dealing with the appropriate dissemination of the RCOG enquiry results regarding cytology analysis. As a separate matter, the Termination of Pregnancy Act 2018 facilitated a pregnancy options service in Irish hospitals from 1st January 2019, under certain statutory conditions. The provision of the different components of these services was introduced across many of our Group hospitals. This has not been without challenges, and would not have occurred without the professional input of the multidisciplinary team of nursing, midwifery, sonography, counselling, administrative and medical staff involved.

Many people who contributed significantly over the years to our Women's and Children's health services in Saolta retired during 2019, and I wish them well. Similarly I welcome a new group of professionals who started during 2019 and will provide our service into the future. The new integrated network across our group hospitals is dependant on the commitment of all staff members who work in it.

There are some people I wish to acknowledge. Thank you to Dr Ethel Ryan, Group Clinical Director, and Dr Una Conway, Group Clinical Lead, before my appointment in 2019, for their significant contribution to advancement of our services in Saolta. Ms Siobhan Canny is the Group Director of Midwifery for the W & C MCAN, and she works tirelessly to promote good practice and sound governance in all our services and hospitals. Siobhan was closely involved in the development of the network. Dr Mary Herzig, as Group Clinical Director of Paediatrics, and Ms Siobhan Horkan, as Group Director of Paediatric Nursing, are committed to integration and development of our paediatric services. Ms Elaine Dobell, General Manager of the W & C MCAN, has steered the complex administrative changes required for the changeover to our network. The Associate Clinical Directors, and Director of Midwifery, on each hospital site have shown great motivation in embracing the network approach on their sites. Ms Grainne Cawley, in our Saolta HSE Project Office, has supported us greatly on the way, prior to, and after our launch. I want to thank the Saolta Group Executive who had the vision to promote and support development of the network in order to improve patient care.

Many people contributed sections to this report, and for that I am grateful. Finally, I would like to thank Mr Colin Coyle, Group Data Analyst, who contributed immensely to this report. We have plans for a more uniform version of this report from each site next year. From my own perspective, it is a privilege to be the Clinical Director of the Women's and Children's Managed Clinical and Academic Network for the Saolta Healthcare Group of hospitals. I hope that we can achieve our goals for delivery of the highest standards of care and excellence to the women and children of our region.

**Professor John J. Morrison**
**Clinical Director W&C Managed Clinical and Academic Network**
**Saolta University Healthcare Hospital Group**

*Professor John J. Morrison*

# *University Hospital Galway: Introduction*

Associated Clinical Director Dr Tom O'Gorman

2019 saw change in the Obstetric and Gynaecology Department at University College Hospital Galway.

Professor John Morrison was appointed as the Director of the Women's and Children's Managed Clinical and Academic Network. This has seen changes in governance and increased integration across the Saolta group.

Renovation work to our former doctor's residence was completed. This new clinical space resulted in the moving of our Early Pregnancy Unit from our main outpatient area to a separate designated space. This allowed the expansion of the EPAU service to a five day a week service and will allow for the commencement of an Ambulatory Gynae service in 2020.

Regarding the obstetric work done in the department.

In 2019, 2839 babies were delivered to 2781 women at University Hospital Galway. There was a slight decrease from 2018. The mode of delivery for the majority of women was normal vaginal delivery at 48.9%. The caesarean section rate was 36% and 14.8% of women had an instrumental vaginal delivery.

The caesarean section rate has been rising yearly and has prompted reflection and the planning of a quality improvement project for 2020.

The number of mothers who had one previous caesarean delivering in 2019 was 414. The percentage of women in this group who attempted vaginal delivery was 39.4%. The successful VBAC rate in this group was 57.7% with 42.3% requiring an emergency caesarean section for delivery. There is a slight increase in the successful VBAC rate from last year.

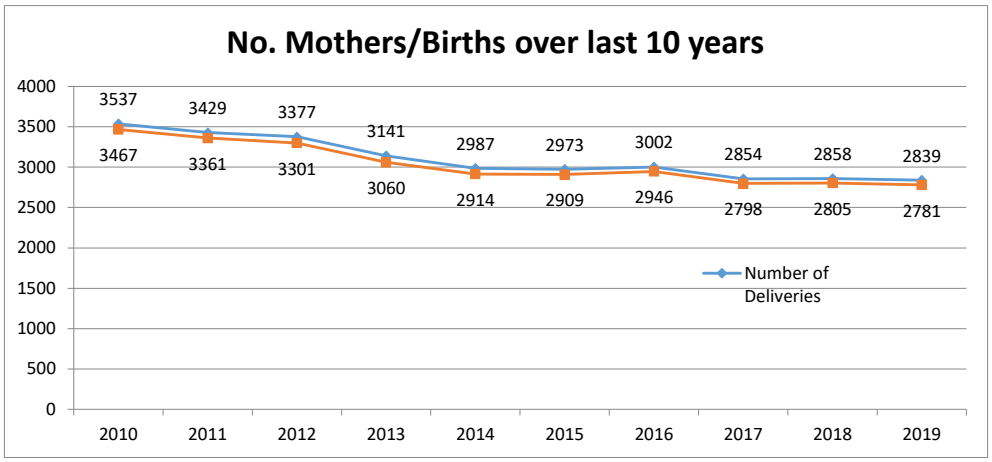
The overall perinatal mortality rate was up from 3.5 in 2018 to 3.9 in 2019 but the corrected perinatal mortality rate was down from 2.1 in 2018 to 0.7 in 2019.

Left to right: Anne Marie Grealish (Assistant Director of Midwifery, GUH), Tom O'Gorman (ACD / Consultant Obstetrician and Gynaecologist, GUH) and Helen Murphy (Director of Midwifery, GUH)

# Section 1: Maternity
## *(a) Statistical Summary*

Ms Clare Greaney Clinical Midwife Manager 2 Informatics & Dr Tom O'Gorman Associated Clinical Director

| Number of Mothers/Births, last 10 years | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 |
|---|---|---|---|---|---|---|---|---|---|---|
| Number of Deliveries | 3537 | 3429 | 3377 | 3141 | 2987 | 2973 | 3002 | 2854 | 2858 | 2839 |
| Number of Mothers | 3467 | 3361 | 3301 | 3060 | 2914 | 2909 | 2946 | 2798 | 2805 | 2781 |




| Obstetric Outcomes (Mothers) | Primip | % | Multip | % | Total | % |
|---|---|---|---|---|---|---|
| Spontaneous Onset | 506 | 45.6% | 770 | 46.1% | 1276 | 45.9% |
| Induction of Labour | 432 | 39.0% | 392 | 23.4% | 824 | 29.6% |
| Epidural Rate | 505 | 45.5% | 632 | 37.8% | 1137 | 40.9% |
| Episiotomy | 356 | 32.1% | 99 | 5.9% | 455 | 16.4% |
| Caesarean Section | 407 | 36.7% | 593 | 35.5% | 1000 | 36.0% |
| Spontaneous Vaginal Delivery | 376 | 33.9% | 983 | 58.8% | 1359 | 48.9% |
| Forcepts Delivery | 94 | 8.5% | 12 | 0.7% | 106 | 3.8% |
| Ventouse Delivery | 228 | 20.6% | 78 | 4.7% | 306 | 11.0% |
| Breech Delivery | 4 | 0.4% | 6 | 0.4% | 10 | 0.4% |
| **Total (Number)** | **1109** | | **1672** | | **2781** | |

| Multiple Pregnancies | Primip (1109) | % | Multip (1672) | % | Total (2781) | % |
|---|---|---|---|---|---|---|
| Twins | 27 | 2.4% | 27 | 1.6% | 54 | 1.9% |
| Triplets | 0 | 0.0% | 2 | 0.1% | 2 | 0.1% |

| Onset for Multiple Pregnancies | Primip (27) | % | Multip (29) | % | Total (56) | % |
|---|---|---|---|---|---|---|
| Induced | 6 | | 7 | | 13 | |
| Spontaneous | 6 | | 3 | | 9 | |
| No Labour | 15 | | 19 | | 34 | |
| Elective C.S. | 10 | | 13 | | 23 | |
| Emergency C.S. | 11 | | 12 | | 23 | |

| Multiple Births | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 |
|---|---|---|---|---|---|---|---|---|---|---|
| Twins | 69 | 66 | 74 | 73 | 69 | 64 | 55 | 52 | 47 | 54 |
| Triplets | 1 | 1 | 1 | 4 | 2 | 1 | 1 | 2 | 3 | 2 |
| Total | 70 | 67 | 75 | 77 | 71 | 65 | 56 | 54 | 50 | 58 |

| Perinatal Deaths | Primigravida | Multigravida | Total |
|---|---|---|---|
| Stillbirths | 4 | 4 | 8 |
| Early Neonatal Deaths | 1 | 1 | 2 |

| Perinatal Mortality | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 |
|---|---|---|---|---|---|---|---|---|---|---|
| Overall PMR per 1000 births | 7.6 | 5.4 | 6.4 | 7.4 | 6.0 | 7.1 | 6.0 | 4.6 | 3.1 | 3.9 |
| Corrected PMR per 1000 births | 6.5 | 3.5 | 3.3 | 4.1 | 5.0 | 4.4 | 3.7 | 3.5 | 2.8 | 0.7 |

| | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 |
|---|---|---|---|---|---|---|---|---|---|---|
| Stillbirth Rate | 0.50% | 0.30% | 0.40% | 0.60% | 0.50% | 0.50% | 0.40% | 0.40% | 0.28% | 0.31% |
| Neonatal Death Rate | 0.30% | 0.20% | 0.20% | 0.10% | 0.10% | 0.20% | 0.20% | 0.10% | 0.07% | 0.11% |
| **Total Rate** | **0.80%** | **0.50%** | **0.60%** | **0.70%** | **0.60%** | **0.70%** | **0.60%** | **0.50%** | **0.35%** | **0.39%** |

| Parity | Number of Mothers | % Rate |
|---|---|---|
| 0 | 1110 | 39.91% |
| 1 | 959 | 34.48% |
| 2 | 492 | 17.69% |
| 3 | 148 | 5.32% |
| 4 | 43 | 1.55% |
| 5 | 13 | 0.47% |
| 6 | 10 | 0.36% |
| 7 | 1 | 0.04% |
| 8 | 1 | 0.04% |
| 9 | 2 | 0.07% |
| 10 | 1 | 0.04% |
| 11 | 1 | 0.04% |
| | **2781** | **2.60%** |

| Parity | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 |
|---|---|---|---|---|---|---|---|---|---|---|
| 0 | 43.2% | 40.2% | 37.9% | 38.4% | 39.7% | 39.5% | 39.3% | 39.2% | 40.9% | 39.91% |
| 1,2,3 | 53.6% | 56.3% | 58.5% | 58.4% | 57.3% | 57.5% | 57.7% | 57.9% | 56.3% | 57.5% |
| 4+ | 3.2% | 3.6% | 3.6% | 3.1% | 3.1% | 3.0% | 3.0% | 3.0% | 2.84% | 2.6% |

| Age | Primigravida | % | Multigravida | % | Total | % |
|---|---|---|---|---|---|---|
| 15-19yrs | 9 | 0.8% | 0 | 0.0% | 9 | 0.3% |
| 20-24yrs | 96 | 8.6% | 41 | 2.5% | 137 | 4.9% |
| 25-29yrs | 132 | 11.9% | 164 | 9.8% | 296 | 10.6% |
| 30-34yrs | 368 | 33.1% | 396 | 23.7% | 764 | 27.5% |
| 35-39yrs | 376 | 33.8% | 733 | 43.9% | 1109 | 39.9% |
| 40-44yrs | 109 | 9.8% | 314 | 18.8% | 423 | 15.2% |
| 45> | 23 | 2.1% | 20 | 1.2% | 43 | 1.5% |
| **Total** | **1113** | **100.0%** | **1668** | **100.00%** | **2781** | **100.0%** |

| Age @ Delivery | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 |
|---|---|---|---|---|---|---|---|---|---|---|
| 15-19yrs | 2.2% | 1.3% | 1.5% | 1.6% | 1.1% | 0.9% | 0.7% | 0.7% | 0.4% | 0.3% |
| 20-24yrs | 9.3% | 8.2% | 7.4% | 6.9% | 6.3% | 6.9% | 6.1% | 5.4% | 4.9% | 4.9% |
| 25-29yrs | 20.9% | 20.3% | 18.4% | 16.5% | 15.4% | 14.8% | 14.1% | 13.5% | 10.2% | 10.6% |
| 30-34yrs | 36.4% | 36.5% | 36.0% | 35.9% | 34.8% | 33.6% | 34.5% | 30.7% | 27.7% | 27.5% |
| 35-39yrs | 25.3% | 27.3% | 29.5% | 32.1% | 32.0% | 33.4% | 34.1% | 37.2% | 39.5% | 39.9% |
| 40-44yrs | 5.5% | 6.0% | 6.8% | 6.5% | 8.8% | 9.8% | 9.7% | 11.7% | 16.4% | 15.2% |
| 45yrs> | 0.5% | 0.3% | 0.4% | 0.6% | 0.6% | 0.7% | 0.7% | 0.8% | 1.0% | 1.5% |

| County Of Origin | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 |
|---|---|---|---|---|---|---|---|---|---|---|
| Galway County | 56.9% | 57.0% | 56.3% | 54.8% | 53.8% | 55.0% | 56.5% | 57.9% | 56.1% | 58.94% |
| Galway City | 35.9% | 35.9% | 36.8% | 38.9% | 39.7% | 37.7% | 37.3% | 36.0% | 37.1% | 33.72% |
| Mayo | 2.3% | 2.3% | 3.4% | 2.6% | 2.3% | 2.9% | 2.1% | 2.5% | 2.5% | 2.91% |
| Roscommon | 1.3% | 1.0% | 2.0% | 2.4% | 1.0% | 1.2% | 0.9% | 1.0% | 1.1% | 1.11% |
| Clare | 3.2% | 3.4% | 1.0% | 0.8% | 2.7% | 2.6% | 2.5% | 1.9% | 2.5% | 2.12% |
| Others | 0.4% | 0.5% | 0.5% | 0.5% | 0.5% | 0.5% | 0.7% | 0.7% | 0.7% | 1.2% |

| Non National Births | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 |
|---|---|---|---|---|---|---|---|---|---|---|
| Number | 929 | 816 | 854 | 732 | 736 | 723 | 731 | 683 | 718 | 682 |
| % | 26.3% | 23.8% | 25.3% | 23.3% | 24.6% | 24.3% | 24.4% | 24.4% | 25.6% | 24.5% |

| Gestation @ Delivery | Primigravida | % | Multigravida | % | Total | % |
|---|---|---|---|---|---|---|
| <28 weeks | 6 | 0.5% | 2 | 0.1% | 8 | 0.3% |
| 28 - 31+6 | 10 | 0.9% | 10 | 0.6% | 20 | 0.7% |
| 32 - 36+6 | 64 | 5.8% | 81 | 4.8% | 145 | 5.2% |
| 37 - 39+6 | 421 | 38.0% | 909 | 54.4% | 1330 | 47.8% |
| 40 - 41+6 | 601 | 54.2% | 667 | 39.9% | 1268 | 45.6% |
| 42 weeks | 7 | 0.6% | 3 | 0.2% | 10 | 0.4% |
| **Total** | **1109** | **100.0%** | **1672** | **100.0%** | **2781** | **100.0%** |

| Birth Weights | Primigravida | % | Multigravida | % | Total | % |
|---|---|---|---|---|---|---|
| <1,000gms | 4 | 0.35% | 4 | 0.2% | 8 | 0.3% |
| 1000-1499gms | 10 | 0.88% | 7 | 0.4% | 17 | 0.6% |
| 1500-1999gms | 13 | 1.14% | 18 | 1.1% | 31 | 1.1% |
| 2000-2499gms | 46 | 4.05% | 41 | 2.4% | 87 | 3.1% |
| 2500-2999gms | 140 | 12.32% | 173 | 10.2% | 313 | 11.0% |
| 3000-3499gms | 382 | 33.63% | 529 | 31.1% | 911 | 32.1% |
| 3500-3999gms | 389 | 34.24% | 615 | 36.1% | 1004 | 35.4% |
| 4000-4499gms | 132 | 11.62% | 265 | 15.6% | 397 | 14.0% |
| 4500-4999gms | 19 | 1.67% | 50 | 2.9% | 69 | 2.4% |
| 5000-5499gms | 1 | 0.09% | 1 | 0.1% | 2 | 0.1% |
| **Total** | **1136** | **100.0%** | **1703** | **100.0%** | **2839** | **100.0%** |

| Birth Weights | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 |
|---|---|---|---|---|---|---|---|---|---|---|
| <500gms | 0.1% | 0.0% | 0.0% | 0.1% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.1% |
| 500-999gms | 0.7% | 0.6% | 0.4% | 0.6% | 0.5% | 0.5% | 0.5% | 0.4% | 0.3% | 0.3% |
| 1000-1999gms | 1.7% | 1.7% | 1.9% | 2.8% | 2.1% | 2.5% | 2.1% | 2.5% | 1.3% | 1.7% |
| 2000-2999gms | 14.2% | 14.2% | 14.8% | 15.0% | 14.8% | 13.7% | 14.7% | 14.3% | 12.5% | 14.1% |
| 3000-3999gms | 66.3% | 68.3% | 67.3% | 66.4% | 66.1% | 67.8% | 68.7% | 67.0% | 69.0% | 67.5% |
| 4000-4499gms | 14.1% | 14.1% | 15.2% | 13.1% | 14.4% | 13.1% | 11.8% | 13.6% | 14.9% | 14.0% |
| 4500-5000gms | 2.7% | 2.5% | 2.5% | 1.9% | 1.7% | 2.2% | 2.2% | 2.2% | 1.9% | 2.4% |
| 5000-5499gms | 0.2% | 0.4% | 0.2% | 0.1% | 0.2% | 0.2% | 0.1% | 0.1% | 0.1% | 0.1% |
| >5500gms | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% |
| **Total Number of Babies** | **3537** | **3429** | **3377** | **3141** | **2987** | **2973** | **3002** | **2854** | **2858** | **2839** |

| Induction of Labour | Primigravida | % | Multigravida | % | Total | % |
|---|---|---|---|---|---|---|
| 2010 | 483 | 32.3% | 452 | 23.0% | 935 | 27.0% |
| 2011 | 429 | 31.8% | 443 | 22.0% | 872 | 25.9% |
| 2012 | 439 | 35.1% | 504 | 24.6% | 943 | 28.6% |
| 2013 | 418 | 35.0% | 429 | 22.8% | 847 | 27.7% |
| 2014 | 431 | 37.3% | 425 | 24.2% | 856 | 29.4% |
| 2015 | 432 | 37.6% | 436 | 24.8% | 868 | 29.8% |
| 2016 | 443 | 38.3% | 455 | 25.4% | 898 | 30.5% |
| 2017 | 460 | 42.0% | 483 | 28.4% | 943 | 33.7% |
| 2018 | 464 | 40.5% | 387 | 23.3% | 851 | 30.3% |
| 2019 | 432 | 39.0% | 392 | 23.4% | 824 | 29.6% |

| Perineal Trauma | Primigravida | % | Multigravida | % | Total | % |
|---|---|---|---|---|---|---|
| Intact | 22 | 3.1% | 237 | 22.1% | 259 | 14.5% |
| Episiotomy | 356 | 49.9% | 99 | 9.2% | 455 | 25.5% |
| 2nd Degree Tear | 198 | 27.8% | 404 | 37.6% | 602 | 33.7% |
| 1st Degree Tear | 53 | 7.4% | 219 | 20.4% | 272 | 15.2% |
| 3rd Degree Tear | 26 | 3.6% | 24 | 2.2% | 50 | 2.8% |
| Other Laceration | 58 | 8.1% | 91 | 8.5% | 149 | 8.3% |
| **Total** | **713** | **100.0%** | **1074** | **100.0%** | **1787** | **100.0%** |

| Incidence of Episiotomy | Primigravida | % | Multigravida | % | Total | % |
|---|---|---|---|---|---|---|
| 2010 | 546 | 53.3% | 175 | 12.0% | 721 | 29.0% |
| 2011 | 495 | 53.8% | 153 | 10.5% | 648 | 27.2% |
| 2012 | 457 | 51.5% | 183 | 12.1% | 640 | 26.7% |
| 2013 | 430 | 55.3% | 141 | 10.7% | 571 | 27.3% |
| 2014 | 433 | 55.5% | 126 | 10.4% | 559 | 28.1% |
| 2015 | 452 | 57.3% | 155 | 12.2% | 607 | 29.5% |
| 2016 | 440 | 58.4% | 139 | 11.2% | 579 | 28.8% |
| 2017 | 449 | 64.1% | 150 | 13.0% | 599 | 32.3% |
| 2018 | 427 | 59.7% | 125 | 11.2% | 552 | 30.1% |
| 2019 | 356 | 49.9% | 99 | 9.2% | 455 | 25.5% |

| B.B.A. | Primigravida | % | Multigravida | % | Total | % |
|---|---|---|---|---|---|---|
| 2009 | 3 | 0.1% | 8 | 0.2% | 11 | 0.3% |
| 2010 | 3 | 0.1% | 6 | 0.2% | 9 | 0.3% |
| 2011 | 2 | 0.1% | 11 | 0.3% | 13 | 0.4% |
| 2012 | 0 | 0.0% | 5 | 0.2% | 5 | 0.2% |
| 2013 | 1 | 0.0% | 12 | 0.4% | 13 | 0.5% |
| 2014 | 1 | 0.0% | 5 | 0.2% | 6 | 0.2% |
| 2015 | 1 | 0.0% | 12 | 0.4% | 13 | 0.4% |
| 2016 | 1 | 0.0% | 11 | 0.4% | 12 | 0.4% |
| 2017 | 1 | 0.1% | 7 | 0.4% | 8 | 0.3% |
| 2018 | 1 | 0.1% | 4 | 0.2% | 5 | 0.2% |
| 2019 | 2 | 0.1% | 9 | 0.3% | 11 | 0.4% |

| 3rd Stage Problems | Primigravida | % | Multigravida | % | Total | % |
|---|---|---|---|---|---|---|
| Primary PPH | 79 | 83.2% | 48 | 76.2% | 127 | 80.4% |
| Manual Removal of Placenta | 14 | 14.7% | 14 | 22.2% | 28 | 17.7% |
| Hysterectomy | 2 | 2.1% | 1 | 1.6% | 3 | 1.9% |
| **Total** | **95** | **100.0%** | **63** | **100.0%** | **158** | **100.0%** |

| Shoulder Dystocia | Primip | | Multip | | Total | |
|---|---|---|---|---|---|---|
| Shoulder Dystocia | 10 | 0.36% | 10 | 0.36% | 20 | 0.72% |

| Fetal Blood Sampling (n - babies) | n = 1136 | % | n = 1703 | % | n = 2839 | % |
|---|---|---|---|---|---|---|
| PH < 7.20 | 8 | 0.7% | 4 | 0.2% | 12 | 0.4% |
| PH 7.20 - 7.25 | 7 | 0.6% | 3 | 0.2% | 10 | 0.4% |
| PH > 7.25 | 88 | 7.7% | 26 | 1.5% | 114 | 4.0% |

| Cord Blood Sampling (n - babies) | n = 1136 | % | n = 1703 | % | n = 2839 | % |
|---|---|---|---|---|---|---|
| PH < 7.20 | 66 | 5.8% | 70 | 4.1% | 136 | 4.8% |
| PH 7.20 - 7.25 | 64 | 5.6% | 37 | 2.2% | 101 | 3.6% |
| PH > 7.25 | 735 | 64.7% | 610 | 35.8% | 1345 | 47.4% |

| Caesarean Sections 2019 | Primigravida | % | Multip | % | Total | % |
|---|---|---|---|---|---|---|
| Elective Caesarean Sections | 118 | 10.6% | 403 | 24.1% | 521 | 18.7% |
| Emergency Caesarean Sections | 290 | 26.1% | 189 | 11.3% | 479 | 17.2% |
| **Total** | **408** | **36.8%** | **592** | **35.4%** | **1000** | **36.0%** |

| Robson Groups 2019 | | | |
|---|---|---|---|
| Group 1 - Nullip Single Ceph Term Spont Lab | 59 | 465 | 12.7% |
| Group 2 - Nullip Single Ceph Term Induced | 242 | 500 | 48.4% |
| Group 2(a) - Nullip Single Ceph Term Induced | 162 | | |
| Group 2(b) - Nullip Single Ceph Term pre-labour CS | 80 | | |
| Group 3 - Multip Single Ceph Term Spont Lab | 13 | 630 | 2.1% |
| Group 4 - Multip Single Ceph Term Induced | 68 | 407 | 16.7% |
| Group 4(a) - Multip Single Ceph Term Induced | 18 | | |
| Group 4(b) - Multip Single Ceph Term Pre-Labour CS | 50 | | |
| Group 5 - Previous CS Single Ceph Term | 400 | 484 | 82.6% |
| Group 5 (1)- With one previous C.S. Single Ceph Term | 241 | | |
| Group 5 (2)- With two or more Previous C.S. Single Ceph Term | 159 | | |
| Group 6 - All Nullip Breeches | 58 | 60 | 96.7% |
| Group 7 - All Multip Breeches | 47 | 51 | 92.2% |
| Group 8 - All Multiple Pregnancies | 46 | 56 | 82.1% |
| Group 9 - All Abnormal Lies | 14 | 14 | 100.0% |
| Group 10 - All Preterm Single Ceph | 53 | 114 | 46.5% |
| **Total** | **1000** | **2781** | **36.0%** |

| Vaginal Birth after Caesarean Section | |
|---|---|
| Total No. Of Mothers who had 1 previous Caesarean Section | 414 |
| No of Mothers who opted for an elective caesarean section after 1 previous Caesarean Section | 251 |
| No of Mothers who went into spontaneous/induced Labour after 1 previous Caesarean Section | 163 |

| | | |
|---|---|---|
| Outcome of this category | SVD | 74 |
| | Ventouse | 18 |
| | Forceps | 2 |
| | **Total VBAC** | **94** |
| | | |
| | Emergency C.S. | 69 |

# Section 1: Maternity
# *(b) Midwifery Report*

Dr Tom O'Gorman Associated Clinical Director, Ms Helen Murphy Director of Midwifery, Ms Annemarie Grealish

The Maternity Unit at University Hospital Galway provided a wide range of inpatient, outpatient and day case clinical services. We continually strive to provide a high standard of care to the women and families who use our services.

The Maternity Unit has close working relationships with the other departments within the hospital and has access to a wide range of expertise within University Hospital Galway.

There were 2839 babies delivered to 2781 mothers in 2019. This is in keeping with the national trend of reducing birth rates. 39.88% of women were Nulliparous whilst 60.12% were multiparous.

46.5% of women had a spontaneous onset of labour, whilst 29.6 had their labours induced. Of these 48.2% had spontaneous vaginal deliveries. There was a 36% Caesarean Section rate of which 17.2% were Emergency Caesarean Section. Assisted deliveries account for 15% of all deliveries.

The Maternity Unit links closely with the National Women's and Infants health programme team to support us in implementing the recommendations from the National Maternity Strategy and has supported us with some of the positive changes within our department these include

- The Introduction of the Pregnancy options services and the appointment of Pregnancy options CMM2
- Appointment of the CMS in Perinatal Mental Health
- Funding for a Home from Home room on the Labour ward.
- Funding for new equipment in the Ultrasound department.

In 2019 the Early Pregnancy Assessment Unit relocated to the 1st floor which is more private for women using these services. Plans are in place to develop this area to include an Ambulatory Gynaecology Department (which opened in 2020).

Throughout the year staff have shown continued dedication and commitment to providing the highest standard of evidence based care to meet the needs of the mothers and babies using our service. This was rewarded when two of our quality initiative projects were successful in coming first place in both Group and National award ceremonies

- Saolta Health care award winners for the Maternity Portal
- Irish Health care award winners for the Maternity Department Quality Initiative
- "I'm just born keep me warm"

# Section 1: Maternity
# *(c) Breastfeeding in UHG*

Ms Claire Cellarius Clinical Midwife Manager 2 Lactation

The research evidence to demonstrate the importance of breastfeeding for the health of both mothers and infants is stronger than ever. Improving our breastfeeding rates will contribute to improvements in child and maternal health, and reduction in childhood obesity and chronic diseases.

At UHG our breastfeeding priorities are to ensure that consistent evidenced based best practice is provided and we strive to facilitate a positive and supportive environment for breastfeeding at all times. While breastfeeding for any length of time is worthwhile we aim to improve our overall rates and support more mothers to breastfeed for longer.

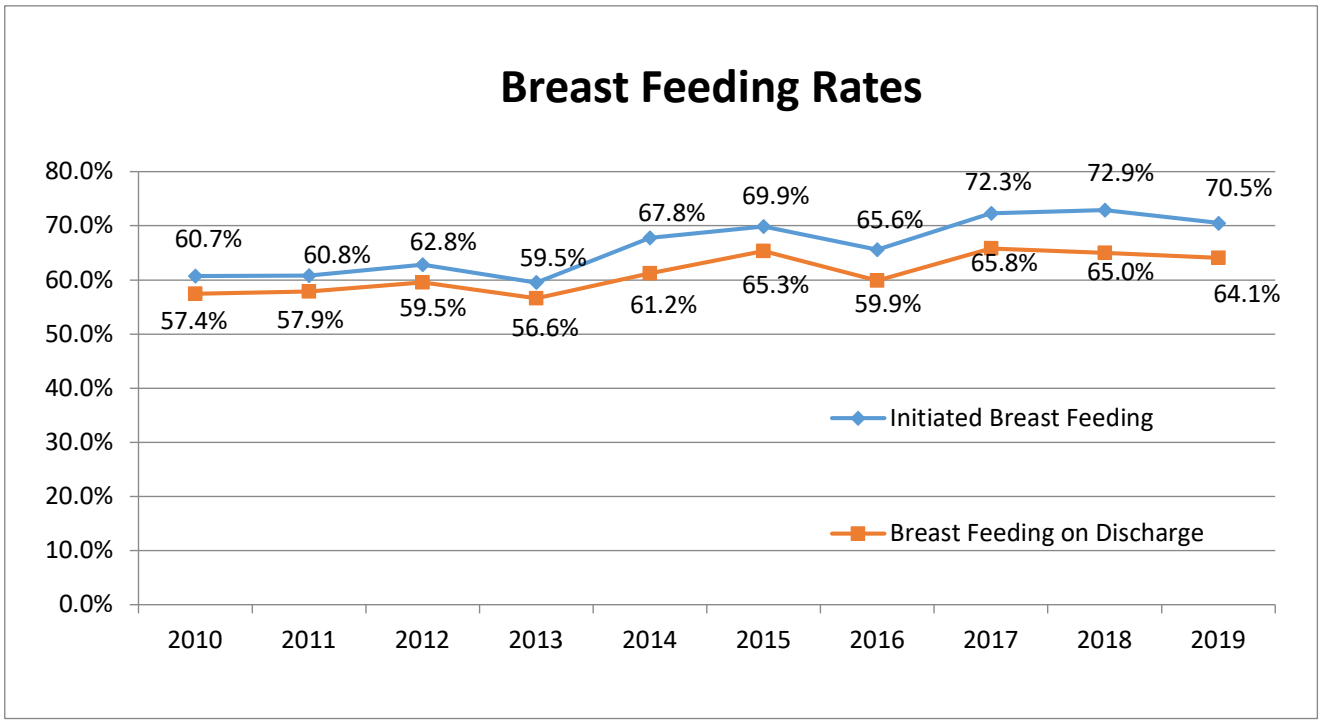
## Education and Training

- Staff training and education continues once a month with our NMBI accredited breastfeeding refresher course.
- Two online breastfeeding modules are also available for all staff on www.hseland.ie
  - 01 Supporting Breastfeeding
  - 02 Breastfeeding Challenges
- Two of our midwives successfully completed the International Board Certified Lactation Consultant exam during 2019.

## Lactation Services available at UHG

- Lactation Support Midwife
- Mother-baby inpatient breastfeeding support
- Referrals from GPs and PHNs
- Consultations with Paediatrics, NICU and MDAU
- Outpatient clinic referrals for antenatal women with specific queries.
- Weekly drop in clinic to support mothers with breastfeeding challenges. Our breastfeeding drop in clinic is held every Tuesday afternoon which offers skilled help and support to mothers experiencing feeding difficulties. 310 mothers (and their babies) attended the Drop In Clinic in 2019.
- Staff training and auditing of practice
- Telephone breastfeeding support

Other activities for National Breastfeeding Awareness week include a promotional and information stand in the hospital main foyer, local radio interview and staff quiz and raffle for new and expectant mums with lots of spot prizes.Our HSE national breastfeeding website www.mychild.ie/breastfeeding is an excellent resource for all breastfeeding information and list of community support groups. It also offers a live chat Monday to Friday with a breastfeeding expert.



# Section 1: Maternity
## *(d) Community Midwives*

Ms Ethne Gilligan Clinical Midwife Manager 2

The Community Midwifery team offer Midwifery led care to women attending the Maternity Department in University Hospital Galway. Antenatal care is provided close to where the woman live and post natal care at home for women who avail of the Early Transfer Home (ETH) service. The Community Midwives pathway provides care for women with normal and low risk pregnancy/birth and their newborn babies, with the vast majority of care occurring in the community.

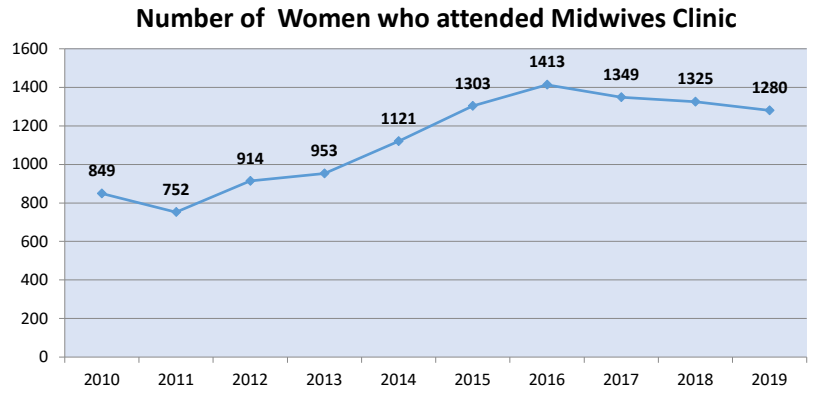
The Community Midwifery team aim to give choice to women, educating and supporting them in planning and preparing for their birth and journey into parenthood. The supported model of care used by the community midwives aspires to normalise birth with the goal to achieve a positive birth and breastfeeding experience.

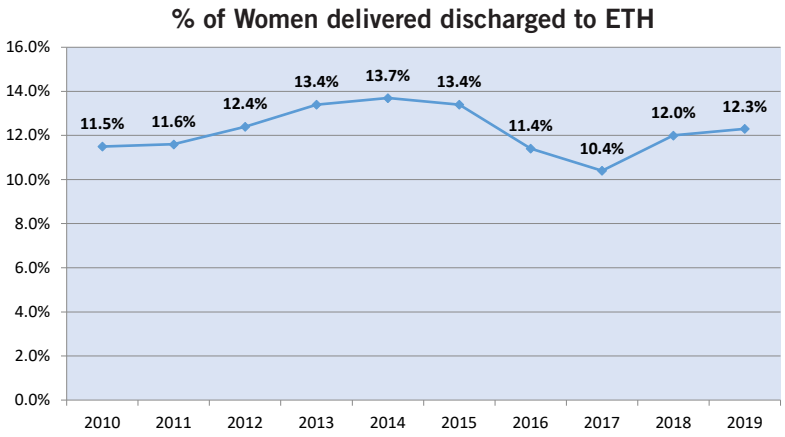
In 2019, the antenatal midwife clinic guidelines were reviewed with multidisciplinary team feedback. The guidelines expanded to incorporate the midwives booking Induction of labour for low/normal risk women at 41+3 gestation who wished to avail of this option. This facilitates the women to remain in the supported care pathway, receiving safe, high quality, continuity of care. In August 2019, the Antenatal midwives clinics were transferred from the hospital to Knocknacarra Medical Centre. This has led to all midwives clinic now being facilitated in the community. There are six outreach clinics are located as follows Tuam, Oughterard, Athenry, Doughiska, Gort and Knocknacarra.

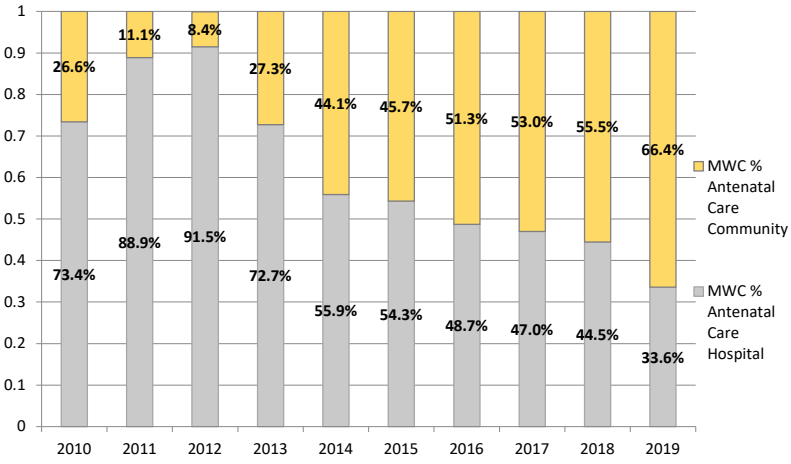
This year saw the appointment of the Candidate Advanced Midwife Practitioner who will work closely with the team to promote midwifery values and a woman centred service. Eithne Gilligan took up the post of Clinical Midwife Manager 2 in September 2019.

The ETH service covering Galway city and including Claregalway and Oranmore facilitated 343 (12.3%) women to leave within 24 hours of birth and receive experienced midwifery and breastfeeding care in their own homes until postnatal day 5. This service is suitable to women to have had an uncomplicated pregnancy and vaginal birth and wish to go home early.

The team carried out service user feedback surveys, assessing antenatal midwives clinics. 98% of respondents rated their experience of the midwives clinics as ≥8/10 and 100% would recommend the service to a friend.




| | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 |
|---|---|---|---|---|---|---|---|---|---|---|
| % Women who attended MWC | 24.7% | 22.4% | 27.7% | 31.1% | 38.1% | 44.8% | 48.0% | 48.2% | 47.2% | 46.0% |
| No. Women who attended MWC | 849 | 752 | 914 | 953 | 1121 | 1303 | 1413 | 1349 | 1325 | 1280 |

# Section 1: Maternity
# *(e) Bereavement & Loss*

Ms Anne Brady Clinical Midwife Manager 2 Bereavement & Loss

## Staff Complement

1 WTE Clinical Midwife Manger 2 for Bereavement & Loss

## Key Performance Indicators

- Provision of anticipatory bereavement counselling support to parents whose baby is diagnosed with a life limiting condition.
- Provision of bereavement counselling support for parents who experience Early Pregnancy Loss & Perinatal Death. This may be at the time of loss, in the weeks and months that follow, and may include care in relation to subsequent pregnancy anxiety.
- Provision of bereavement counselling support for families following termination of pregnancy for medical reasons.
- Co-ordinating the formal structured follow up care of bereaved parents who have experienced a Stillbirth following MDT discussion at the Monthly Perinatal Mortality meeting.
- Advocacy role of the needs of bereaved parents, and development of service provision in response to identified needs of bereaved families.
- Development of a holistic approach in Bereavement Care in line with evidence-based practice (NICE 2014).
- Resource & informal support to staff impacted in their care of bereaved families.
- Forged links with the Voluntary Support agencies that provide care to bereaved families in the community, with recognition of their invaluable support of families.

As a relatively new service much of 2019 has seen the foundations of service being established. We support families who suffer all types of pregnancy and infant loss in the perinatal period. Figures for 2019 include:

| PREGNANCY LOSS AND PERINATAL DEATH FIGURES 2019 | |
|---|---|
| Miscarriage | 812 |
| Ectopics | 16 |
| Stillbirths | 8 |
| Neonatal deaths | 5 |
| Late miscarriage | 25 |

## Achievements in 2019 include:

- The establishment of a Bereavement Support Clinic in conjunction with our lead Obstetrician, Dr Mark Dempsey in order to support families following perinatal bereavement and loss and in subsequent pregnancies
- The establishment of a Bereavement Support Clinic (Midwife led) based in the community to accommodate couples who do not wish to attend the hospital
- The building of a Bereavement training & education strategy to include inputting on Midwifery programmes in the CNME, for staff midwives, the undergraduate programmes in NUIG, staff induction sessions, as well as informal education in the clinical setting.
- An annual one day Bereavement and Loss training day programme was also developed and made available across all sites in the Saolta Group.
- The provision of a 'Schwartz Round' dedicated to all our staff involved in providing care for those who are experiencing the trauma of Perinatal death in a bid to further enhance the support structures available
- The participation in National strategies for the development of services with respect to Perinatal Bereavement and Loss
  - Presented on 'Experiences of Setting up a Bereavement Support Service" at the National Bereavement Forum in UCC.
- The hosting of our Annual Service of Remembrance, the preparations for which included:
- The upgrading of our Maternity Garden to include a remembrance tree.
- The participation in the 'International wave of light' celebrations on October 15 for which the hospital was lite up in pink and blue in memory of all babies who have died too soon. This was made possible with the help of the John Forde and his team and we hope to continue this tradition into the future.
- The setting up of the 'Maternity Bereavement Comfort Care Fund' , the contributions to which shall be used to build and improve on our service.
- The erection of a plaque demonstrating the 'End of Life' symbol and its meaning in the Out Patients department in order to promote awareness of end of life care within the unit.

# Section 1: Maternity
# *(f) Parent Education Clinical Report 2019*

Ms Carmel Connolly Clinical Midwife Manager 2

## Introduction

Parent Education aims to empower women and their families with skills and knowledge to navigate their journey of pregnancy, prepare them for birthing their babies and equip them with the necessary tools for their transition into parenthood.

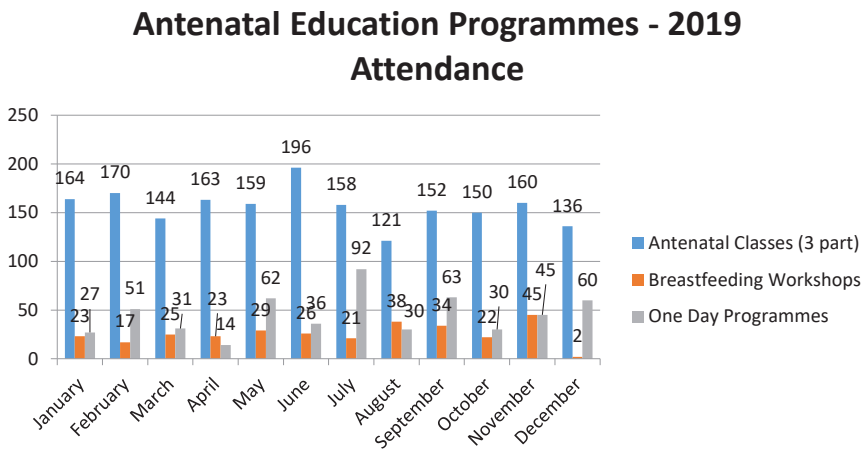
Our philosophy in Parent Education at UHG is to promote, support and protect normal childbirth and to empower women to trust their bodies in the physiological birthing process by acquiring the best evidence available.

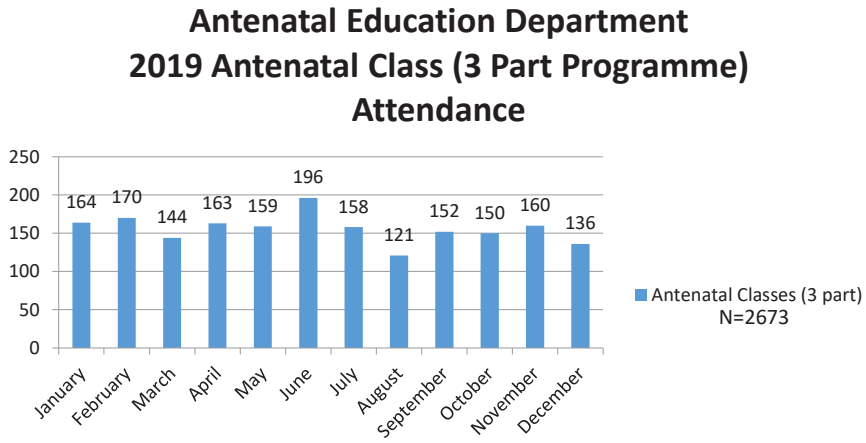
We aim to provide an equitable antenatal education service. The curriculum is designed to meet the individual needs of pregnant women and their partners. Adult learning theories and group facilitation facilitated via a multidisciplinary team are key to the delivery of a parent centred service with respect for parental input.

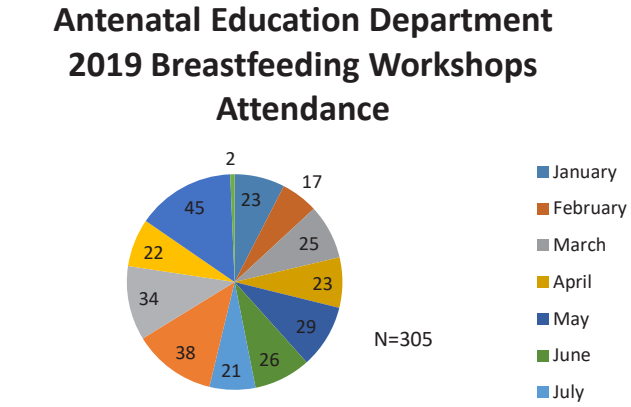
All programmes were very positively evaluated via programme evaluations completed by the women and their partners. Demands for our programmes and expertise continue to increase, hence the requirement for a virtual tour of the Maternity Department which incorporates the Multidisciplinary Team.

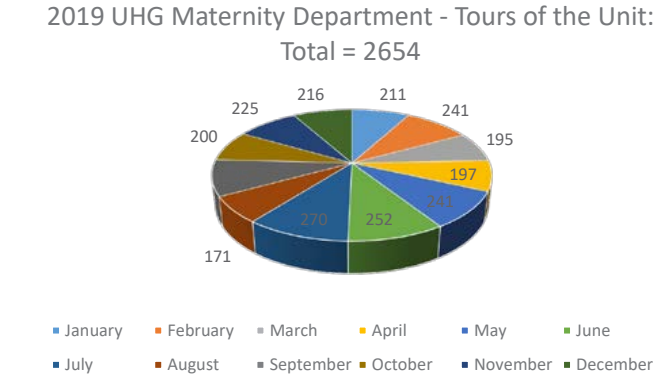
## 2019 Achievements

- Overall Winner in Saolta Non Clinical Innovation Category for www.uhgmaternity.com.
- Finalist in Irish Healthcare Centre Awards 2019 in Midwifery Led Project of the Year.
- 2nd Place for National HR HSE Story-telling Competition (Midwifery Category).
- Funding secured for maternity virtual tour.
- Virtual Tour of Maternity Department filmed.
- Information on Maternity Information Portal translated into Gaeilge.
- Presented in Schwartz Round; A little life-time that's lasts forever.
- Acceptance on Leadership & Quality Diploma RSPI Dublin - Team Project.
- Patient condition specific Information leaflets added and updated on Maternity Information Portal.
- Acquired funding from CNME for Hypnobirthing Training for 25 Midwives.
- First Outreach One Day Antenatal Education Programme in Merlin Park on 18th December as per Slainte Care Strategy.



# Section 1: Maternity
# *(g) Antenatal & Gynaecology Clinics Report*

Ms Fidelma Kenny Clinical Midwife Manager 2

We aim to provide an efficient service that is safe and accessible, and woman centred. All referral letters are triaged by the Consultants weekly. The CMM2 then assesses the antenatal booking letters, and in conjunction with the secretarial staff appointments are given as available.

## Antenatal clinics

In 2019, 2518 women booked for antenatal care which was a decrease of 94 on the previous year (see table 1). 7 antenatal clinics are held in the Maternity Outpatients department weekly. A high risk Endocrinology/ Diabetic antenatal clinic is held on alternative Wednesdays, This Clinic is facilitated by a Consultant Obstetrician and team, Consultant Endocrinologist and team, diabetic nurse specialist and midwives. The routine antenatal clinic runs in conjunction with this clinic. There are 2 extra booking clinics on Thursday and Friday. Midwives in the outpatients department take a detailed history and the necessary blood tests. The National Policy on Domestic Violence screening continues.

## High Risk Obstetric / Fetal Medicine Clinic

The High Risk Obstetric/ Fetal Medicine Clinics are described separately in the Fetal Medicine Unit report.

## High Risk Anaesthetic Clinic

This clinic takes place every Wednesday with a Consultant Anaesthetist. Referral to the Anaesthetic clinic is made by Consultant Obstetrician. All women attending this clinic have appointments scheduled via a specific referral system; this activity is recorded on the Patient Administration System (PAS).

## Gynaecology clinics

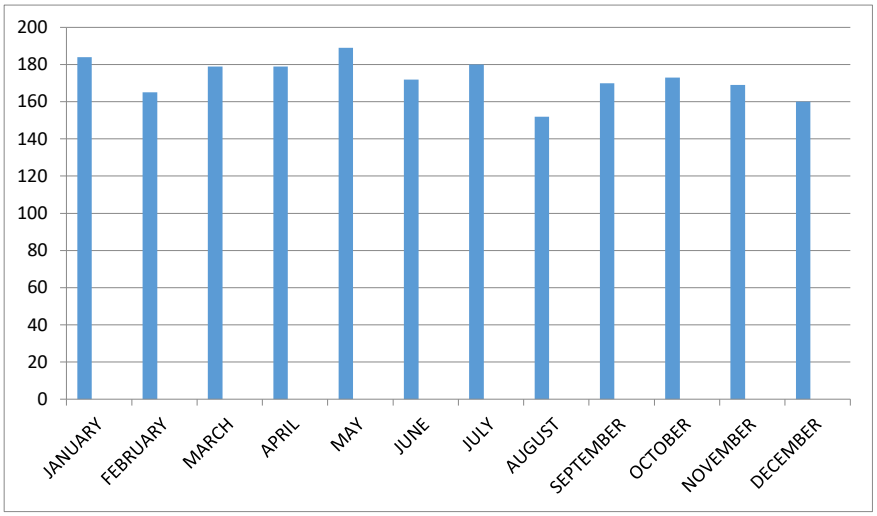
There are 8 gynaecology clinics held weekly in the outpatients department. This includes 2 Fertility clinics and specialist Gynaecological Oncology clinics.

# Section 1: Maternity
# *(h) Early Pregnancy Statistics & Report 2019*

Ms Runagh Burke Clinical Midwife Manager 2

| 2019 | Jan | Feb | March | April | May | June | July | Aug | Sept | Oct | Nov | Dec |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 184 | 165 | 179 | 179 | 189 | 172 | 180 | 152 | 170 | 173 | 169 | 160 |

New Patients - 1376
Review Patients - 696
Total - 2072




## Early Pregnancy Assessment Unit (EPAU) 2019 Report

The EPAU relocated to the first floor newly renovated area of St Monica's Ward during the later part of 2020. EPAU will share facilities with the Ambulatory Gynaecological Unit which will open in early 2020. This is a purpose built facility with two scan/ treatment rooms, a reception area, clinical room and meeting room for women who has being diagnosed with a miscarriage. A large waiting area is also accommodated in this new unit.

EPAU is staffed by a team which includes a lead consultant, sonographers and clerical support. In addition a bereavement CNS is available upon request. The department provides care, support and advice to women who develop complications during the first 13 weeks of pregnancy. In addition a scanning service was provided for pregnancy options referrals from GP's during 2019.

The unit is open currently four mornings a week, the service is hoping to expand to five mornings in early 2020. The majority are scheduled appointments from 8- 12 scans per session from 8AM – 1PM. Inpatient and emergency referrals are facilitated daily also.

Staff provide women with verbal and written information on diagnoses following their scans. Information is given in a sensitive, caring and supportive manner.

Referrals are accepted from
- GPs
- Consultant and NCHDs

Referrals are by post, fax and email

# Section 1: Maternity
# *(i) Fetal Medicine Unit*

Dr G Gaffney, Consultant Obstetrician Gynaecology, Ms A Burke Clinical Midwife Manager 3 Fetal Medicine Department, Professor John Morrison Consultant Obstetrician Gynaecology Clinical Director of Saolta MCAN

In 2019 12,522 ultrasound scans were performed at GUH, an increase of 4.5% from 2018. Of these, 10,387 ultrasound examinations were performed in the fetal medicine unit (FMU), and the remainder (19) were gynaecological scans. Currently, the majority of gynaecological scans are performed in the radiology department.

The Early Pregnancy Assessment Unit (EPAU) provides a dedicated ultrasound service for women who experience complications during the first 13 weeks of pregnancy. There were 2135 scans performed there in 2019, details of these are in the EPAU report.

The ultrasound examinations performed in the FMU included first trimester scans, fetal anatomy scans at 20-22 weeks gestation, and referrals for assessment of fetal growth and well-being. In addition, there are twice weekly dedicated fetal medicine clinics that accept patients with either fetal or maternal problems during pregnancy. In 2019, 92% of patients booking had a first trimester scan and a detailed anomaly scan – an increase of 2% from 2018.

The unit is staffed by 3 Fetal Medicine consultants. We have a Clinical Midwife Manager III, 2 Clinical Midwife Specialists, 2 half time Clinical Specialist Radiographers and 1 Midwife Sonographer. We also have one midwife who has commenced her Masters in ultrasound in UCD. We have support of a clerical officer.

In addition to two weekly high risk fetal medicine clinics, there is a weekly diabetic clinic. Women attending these clinics all have first trimester and fetal anomaly scans. Follow on growth and wellbeing ultrasound scans are performed at 28, 32 and 36 weeks for those with pregestational diabetes, gestational diabetes on insulin or treated with oral hypoglycaemic agents. Follow on ultrasound scans are performed at 28 and 36 weeks for those with gestational diabetes on dietary treatment. In 2019, there were 355 diabetic patients of whom 25 had pregestational and 330 had gestational diabetes.

Multiple pregnancies are generally seen in the high risk clinic. DCDA pregnancies are seen every 4 weeks and MCDA pregnancies every fortnight. More frequent visits may be necessary according to clinical indication. There were 77 sets of twins (59 sets were DCDA and 18 sets were MCDA and there were 2 sets of triplets in 2019.

## High Risk Fetal Medicine Clinic

In 2019 there were 1156 visits to the high risk clinic. The reason for referral was either for fetal or maternal complications in pregnancy. The majority of patients were booked to deliver at University Hospital Galway. However, we saw 49 referrals from other hospitals in the Saolta Hospital Group which is a large increase from the 8 outside referrals seen in 2018. The services offered at this clinic included confirmation and management of fetal abnormality, monitoring of multiple pregnancies, prenatal non-invasive screening, invasive prenatal testing, monitoring of medical complication of pregnancy and monitoring of pregnancies where there were maternal antibodies to red blood cell antigens and fetal platelet alloimmune disease.

During 2019 there were 1156 attendances at the high risk clinics. There have been an increase in referrals both from within GUH and from the Saolta group.

## External referrals for 2019 (49)

| | |
|---|---|
| PUH | 35 |
| Mayo | 6 |
| SUH | 7 |
| Letterkenny | 1 |

During 2019 there were 70 pregnancies with one or a number of fetal malformations diagnosed leading to further testing or management options.

There were a total of 25 invasive procedures performed. 21 amniocentesis and 4 CVS in 2019. The cases of fetal aneuploidy detected were as follows:

## Fetal Abnormalities

During 2019 there were 70 pregnancies with one or more fetal malformations. As always, the diagnosis of a fetal anomaly may require further investigation by invasive methods for fetal karyotyping, and fetal MR. In addition pregnancies that will be complicated by neonatal problems are seen by a member of the neonatal team and may be referred to a tertiary centre that will be responsible for postnatal management, the management of fetal cardiac structural anomaly for example. This referral pattern permits seamless transition after birth for the child with prenatally diagnosed problems and is very much welcomed by parents. Maeve Tonge our dedicated social worker offers invaluable advice to parents where there has been a diagnosis of serious fetal anomaly. She links parents with support services and links for postnatal and community services. Our neonatologists provide a service that helps parents with planning the events that will take place after the birth of children with serious fetal anomaly. Finally Anne Brady, our Bereavement Support Midwife helps patents where there has is a serious fetal anomaly that may or will lead to loss of the baby. The major change to service that occurred in 2019 was the introduction of the 2018 Termination of Pregnancy Act, with a resultant increase in service in compliance with the fatal fetal abnormality section of this law.

The ultrasound unit participates in ongoing research projects such as the EMERGE, IRELAnD and the PARROTT studies. Drs Dempsey and Gaffney participate in the midwifery education programme regarding TOP for fatal fetal abnormality. Prof Morrison and Dr Gaffney are part of the national fetal medicine group working party. We provide ultrasound support to the Pregnancy Options Service in cases of fetal abnormality.

## Fetal abnormalities Diagnosed 2019

**CNS (11)**
- Severe ventriculomegaly
- 2 x anencephaly.
- Arnold-Chiari malformation
- Exencephaly
- Exencephaly with exomphalos.
- Absent Cavum Septum Pellucidum, ventriculomegaly and enlarged cisterna magna. Colpencephaly.
- MCDA twins with death of one twin after laser. Surviving twin had a cystic space in the posterior fossa
- Hydrocephalus.
- Ventriculomegaly with blockage of the Aqueduct of Sylvius.

**CVS (13)**
- Total anomalous pulmonary venous drainage, single ventricle.
- Transposition of the Great Arteries x 3.
- Hypoplastic left ventricle.
- Severe mitral stenosis, borderline left ventricular dimensions. Hypoplastic aortic valve & aorta.
- Tetralogy of Fallot.
- VSD and single umbilical artery with a low probability NIPT.
- VSD.
- Hypoplastic L heart.
- VSD in one twin.
- TGA and VSD in one DCDA twin
- Single left sided SVC.

**Pulmonary (3)**
- 2 x Congenital Cystic Adenomatoid Malformation
- Fetal thoracic cyst.
- Abdominal (5)
- Gastroschisis.
- Exomphalos.
- Probable omphalo-mesenteric cyst.
- Duodenal atresia x 2.

**Skeletal (6)**
- Osteogenesis Imperfecta type 3.
- Talipes, postero-medial bowing of the tibia.
- Isolated talipes x 2.
- Thanatophoric dysplasia.
- Fetal focal femoral hypoplasia.

**Renal tract (10)**
- 2 x Potter's sequence.
- Megacystis, mega-ureter, microcolon syndrome 47xx +16.
- Enlarged fetal kidneys.
- Bladder extrophy. IUD at 21 weeks.
- Large cystic hygroma and mega-cystis.
- Enlarged fetal bladder and cyst in cord.
- Pelvic kidney.
- Severe bilateral pyelectasis.
- Absent right kidney.

**Chromosomal (15)**
- 3 x T13 (1 x increased NT) 1 x semi-lobar holoprosencephaly
- 4 x T 21 (1 duodenal atresia)
- 6 x Trisomy 18.
- Triploidy with dilated ventricles. VSD. 2 vessel cord.
- Deletion of 18p with gross polyhydramnios.

**Miscellaneous (8)**
- Multiple fetal rhabdomyomata caused by tuberous sclerosis in one of DCDA twins.
- Enlarged nuchal and an abdominal wall defect. Body stalk anomaly.
- 4 x cystic hygromata.
- 46 Wolf-Hirschhorn syndrome with ventricular and great atrial disproportion.
- 46 Xym, der(4)t(4.5)(p15.3?2;q33.1)
- Cleft lip.

# Section 1: Maternity
# *(j) Maternity Admissions & Maternity Day Assessment Unit*

Ms Anne Marie Culkin Clinical Midwife Manager 2

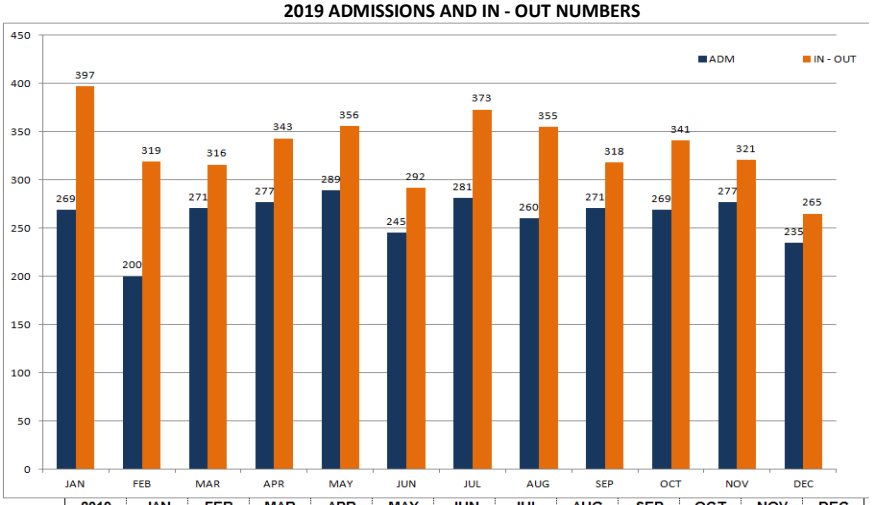
## Maternity Admissions

The admissions/emergency department for Maternity and gynaecology facilitates elective and emergency assessments and admissions.

Referrals are received from consultant, NCHD's, GP's, Public Health Nurse's, Midwives Clinic and self referral. The number of women assessed in this department continues to rise. The department is open 5 days per week. Monday – Friday 8am – 5 pm

7140 women were assessed in the department in 2019, 3144 were booked admissions and 3996 were unplanned / emergency presentations. This data is represented on the chart on the right.

**2019 ADMISSIONS AND IN - OUT NUMBERS**

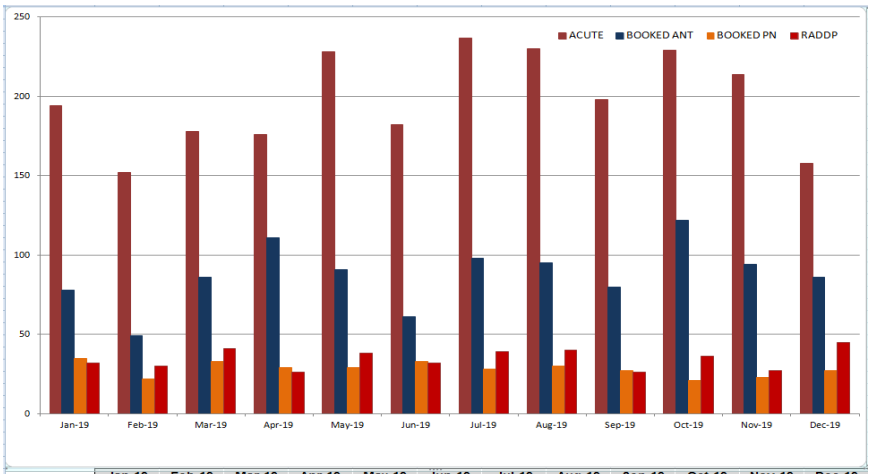



| 2019 | JAN | FEB | MAR | APR | MAY | JUN | JUL | AUG | SEP | OCT | NOV | DEC |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ADM | 269 | 200 | 271 | 277 | 289 | 245 | 281 | 260 | 271 | 269 | 277 | 235 |
| IN - OUT | 397 | 319 | 316 | 343 | 356 | 292 | 373 | 355 | 318 | 341 | 321 | 265 |
| TOTAL | 666 | 519 | 587 | 620 | 645 | 537 | 654 | 615 | 589 | 610 | 598 | 500 |

## Maternity Day Assessment Unit (MDAU)

The aim of the MDAU is to provide care to women who develop potential complication during pregnancy (from 13 weeks gestation) and up to six weeks postnatally. This care is provided on an outpatient basis, thus avoiding unnecessary stays in hospital. A Standard Operational Procedure is available for reference.

**2019 MATERNITY DAY ASSESSMENT UNIT (MDAU) STAT**




| | Jan-19 | Feb-19 | Mar-19 | Apr-19 | May-19 | Jun-19 | Jul-19 | Aug-19 | Sep-19 | Oct-19 | Nov-19 | Dec-19 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ACUTE | 194 | 152 | 178 | 176 | 228 | 182 | 237 | 230 | 198 | 229 | 214 | 158 |
| BOOKED ANT | 78 | 49 | 86 | 111 | 91 | 61 | 98 | 95 | 80 | 122 | 94 | 86 |
| BOOKED PN | 35 | 22 | 33 | 29 | 29 | 33 | 28 | 30 | 27 | 21 | 23 | 27 |
| RADDP | 32 | 30 | 41 | 26 | 38 | 32 | 39 | 40 | 26 | 36 | 27 | 45 |

There were 2839 deliveries to 2781 mothers (1109 Primigravida, 1672 Multigravida) in UHG in 2019.

## Conditions Managed in MDAU:

- Hypertension disorders of pregnancy: including mild and moderate hypertension and chronic hypertension controlled on medication.

## Maternity Day Assessment Unit

Women who present acutely and or are scheduled presentation from 13 weeks gestation are referred to MDAU for assessment and plan of care.

Referrals are made using a specific referral form and sources of referral are as follows: Consultant obstetrician, Obstetric team on call, Fetal Assessment Staff, Community Midwives and Maternity Admissions.

Care is provided as per clinical care pathways and clinical guidelines for specific conditions as appropriate. Pathways are kept under periodic review in light of experience and developments in best practice, locally, nationally, and internationally. The following table displays the number of women seen in MDAU. These include Acute Referrals, booked postnatal referrals and women booked for Routine Antenatal Anti-D Prophylaxis.

# Section 1: Maternity
# *(k) Anaesthetic Report 2019*

Dr Joey Costello Consultant Anaesthetist and clinical lead for Obstetric Anaesthetics

In 2019, 2450 procedures were performed in theatre of which 1706 were elective and 744 were emergencies. This number included all gynaecological and obstetric procedures for which anaesthesia care was provided.

344 (76 instrumental deliveries, 42 repair of 3rd degree tear, 24 manual removal of placentas and 202 emergency LSCS) procedures were performed in the labour ward theatre which necessitated the presence of anaesthesia services (this number is included in the overall procedure number of 2450).

There were 2839 deliveries to 2781 mothers (1109 Primigravida, 1672 Multigravida) in UHG in 2019.

## Epidurals:

- 1136 epidurals were performed (40.8% see Figure 1).
- 643 primigravidae (56.6%) received an epidural.
- 494 multigravidae (43.4%) received an epidural.
- (29.2%) of those primigravidae who had an epidural had a ventouse delivery and (12.9%) had a forceps delivery (Forceps 7.9%, failed ventouse, forceps 4.9%).
- (13.0%) of multigravidae who received an epidural had a ventouse delivery while (1.8%) had a forceps delivery (forceps 1.2%, failed ventouse, forceps 0.6%).
- 434 Primigravidae were induced and337 of this group (77.6 %) received epidurals.
- 518 Primigravidae went into spontaneous labour and 313 of this group (60.4 %) received an epidural.
- 390 Multigravidae were induced and 233 of this group (59.7 %) received epidurals.
- 774 Multigravidae went into spontaneous labour and 263 of this group (34.0%) received an epidural.

## Caesarean Deliveries:

1000 women (36.0%) were delivered by caesarean delivery (see statistical summary).

52 caesarean deliveries were performed under general anaesthesia (5.2% of all caesarean deliveries) see Figure 2.

**Fig 2. Mode of Anaesthesia for Elective Caesarean Delivery**

| | Primip | Multip | Total | |
|---|---|---|---|---|
| Spinal | 111 | 390 | 501 | 96.2% |
| Epidural | 1 | 2 | 3 | 0.6% |
| Combined Spinal | 0 | 6 | 6 | 1.2% |
| General Anaesthetic | 6 | 5 | 11 | 2.1% |
| Total | 118 | 403 | 521 | 100.0% |

**Mode of Anaesthesia for Emergency Caesarean Delivery**

| | Primip | Multip | Total | |
|---|---|---|---|---|
| Spinal | 121 | 144 | 265 | 55.3% |
| Epidural | 93 | 15 | 108 | 22.5% |
| Combined Spinal | 51 | 14 | 65 | 13.6% |
| General Anaesthetic | 25 | 16 | 41 | 8.5% |
| Total | 290 | 189 | 479 | 100.0% |

**Mode of Anaesthesia for Caesarean Delivery following Unsuccessful Attempt at Instrumental Delivery**

| | Primip | Multip | Total | |
|---|---|---|---|---|
| Spinal | 0 | 1 | 1 | 6.2% |
| Epidural | 5 | 1 | 6 | 37.5% |
| Combined Spinal | 4 | 1 | 5 | 31.3% |
| General Anaesthetic | 1 | 3 | 4 | 25.0% |
| Total | 10 | 6 | 16 | 100.0% |

## Post Dural Puncture Headaches

- There were 6 inadvertent dural punctures documented at attempted epidural siting in 2019 (documented @ delivery on Euroking system), giving a dural puncture rate of 0.53%. 13 Dural taps were noted in the manual "Dural Puncture Follow-up Diary" (giving an inadvertent dural puncture rate of 1.15%). This discrepancy between figures is currently being reviewed.
- 14 (1.2%) of women needed an epidural blood patch, 15 (1.3%) women were documented as having complained of epidural headache. This figure included women who did not have a dural tap documented at epidural but were later treated with blood patch.

**Figure 1. Overall trend in Epidural rates (numbers) since 2010.**

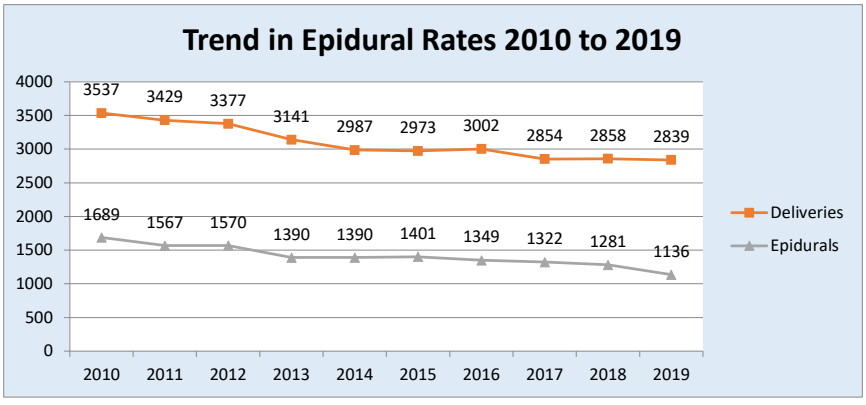


**Figure 2. Percentage of caesarean delivery deliveries performed under general anaesthesia since 2010.**

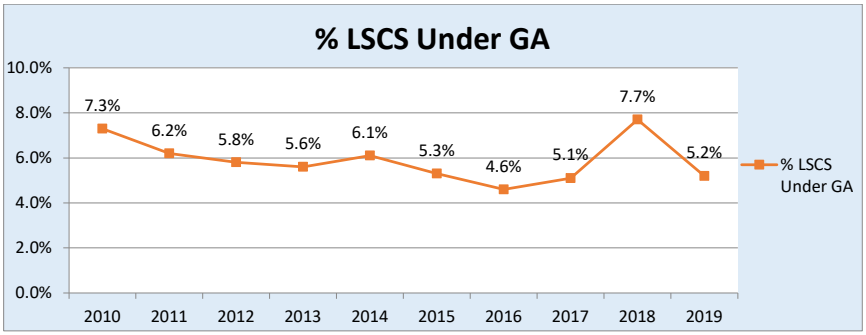



**Figure 3. Percentage of Elective/Emergency caesarean deliveries under General Anaesthesia**

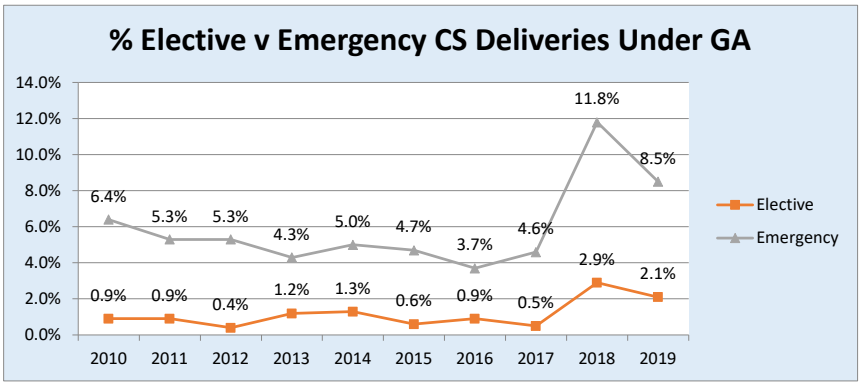



**Figure 4. Percentage of Caesarean deliveries performed under Spinal anaesthesia since 2009**

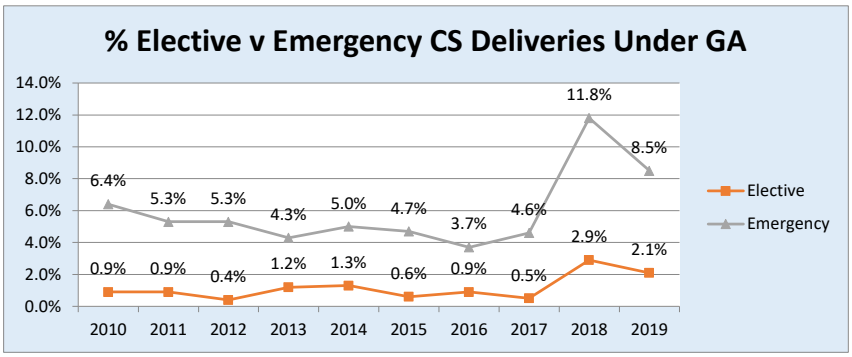
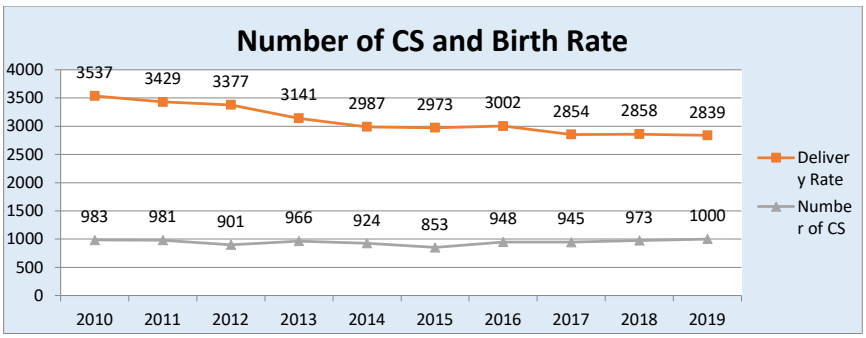



**Figure 5. Number of Women who had a caesarean delivery**




## Intensive Care/High Dependency Unit (ICU/HDU) Level 3 care, Admissions 2019

### Obstetrics

There were a total of 103 patients admitted to either ICU/HDU/Post Anaesthesia Care Unit (PACU) from the Obstetrics/Gynaecology services in 2019. There were 10 obstetrical admissions to ICU/HDU in UHG in 2019.

### Obstetric Patients admitted to ICU:

- 1 case of pericarditis
- 1 case of cardiac arrest post LSCS
- 3 case of sepsis
- 5 cases of major post-partum haemorrhage

### Gynaecology Patients

- 69 patients were admitted to PAU following elective gynaecological surgery in 2019.

### Summary of patients needing Level 2 care on the labour ward in 2019

- 103 women required level 1 or 2 care on the labour ward in 2019 (3.7% of all deliveries). This was an increase from 83 women (3.0%) in 2018.

### High risk Obstetric Anaesthesia Clinic

- 227 were reviewed in the High Risk Obstetric Anaesthesia Clinic in 2019.

### Caesarean Hysterectomies

- There were three caesarean hysterectomies in 2019, down from 7 in 2018.

# Section 2: Neonatology
# *(a) Neonatal Clinical Report 2019*

Dr Donough O'Donovan Consultant Neonatologist and Paediatrician

During the year 2019 a total of 2839 infants were born at GUH, of which 387 (13.6%) were admitted to the neonatal unit. Another 22 admissions, infants born at other hospitals or returned to the unit from a specialised care centre, brought the total number of 2019 neonatal unit admissions to 409. Yearly admissions rates have remained relatively constant, at around 400 infants/year, for the last seven years (Figure 1).

Sixty percent (249 infants) of the neonatal unit admissions in 2019 were > 37 wks gestation, whereas 160 infants (40%) were premature. GUH is a Level 2 (Regional) Neonatal Unit and provides neonatal intensive care to infants > 27 wks gestation. Of the premature infants 11 were ELBW (BW < 1000g) and 20 infants weighted between 1000g and 1500g at birth (VLBW). Eight of the premature infants were < 28 wks gestation, 27 were born between 28 and 31+6 wks gestation and 125 were born between 32 and 36+6 wks gestation (Table 2). The numbers and gestational age categories of premature infants admitted to the neonatal unit in 2019 were almost identical to the 2018 report (Figure 2).

One hundred and forty infants (34%) were admitted from the Labour Ward, 179 (44%) from Gynae Theatre and 68 (17%) from the Post Natal ward (Table 3). Twenty-two infants (5%) were transferred into the neonatal unit from outside hospitals. Seventeen percent of all infants born via C-Section (1041 infants born via CS in 2019) were admitted to the neonatal unit, a 6% increase compared to 2018.

Consistent with previous reports prematurity, respiratory distress and evaluation for sepsis remain the commonest conditions requiring admission to the neonatal unit, accounting for 74% of all admissions in 2019. Only two infants were transferred to Dublin for Therapeutic Brain Cooling in 2019, substantially less than in 2018 (5 Infants).

While respiratory disorders continuing to be one of the main reasons for admission to the unit, most infants who required respiratory support in 2019 were managed with non-invasive ventilation, with only 7 infants requiring a period of mechanical ventilation. In addition, most of the infants who received Surfactant treatment in 2019 had it administered via the least invasive and currently recommended LISA technique (Less invasive Surfactant administration).

There were 3 neonatal unit related deaths in 2019 (Details below). The 2019 overall neonatal unit related mortality rate (Number of neonatal unit related deaths per 1,000 live births) was around 1 per 1000. A 2008 to 2019 mortality table with gestational age related survival rates for VLBW infants born at GUH is presented below.

The following figures and tables give an overview of the activity in the neonatal unit during the year 2019.

**Figure 1**

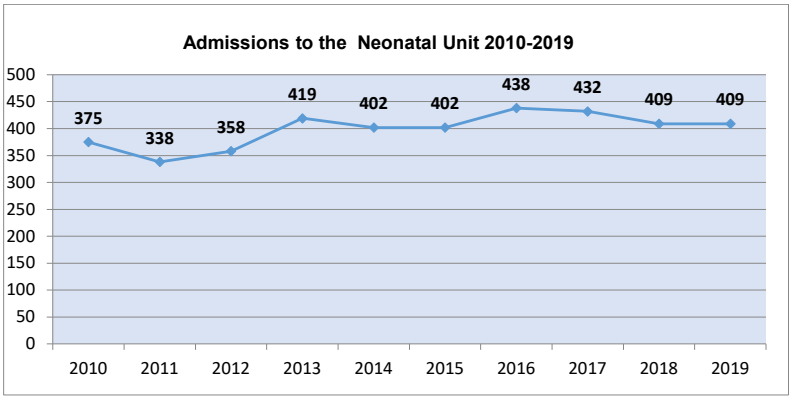
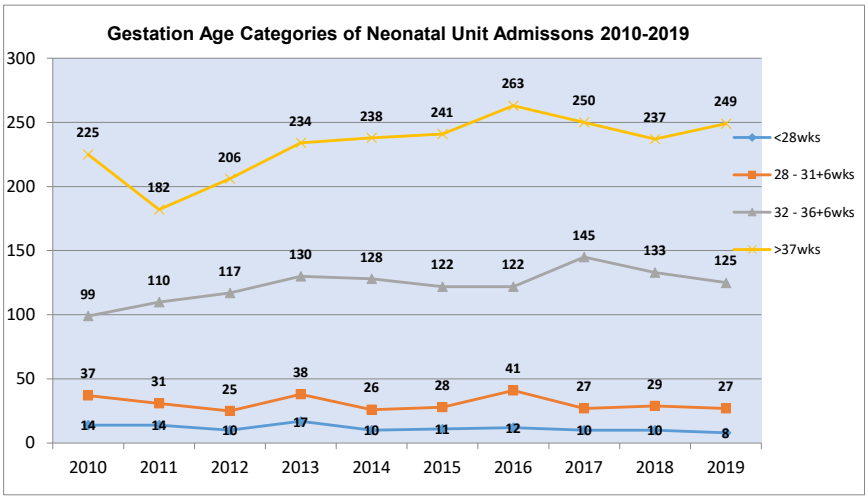



**Figure 2**




**1. Baby Weights on Admission 2019**

| Weight | No. | % |
|---|---|---|
| 500-599gms | 0 | 0.0% |
| 600-699gms | 0 | 0.0% |
| 700-799gms | 0 | 0.0% |
| 800-899gms | 5 | 1.2% |
| 900-999gms | 6 | 1.5% |
| 1000-1249gms | 7 | 1.7% |
| 1250-1499gms | 13 | 3.2% |
| 1500-1749gms | 16 | 3.9% |
| 1750-1999gms | 13 | 3.2% |
| 2000-2249gms | 36 | 8.8% |
| 2250-2499gms | 37 | 9.0% |
| 2500-2999gms | 53 | 13.0% |
| >3000gms | 223 | 54.5% |
| **Total** | **409** | **100%** |

| 2. Gestation Age of Neonatal Unit Admissions in 2019 | | |
|---|---|---|
| <28wks | 8 | 2.0% |
| 28-31+6wks | 27 | 6.6% |
| 32-36+6wks | 125 | 30.6% |
| >37wks | 249 | 60.8% |
| **Total** | **409** | **100%** |

| 3. Source of Admission 2019 | | % |
|---|---|---|
| Delivery Suite | 140 | 34% |
| Theatre | 179 | 44% |
| St. Angela's Ward | 68 | 17% |
| Transfer in/ Readmitted/Other | 22 | 5% |
| **Total** | **409** | **100%** |

| 4. Survival of Neonatal Unit Infants 2019 | | |
|---|---|---|
| **Weight** | **Number** | **Deaths** |
| ≤1000g | 11 | 0 |
| 1001 - 1500g | 20 | 0 |
| 1501 - 2500g | 102 | 2 |
| >2500g | 276 | 1 |
| **Total** | **409** | **3** |

| 5. General Neonatal Morbidity | |
|---|---|
| IPPV | 7 |
| NCPAP | 137 |
| Respiratory Disorders: RDS/ TTN | 170 |
| Meconium Aspiration | 6 |
| Pneumothorax / Chest Drains (0) | 6 |
| Evaluation for Sepsis | 153 |
| Hypoglycemia | 52 |
| Perinatal Stress/Low Cord pH | 14 |
| Jaundice/HDN/NAIT/ Thrombocytopenia | 29 |
| IVH/Perinatal stroke (2) | 5 |
| Birth Trauma | 7 |
| Transferred for Therapeutic Cooling | 2 |

| 6. Notable Significant Malformations / Other | |
|---|---|
| Cleft Lip & Cleft Palate | 2 |
| Gastroschisis | 1 |
| Duodenal Atresia | 1 |
| Imperforated Anus | 1 |
| Hypospadias | 4 |
| Amniotic band syndrome | 1 |
| Myelomeningocele | 1 |
| CCAM | 1 |

| 7. Cardiac/ CHD / Significant ECHO Findings | |
|---|---|
| ASD / VSD/ PDA /PPHN | 26 |
| TAPVD | 1 |
| Tetralogy of Fallot | 1 |

| 8. Neonatal Sepsis 2019: 12 Infants had Positive Blood Cultures (Non-contaminant +BC) | |
|---|---|
| GBS | 1 |
| Coagulase Negative Staphylococcus | 8 |
| Other Mixed Staph/Strep | 3 |

| 9. Surfactant Administration | |
|---|---|
| LISA | 19 |
| INSURE | 3 |
| ET | 7 |
| **Total** | **29** |

| 10. Central Lines Inserted | |
|---|---|
| PICC | 33 |
| UVC | 14 |
| UAC | 9 |
| Total | 56 |

| 11. Neonatal Transfers Out in 2019 | |
|---|---|
| NTP | 9 |
| Ambulance + NICU Nurse | 18 |
| Total | 27 |

| 12. Final Diagnosis 2019 (Often more than 1) | | |
|---|---|---|
| **Reason for Neonatal Admission*** | **Year** | **%** |
| Prematurity / Low Birth Weight / RDS | 140 | 34.2% |
| Respiratory Distress / Grunting | 111 | 27.1% |
| Other Fetal Reasons | 57 | 13.9% |
| Sepsis at Risk | 52 | 13.0% |
| Observation | 6 | 1.5% |
| Hypoglycaemia / Poor Feeder | 10 | 2.4% |
| Jaundice | 7 | 1.7% |
| Low Apgars / Low Cord PH | 9 | 2.2% |
| Low Saturations | 9 | 2.2% |
| Congenital Abnormality | 1 | 0.2% |

## 13. Mortality Table 2008-2019

| Inborn infants ≤ 1500g reported to the Vermont Oxford Network (Including Chromosome Abnormalities/Syndromes/ Lethal Congenital Malformations) | | | |
|---|---|---|---|
| **Gestation** | **Number** | **Survival to 28 days** | **Survival to discharge** |
| 23wks | 3 | 1 (33%) | 1 (33%) |
| 24 wks | 21 | 9 (43%) | 8 (38%) |
| 25 wks | 25 | 16 (64%) | 15 (60%) |
| 26 wks | 27 | 24 (89%) | 23 (85%) |
| 27 wks | 45 | 41 (91%) | 41 (91%) |
| 28 wks | 59 | 54 (92%) | 54 (92%) |
| 29 wks | 75 | 74 (99%) | 74 (99%) |
| 30 wks | 66 | 64 (97%) | 64 (97%) |
| >30 wks | 116 | 111 (96%) | 111 (96%) |
| Total | 437 | 394 (90%) | 391 (89.5%) |

| | | |
|---|---|---|
| Social Reason | 5 | 1.2% |
| Sent for Cooling | 2 | 0.4% |
| Total | 409 | 100% |

## 14. Summary Neonatal Unit Deaths in 2019

| Diagnosis | GA | BW | Location of Death |
|---|---|---|---|

## 15. Neonatal Unit Related Deaths in 2019

A brief synopsis of each neonatal unit related death including relevant obstetric data is outlined below.

**1. Pregnancy:** Gestation 34+5/40, BW 2910gms, Female, Singleton, SVD & breech extraction, Antenatal diagnosis of echogenic fetal kidneys and Anhydramnios, Antenatal steroids and Magnesium sulfate, Mother 39yo, G2P1.
**Neonatal Course:** Resuscitation with PPV, chest compressions and ET Intubation. Apgars 41 & 45. Transferred to NICU intubated and ventilated. Respiratory distress/failure, pneumothorax and PPHN: High ventilator pressures, iNO, Surfactant treatment and NICU care. Transferred to Coombe Hospital by NNTP at 5h of life. Continued critically ill with severe PPHN, respiratory failure and progressive renal failure 2nd to polycystic kidney disease. Progressed to multiorgan failure. Decision to withdraw ICU care on DOL8. RIP on DOL 8 in Coombe neonatal unit.
**Diagnosis:** Polycystic kidney disease.
**Postmortem:** No.

**2. Pregnancy:** Gestation 37+5/40, BW 1800 gms, Female, Singleton, LSCS for previous C-Section/breech, Antenatal diagnosis of T18, VSD and abnormal CNS, Antenatal steroids, Mother 39yo, G2P1.
**Neonatal Course:** PPV for 3-4 min. Apgars 61 & 85. Dysmorphic features consistent with T18. Comfort care on PNW. Palliative care team review. RIP on PNW on DOL 2.
**Diagnosis:** Trisomy 18, ASD and abnormal CNS.
**Postmortem:** No.

**3. Pregnancy:** Gestation 32+6/40, BW 1630 gms, Female, Singleton, EMCS for PPROM and APH, Antenatal diagnosis of IUGR and Oligohydramnios, IVF pregnancy, Mother 43yo primigravida,
**Neonatal Course:** PPV after birth. Apgars 21 & 45. SGA and dysmorphic features. Infant's condition rapidly deteriorated after arrival in NICU: Refractory respiratory failure, pulmonary haemorrhage, cardiac dysfunction, acidosis and severe hyperkalemia. CXR 'white out'. ET intubation, HFOV, IVF, IV Antibiotics and Sodium Bicarbonate. Failed to respond to NICU care and RIP at 2h of age. Mother transferred to ICU after delivery: Sepsis with high CRP and PPH. Examination of the placenta demonstrated evidence of an ascending infection.
**Diagnosis:** Premature, non-specific dysmorphic facial features and pulmonary infection.
**Postmortem:** Coroners PM.

# Section 3: Gynaecology
# *(a) Gynaecological Surgery*

Prof John Morrison Consultant Obstetrician Gynaecology Clinical Director of Saolta MCAN

| | |
|---|---|
| Elective LSCS | 514 |
| Emergency LSCS | 494 |
| ERPC | 169 |
| Laparotomy Abdominal hysterectomy +/- BSO | 51 |
| Radical hysterectomy | 3 |
| TAH, BSO & PLND | 7 |
| TAH, BSO & omentectomy & appendicectomy +/- PLND | 27 |
| Omentectomy | 2 |
| Ovarian debulking | 24 |
| Caesarean hysterectomy | 3 |
| Myomectomy | 7 |
| Laparotomy | 23 |
| Diagnostic laparoscopy | 32 |
| Laparoscopy Hysterectomy/ BSO/PLND | 14 |
| Lap Radical Hysterectomy/ BSO/PLND | 1 |
| Laparoscopic hysterectomy +/- BSO | 27 |
| Laparoscopic BSO | 20 |
| Laparoscopic unilateral salpingo-oophorectomy | 35 |
| Laparoscopic tubal ligation | 7 |
| Laparoscopic ectopic | 19 |
| Laparoscopic sacrocolpoplexy | 0 |
| Laparoscopic hysterectomy & sacrocolpoplexy | 0 |
| Laparoscopic dye hysteroscopy | 75 |
| Laparoscopic cystectomy | 37 |
| Hysteroscopy D & C | 529 |
| Mirena insertion | 111 |
| Endometrial ablation | 29 |

| | |
|---|---|
| TCRE | 19 |
| Vaginal hysterectomy | 6 |
| Vaginal hysterectomy and PFR | 5 |
| Pelvic Floor Repair | 32 |
| Vulvectomy | 5 |
| TVT | 0 |
| Removal of TVT mesh | 0 |
| Cystoscopy | 21 |
| Macroplastic collagen | 0 |
| Examination under anaesthetic | 33 |
| Cervical Suture | 11 |
| Removal of Cervical Suture | 0 |
| Fentons procedure | 8 |
| Vulval biopsy | 20 |
| LLETZ | 4 |
| Bartholins | 12 |
| Instrumental delivery | 76 |
| Third degree tear repair | 42 |
| Manual removal of placenta | 24 |
| Excision of Skin tag | 1 |
| Removal of drain | 1 |
| PPH Bakri balloon insertion | 4 |
| Removal of mirena coil | 26 |
| Cervical smear under GA | 15 |
| Colpoclesis | 3 |
| Labiaplasty | 0 |
| Excision of labial cyst | 0 |
| Major | 1353 |
| Minor | 1097 |
| Elective Cases | 1706 |
| Emergency Cases | 744 |
| **Total** | **2450** |

This section describes all of the operative procedures performed at University Hospital Galway during 2019. There are a few trends apparent in the statistics. There was an increase in the number of laparoscopic procedures in Gynaecology, for benign reasons and for oncology procedures. There was a concomitant reduction in the number of laparotomy procedures for hysterectomy and/or adnexal pathology. There was a notable absence of surgery for urinary stress incontinence due to national guidelines on this topic. Development of referral pathways for specialist gynaecology services across the Saolta Healthcare Group of hospitals has resulted in greater demand on operative services at GUH, and it is likely that this trend will continue.

## Saolta Group Gynaecological Oncology

A tertiary referral gynaecological oncology services is provided at Galway University Hospital which serves to provide this service throughout the Saolta Group. The service provided at Galway University Hospital includes surgery, medical oncology, radiotherapy, and a multidisciplinary team of radiologists, pathologists, nurse specialists, psychologists, dieticians, physiotherapists and research nurses. The services are delivered on an outpatient, ambulatory and inpatient basis. In 2019 the team managed over 100 new woman and coordinated the care for ongoing cases. In addition to this, the team were responsible for the coordination of the care of an additional 120 women undergoing adjunct therapy and palliative care.

## Saolta Placenta Acreta Pathway

Within the Saolta Hospital Group a Saolta Gynaecological Oncology has been developed to care for women with uterine and placental disorders including placenta acreta. This pathway accepts transfers from within the Hospital Group for delivery and management of the patient as well as complicated post-partum patients.

This service is delivered in UHG and is a collaboration of Obstetrics and Gynaecology services, Fetal Medicine, Specialised Obstetric Anaesthetist, blood and tissue establishment, interventional radiology. Additionally Level 3 intensive care facilities, cell salvage and a hybrid operating room are available.

## Total surgeries

| Year | Endometrial | Ovarian | Vulval | Cervix | Total Surgeries | Total Adjunct therapy and palliative treatment | Total |
|---|---|---|---|---|---|---|---|
| 2019 | 42 | 52 | 1 | 6 | 101 | 120 | 221 |

| Year | Number of Acreta | Elective | Emergency | Outcome Hysterectomy | Baby |
|---|---|---|---|---|---|
| 2018 | 7 | 5 | 2 | 3 | All live births |
| 2019 | 3 | 3 | 0 | 1 | All live births |

# Section 3: Gynaecology
# *(b) In-Patient Gynaecology Report*

Ms Pauline Tarpey Clinical Midwife Manager 2

St. Monica's Gynaecology ward has a capacity for 15 inpatient beds and 4 additional day case trolleys is predominately a surgical ward that specialises and provides care to women in early pregnancy up to 16 weeks gestation, and Gynaecology (general and specialist) services to women of all ages. Our philosophy of care on St. Monica's is to provide holistic women centered care that is both efficient and accessible to all women in a sensitive manner taking into account the physical, social, psychological and spiritual needs of our diverse and often complex patient group.

We work closely with our Gynaecological - Oncology team. Our Gynaecological Oncology Multidisciplinary Team (MDT) is a well established group of experts with a specialist role in the diagnosis, treatment and management of women with gynaecological cancers. The MDT team meets every second Friday to discuss, patients including newly referred patients within our Saolta group.

St. Monica's Gynaecology ward also works closely with our Early Pregnancy Assessment unit. It provides scans, care support and advice for our inpatients up to 12 weeks gestation.

Further developments on St. Monica's Gynaecology ward in 2019 included the

- Organisation of local education sessions relevant to practice including pain management, VHI homecare, PICO, Pharmacy, medication management and early pregnancy complications.
- Audit of practice including monthly metrics, ERPC, IV cannulation and Hygiene audits.
- Training and ongoing professional development of our staff continues. 4 staff completed the postgraduate (Level 9) module with NUIG.
- Staff are actively involved in facilitating on the Saolta Surgical Nursing study days and values appreciation.

The majority of our admissions are surgical patients, as highlighted below.

In conclusion St Monica's Gynaecology ward remains committed to providing quality and excellence for service users in partnership with the multidisciplinary team.

**St Monicas Admissions in 2019**

| Months | ED | Elective | Non Elective | Grand Total |
|---|---|---|---|---|
| 2019-01 | 14 | 98 | 59 | 171 |
| 2019-02 | 18 | 91 | 45 | 154 |
| 2019-03 | 11 | 117 | 47 | 175 |
| 2019-04 | 16 | 106 | 55 | 177 |
| 2019-05 | 16 | 112 | 36 | 164 |
| 2019-06 | 16 | 89 | 37 | 142 |
| 2019-07 | 7 | 107 | 38 | 152 |
| 2019-08 | 11 | 89 | 47 | 147 |
| 2019-09 | 14 | 94 | 43 | 151 |
| 2019-10 | 16 | 108 | 38 | 162 |
| 2019-11 | 14 | 104 | 38 | 156 |
| 2019-12 | 4 | 80 | 35 | 119 |
| Grant Total | 157 | 1195 | 518 | 1870 |

# Section 3: Gynaecology
# *(c) Colposcopy Clinic Report 2019*

Dr Michael O'Leary Consultant Obstetrician Gynaecologist, Ms Maura Molloy Advance Midwife Practitioner

## Team

**Administration:** Ger Dooley, Ann Keane and Caitriona O'Toole Curley, Janet Traynor.
**Consultant:** Dr Michael O'Leary (Lead Colposcopist) and Dr Katharine Astbury
**Nursing Midwifery:** Pat Rogers (AMP), Maura Molloy (AMP), Assumpta Casserly CNS, Marguerite Bourke SM, Cara McNally SM.
**Healthcare assistant:** Karen McGinley

## Activity

There were 4604 women attended Galway Colposcopy clinic in 2019, of these 1749 were first visits and 2855 were review appointments. A total of 1797 referrals to Colposcopy were received, 244 high grade smears, 853 low grade smears and 244 had clinical indication for referral. In 2018 there were 370,000 smears taken in Ireland, increased from 280,000 in 2017. This increase in screening was a result of a Government decision to fund out of programme smear tests up to December 2018 and it led to large numbers of referrals to colposcopy. Non attendance was 6.5% and the target for DNA set by Cervicalcheck is <10%. Reminders were issued by text message one week in advance of appointments. Referrals were received from counties Galway, Mayo, Roscommon, Clare, Westmeath, Offaly and Longford. Cervical screening was provided by colposcopy clinic staff at the request of Neurology department for a small number of women prior to therapy for multiple sclerosis.

Cytology and high risk HPV testing were provided by Medlab Pathology and Coombe laboratory. Histology services were provided by UHG laboratory. Multidisciplinary team meetings between Colposcopy clinical staff, the cytology laboratory and UHG histology laboratory were held quarterly using gotomeeting software. Complex cases including glandular abnormalities, persistent disease and discrepancies between laboratory and clinical impression were discussed at these meetings and plans agreed.

There were 345 LLETZ treatments performed and 1817 cervical bioipsies taken in 2019. Cervicalcheck standards were met (>80% of excisions should have CIN on histology). There were 70 ablative treatment carried out in 2019, 39 Cold coagulation for low grade disease, and 31 diathermy destruction.

| Histology Result 2019 | Diag. Biopsy | Excision | Total |
|---|---|---|---|
| Cervical Cancer | 12 | 8 | 20 |
| Adenocarcinoma in situ / CGIN | 9 | 9 | 18 |
| CIN3 | 130 | 141 | 271 |
| CIN2 | 190 | 91 | 281 |
| CIN1 | 660 | 74 | 734 |
| CIN Uncertain Grade | 3 | 0 | 3 |
| VAIN3 | 4 | 0 | 4 |
| VAIN2 | 10 | 0 | 10 |
| VAIN1 | 29 | 1 | 30 |
| VIN3 | 2 | 0 | 2 |
| VIN2 | 1 | 0 | 1 |
| VIN1 | 2 | 0 | 2 |
| HPV / cervicitis only | 470 | 17 | 487 |
| No CIN / No HPV (normal) | 263 | 4 | 267 |
| Inadequate | 12 | 0 | 12 |
| Other* | 20 | 0 | 20 |
| Total | 1817 | 345 | 2162 |

*endometrial pipelle

## Cancer

There were 23 cases of cancer diagnosed, 21 had cervix cancer and 1 woman had serous adenocarcinoma of vagina which originated in a fallopian tube and 1 had vault recurrence of endometrial adenocarcinoma. Ages of women with cancer diagnosis ranged from 25 to 81years, 13 of them were under 50 years highlighting that cervix cancer is a significant disease in young women. Of the cervix cancers 8 were microinvasion and 13 were more advanced. Histologically squamous cell carcinoma was reported in 16 cases, adenocarcinoma in 3 cases (2 microinvasion) and neuroendocrine in 1 case with 1 poorly differentiated carcinoma. Treatments for cancer diagnosed in colposcopy included local excision, LLETZ (7), Simple Hysterectomy (2), Radical Hysterectomy with Lymph node dissection (2) and 10 women were referred for chemo/ radiotherapy.

## Outreach clinic

Midwifery staff from Galway Colposcopy clinic continued a smear clinic at Portiuncula University Hospital Ballinasloe on two Friday afternoons per month, 258 women attended the outreach clinic in 2019. The outreach clinic saves women from the midland counties having to travel to and park at UHG for follow up smear.

## Reporting

Monthly, quarterly and annual report of activity (colp1) was generated and submitted to Cervicalcheck.

## Staff

Assumpta Casserly was appointed CNS in November 2019. Maura Molloy, Advanced Midwife Practitioner was released 2 days per week in November and December to work with Cervicalcheck on the introduction of HPV primary screening. Cara McNally SM came to work in the unit in November 2019.

## Summary

Our colposcopy team both clinical and clerical continued to work exceptionally hard in 2019 to manage large numbers of referrals and extra clinics were run to ensure that women were seen within recommended targets set by Cervicalcheck. Clinical indications including suspicious cervix and postcoital bleeding continued to add to the Colposcopy workload.

# Section 3: Gynaecology
# *(d) Urogynaecology Report*

Dr Susmita Sarma Consultant Obstetrician & Gynaecologist

The urogynaecological service continues to expand and develop. We continue to be indebted to the Physiotherapists in women's health, who provide the bulk of conservative management for patients with prolapse and urinary symptoms and continue to facilitate a combined clinic on a Monday morning. Special thanks are given to Debbie Fallows, Physiotherapist for her invaluable help.

## Urodynamic:

In 2019, 80 appointments were sent and 60 urodynamic investigations were performed. Cystistat is used to treat painful bladder syndrome and is administered during the urodynamic clinic session. Geraldine Adair continues her role as urodynamic nurse and is a very welcome addition to the urodynamic service. We would also like to acknowledge the help of Suzana Muhja HCA.

Total Urodynamic Investigations: 60

## Diagnosis:

Stress Urinary Incontinence:20 (33 %)
Mixed Urinary Incontinence:7 (11.6%)
Normal16 (26.6%)
Detrusor overactivity 11 (18.3%)
Voiding problems:6 (10%)

## Surgery:

Cystoscopy 15
Sacrospinous fixation 4
Colpocleisis4

Surgery using mesh for stress incontinence was suspended by the CMO in July 2018 and there have been for procedures for stress incontinence carried out since in GUH.

## Perineal Clinic

The Perineal Clinic commenced in January 2019. Women are referred who have sustained 3rd/4th perineal tears and complex pelvic floor issues. This is a multidisciplinary clinic with Ms Aisling Hogan Colorectal Surgeon, Dr Susmita Sarma Urogynaecologist, Ms Debbie Fallows Physiotherapist.

There were 9 sessions with 92 patients seen. Ultrasound and manometry was commenced in 2020.

# Section 3: Gynaecology
# *2019 Galway Sexual Assault Treatment Unit*

Clinical Director: Dr Andrea Holmes, Unit Manager: Ms Maeve Geraghty, Forensic Clinical Nurse Specialists: Ms Susan Hogan, Ms Cathy Shortt, Ms Cathy Bergin and Ms Mary Mahony

## Attendances:
- In 2019 there were 102 acute attendances at the Galway SATU, an increase of 5 (5%) from 2018 and our busiest year to date
- 96 (95%) of reported incidents took place within the Republic of Ireland, 6 (5%) reported incidents took place outside the Republic of Ireland
- October was the busiest month with 14 (14%) acute attendances and Sunday was the day of the week that most attendances 31 (30%) occurred
- 84 (82%) of incidents occurred between the hours of 20:00 and 07:59

## Type of Reported Sexual Crime, Assailant, Relationship to Assailant
- 83 (81%) were recent sexual assaults
- 93 (91%) cases involved a single assailant; 9 (9%) cases involved multiple assailants
- In 33 cases (29%), the alleged assailant was a previously known acquaintance

## Gender, Age Profile, Referral Source
- 95 (93%) of patients were female, 6 (6%) patients were male and 1 patient (1%) gender-identified as trans-female.
- The mean age of patients was 25 years of age, with a range of 14 years to over 70 years of age
- An Garda Síochána referred 72 (71%) patients; 19 (18%) patients self-referred and 11 (11%) patients were referred by others (Rape Crisis Centre, GPs, Emergency Department etc.)
- 15 (15%) patients had a Forensic Clinical Examination and storage of evidence without initially reporting to An Garda Síochána (Option 3) and of these:
- 3 (20%) patients went on to make a formal complaint and the samples were released to An Garda Síochána

## Psychological Support Worker Attendance
- 80 (78%) patients had the opportunity to speak to a Psychological Support Worker from Galway Rape Crisis Centre (RCC) at their first SATU visit. All patients are given contact details for RCC.

## Physical Trauma
- 39 (38%) patients had physical injuries recorded, of these of 1 (1%) injury required follow-up in hospital and was admitted.

## Alcohol and Drug Use
- 73 (71%) patients seen had consumed alcohol in the 24 hours prior to their incident, of which 55 (53%) patients had consumed >6 standard drinks of alcohol
- 11 (11%) had taken recreational drugs prior to the reported incident
- 16 (16%) patients were concerned that drugs were used to facilitate sexual assault
- 13 (13%) patients were unsure if drugs were used to facilitate sexual assault

## Patient awareness of whether sexual assault had occurred
- 79 (77%) patients stated a sexual assault had occurred, 17 (17%) were unsure whether a sexual assault had occurred. In 6 (6%) cases this metric was not recorded.

## Emergency Contraception (EC)
- 36 of 38 female patients who presented within 120 hours of the incident and met criteria for consideration of post-coital contraception had it administered.

## Sexually Transmitted Infection Prophylaxis and (STI) Screening
- 75 (74%) patients received Chlamydia prophylaxis
- 65 (64%) commenced Hepatitis B immunisation programme at first SATU visit
- 4 (4%) patients received Post Exposure Prophylaxis (PEP) for HIV

## Follow-up Appointment for Sexual Health Screening
- 66 (64%) patients were given a follow-up appointment for STI screening, of these, 52 (90%) patients attended first follow-up appointment.

## Outcome of Sexual Health Screening
- 2 (3% of those screened) had a positive result for chlamydia
- 1 (2%) has a positive result for syphilis

## Referrals to Túsla (Child & Family agency)
- Each of the 20 patients who attended SATU aged less than 18 years was referred to Túsla.

# Section 3: Gynaecology

# *Child & Adolescent Sexual Assault Treatment Unit Galway Executive Report 2019*

Dr Joanne Nelson, Clinical Director, CNS SAFE: Cathy Bergin, Susan Hogan, Mary Mahony, Caitriona Shortt and SATU Manager Maeve Geraghty

***The Child and Adolescent Sexual Assault Treatment Unit (CASATS)***, based in Galway but serving a wide geographical area in West and Mid-West Ireland, has been an HSE service since April 2011. It is co-located with SATU services, established in Galway since 2009. CASATS provides Forensic Medical evaluation for children 0-14 years suspected of having been sexually abused. CASATS also supports those 14-18 years presenting outside the forensic window for sampling. Acute adolescent cases 14-18 years are assessed through SATU services, on the same site, with capacity for joint CASAT/ SATU Forensic Examiners depending on the best interests of the child. The service remains the only 24/7 service in Ireland for child sexual abuse.

Since 2014 CASATS patients and their families have been supported, during the forensic medical examination, by trained volunteers from the charity CARI with capacity for telephone aftercare if indicated. This service has proved invaluable to patients, parent, guardians and professionals.

Barnahus One House Galway: In late 2017, CASATS and SATU Galway was successful in its application to become the first pilot site in Ireland for a multi-agency support and assessment team for child and adolescent sexual abuse called the Barnahus / One House. The Barnahus Galway was formally launched in September 2019 by Dr Katherine Zappone, Minister for Children and Youth Affairs and Charlie Flanagan, Minister for Justice and Equality with endorsement by the Minister for Health, Simon Harris. It aims to provide integration of medical, social, psychological therapy and Garda collaboration in responding to children under 18 years of age where sexual abuse is suspected. Whilst a building to accommodate all members of the Barnahus team is not yet in place, interagency working, including regular interagency meetings, cases discussions and interagency education has occurred throughout 2019 leading to an increase in children and adolescents accessing forensic medical care. 2019 saw the highest number of child and adolescent attendances in CASATS for Forensic Medical examination since its opening in 2011.

Currently within the CASATS service, the 24/7 rota is covered by two forensic physicians, with ongoing training of doctors and nurses in developing skills and knowledge in paediatric forensic examinations. The team work in compliment with SATU services.

We would like to extend enormous thanks to all our dedicated staff, to our partner agencies in the Barnahus to the volunteers from CARI and to those who have supported and endorsed the Barnahus in its infancy. We look forward to innovation, expansion, research and interagency development focused on best meeting the needs of the children and their families going forward.

## Total Attendances:

- Total number of attendance increased from 75 in 2018 to 115 in 2019, a 53% increase.
- 22 (19%) patients were aged between 14-18 years of age
- 17 (15%) patients were seen out of hours (between 16.00-08.00 Mon-Fri or over the weekend/bank holiday).
- Of the 115 patients who attended Galway CASATS, 14 were Acute Forensic Examinations and 101 were non-acute Forensic Examinations.

## Gender, Age Profile, Referral source:

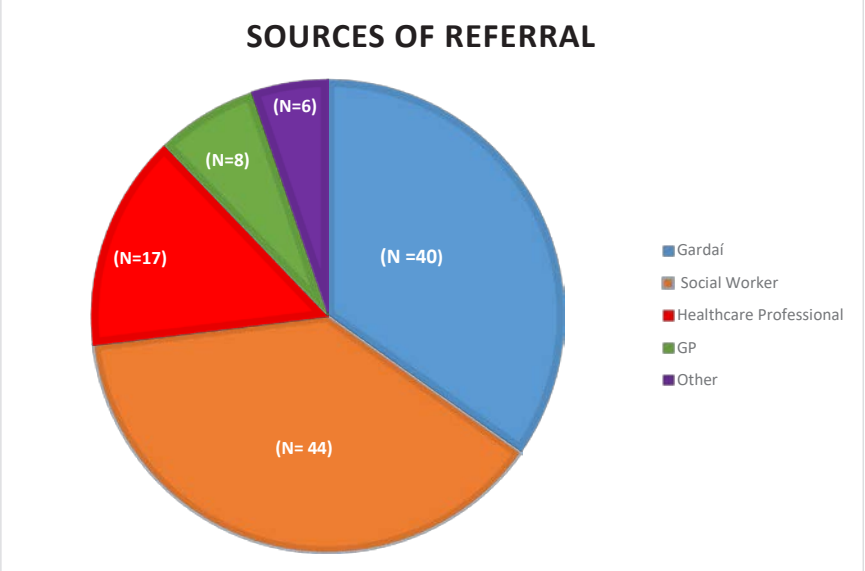
- 87 (76%) patients were female and 28 (24%) patients were male. The mean age was 6.3 years (Range 0-17 years).

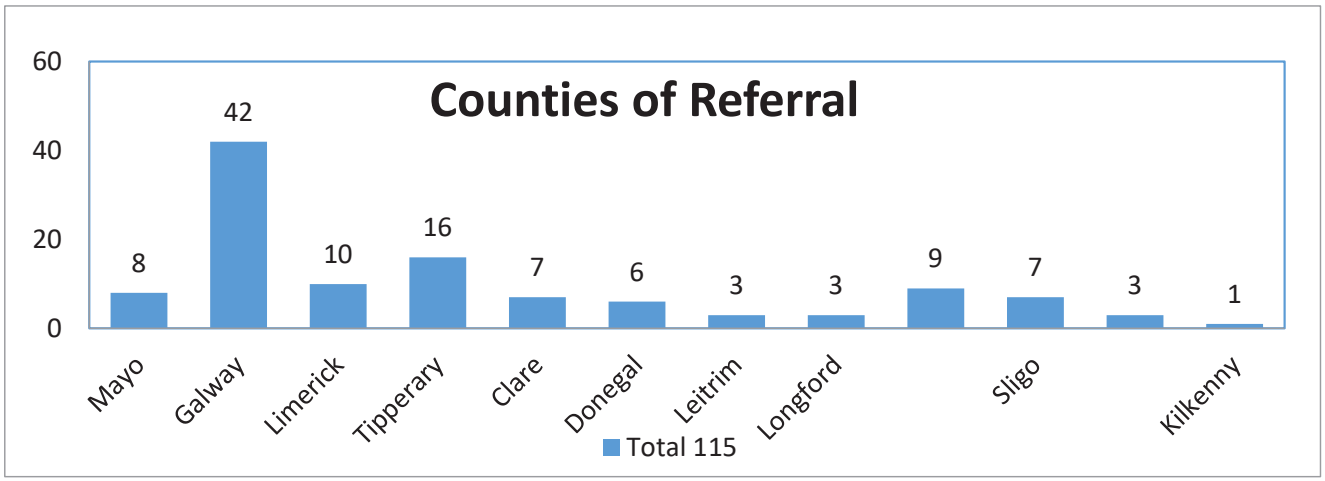
## Intimate images:

- Intimate Images were taken using colposcopy in 105 (91%) cases and in 10 (9%) cases Colposcopy images were not taken as they were either declined or not indicated.

## Counties of Referral:

- The Majority of attendee's to CASATS came from Galway (36%), Tipperary (14%) and Limerick (9%).






## Medications:

- Emergency contraception was prescribed and given to 1 patient.
- Hepatitis B vaccination schedule was commenced for 8 patients.
- STI prophylaxis (Azithromycin) was prescribed and given to 2 patients.
- No patients received HIV Post Exposure Prophylaxis in 2019.
- 104 (90%) patients had STI screening carried out as part of their initial examination, 3 had STI screening done at Follow-up, STI screening was not indicated at follow up in 2 cases, 4 patients had no STI screening carried out at initial examination and 2 declined STI screen to be carried out.

## Alleged Perpetrators:

Child perpetrators (Defined as <13 years at the time of the alleged assault)

- 9 (8%) of cases involved child perpetrators.
- Teenage Perpetrators (Defined as 14-17 years at time of alleged assault)
- 12 (10%) of cases involved teenage perpetrators.
- Adult Perpetrators (Defined as ≥ 18 years at the time of the alleged assault)
- In 45 (39%) of cases the alleged perpetrator was a family member
- In 30 (27%) of cases the alleged perpetrator was known to the patient
- In 1 (1%) case the alleged perpetrator was unknown
- In 5 (4%) of cases there were multiple perpetrators

In 13 (11%) of cases the details there may not have been a definitive allegation of child sexual abuse however, examination was deemed appropriate due to factors e.g online child exploitation, inappropriate sexualised behaviour.

## Support Worker in Attendance:

- In 79 (68%) patients had access to a CARI, Child and Family accompaniment support worker at their initial attendance in CASATS. In 1 case a RCC (Rape Crisis Centre) support worker was present.

# Section 4: Paediatrics
# *(a) Paediatric Outpatient Report*

Dr. Mary Herzig Consultant Paediatrician

## Introduction

This report presents the available data on medical paediatric out-patient clinical activity for year-end December 31, 2019. Our paediatric day ward opened in 2018 and that activity is now captured in the in-patient activity report. The day ward now supports the out-patient department, particularly with on demand services such as phlebotomy.

The paediatric out-patient department runs 13 medical clinics per week accommodating 7 full and part-time paediatric consultants. There are additional clinics facilitated via the current OPD facility including urology, dermatology, and cardiology which are not included in this report. There are also nurse led clinics for diabetes, physiotherapy hip clinic, allergy and cystic fibrosis. The following figures represent the cumulative number of patients seen across consultant led paediatric medical clinics. All medical paediatric clinics in UHG are mixed general paediatric with the exception of specialist asthma, diabetic, disability, neurology, and allergy/immunology clinics.

## 2019 DATA

### Number of Medical Consultant Patients

The total number of out-patients appointments offered to patients is increased again to n=7589 (14.6%) from 2018. There were 2165 new (29%) and 5424 return (71%) appointments. There is very little scope to increase this number due to infrastructure restrictions.

| Year | Number of Appointments |
|---|---|
| 2006 | 5645 |
| 2007 | 6345 |
| 2008 | 6626 |
| 2009 | 6814 |
| 2010 | 6114 |
| 2011 | 5519 |
| 2012 | 5638 |
| 2013 | 5742 |
| 2014 | 5781 |
| 2015 | 6562 |
| 2016 | 6512 |
| 2017 | 6640 |
| 2018 | 6622 |
| 2019 | 7589 |

### Non-Attendance Medical Consultant Clinics

Historically the usual DNA rate was 20% for "new" patients and 30% for "return" patients. This improved in 2014 due to guidelines from the HSE on the allowable number of missed appointments before discharge back to GP, and also improvement in text messaging reminder system for patients. This still seems to be working. There is a trend to a higher DNA rate in the general versus specialty clinics.

| DNA Rates | New | Return |
|---|---|---|
| Historical until 2013 | 20% | 30% |
| 2014 | 7% | 24% |
| (HSE Policy on DNA's introduced + text) | | |
| 2015 | 11% | 29% |
| 2016 | 13% | 20% |
| 2017 | 15% | 15% |
| 2018 | 17% | 16% |
| 2019 | 11% | 11% |

DNAs are taken into consideration when booking clinics (overbooked).

### Waiting List Medical Consultant Clinics

Data is collected by consultant staff in order to monitor trends in waiting list times. Data indicates a continued trend of increased referrals which has been reported in all units nationally with the advent of free GP care for children.

Consultants have prioritized new referrals over review patients since 2017 to reduce the number of patients waiting and their wait time. Despite this, our median wait time has fallen in 2019 due to extra new patient clinics. This initiative should be adequately resourced in order to continue in 2020.

| Number of Patients Referred to Paediatric Wait List Total | |
|---|---|
| 2013 | 432 |
| 2014 | 723 (+67%) |
| 2015 | 1086 (+50%) |
| 2016 | 1227 (+13%) |
| 2017 | 1008 (-18%) |
| 2018 | 1008 (even) |
| 2019 | 872 (-13%) |

### Out-Patient Waiting List 2009-2016

| Year | Median Wait |
|---|---|
| 2009 | 5.2 months |
| 2010 | 9.1 months |
| 2011 | 3.2 months |
| 2012 | 4.4 months |
| 2013 | 4.8 months |
| 2014 | 4.0 months |
| 2015 | 5.5 months |
| 2016 | 10.5 months |
| 2017 | 7 months |
| 2018 | 6.3 months |
| 2019 | 3.2 months |

# Section 4: Paediatrics
# *(b) Paediatric Report 2019*

Dr Edina Moylett Consultant Paediatrician

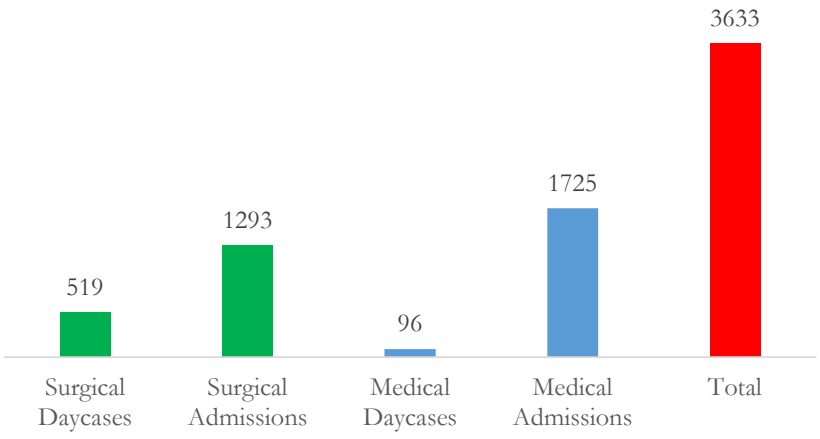
## Introduction

The following report includes all clinical activity on St. Bernadette's ward (the paediatric in-patient unit) of University Hospital Galway (UHG) for the period January 1 to December 31 2019. Data are also included for paediatric activity in the Emergency Department (ED), all admissions to UHG up to 16 years old and the paediatric admissions to the Intensive Care Unit. In addition, activity for the Paediatric Day Unit is included, January to December inclusive.

The majority of paediatric aged (0-14 years) patients attending UHG are admitted to St Bernadette's ward with some exceptions. Owing to capacity and staffing limitations, children beyond their 12th birthday with a surgical diagnosis historically are admitted to general surgical wards; those < 12 years are admitted to St Bernadette's. All children up to 14 years with an orthopaedic diagnosis admitted to St Bernadette's. Finally, the age limit for paediatric medical admissions to St Bernadette's is the 14th birthday, the latter is not in line with national recommendations (up to 16th birthday); the age limit is set at 14 owing to capacity limitations, accommodation suitability, lack of dedicated adolescent service, and staffing limitations on St Bernadette's ward. Neonates (0 to 4 weeks) are admitted to St Bernadette's, excluding recent NICU discharged premature infants who may not be suitable for the paediatric unit owing to specific specialist neonatal requirements.

Admission data are broken down into those admitted to St Bernadette's and those admitted to adult wards within the hospital concerning children up to 16 years old. Data are further divided into Day and Overnight admissions, ED admissions, elective admissions and 'other' sources (likely OPD). Transfer data, where available, provided for UHG ICU admits and elective/ emergency tertiary hospital transfers.

Figure 1. Bernadette's Activity, UHG 2019 - 3,633




| Specialty | Overnight admissions | Day Cases | Total |
|---|---|---|---|
| *ENT* | 283 | 213 | 496 |
| *Maxillofacial* | 55 | 28 | 83 |
| *Ophthalmology* | 8 | 53 | 61 |
| *Orthopaedics* | 349 | 83 | 432 |
| *Plastic surgery* | 294 | 95 | 389 |
| *General surgery* | 252 | 14 | 266 |
| *Urology* | 52 | 33 | 85 |
| **Total** | **1,293** | **519** | **1,812** |

## Admission Information

The majority of data for this report obtained from Mr. Richard Malone in Information Services, UHG (via PAS system) with Intensive Care Unit activity obtained from the Clinical Information System in ICU/HDU (Ms Fiona Burke). Paediatric ambulatory care (day unit) data and patient transfer data received from Ms Anne Matthews, CNM3 Paediatrics, with assistance from Ms Patricia Freely, RN. Comparative data, where available, provided for preceding years.

## Admissions Bernadette's Ward

Figure 1 outlines all paediatric activity for St Bernadette's ward, UHG during 2019; note 3,633 (3,960 in 2018) children admitted to St Bernadette's ward, c. 10/day; 1,821 medical and 1,812 surgical cases. Of the 1,821 medical cases, only 96 day case procedures, 5% general paediatric activity. By comparison, 29% of the surgical activity was day case related (519/1,812), see breakdown by specialty in Table above.

The majority of acute paediatric medical admissions are direct from the ED, during 2019, 82% admissions via the ED.

## Adult wards in UHG

Figure 2 outlines children up to their 16th birthday admitted to a ward other than St Bernadette's (excluding NICU) during 2019; 1,078 (1,382 in 2018) children up to 16 years old were admitted to 'adult' UHG wards, c.3/ day. Of the 1,078 children on adult wards, 502 admitted as day cases, 576 overnight admissions. Close to 300 children admitted with a 'surgical' diagnosis to adult wards during 2019, 442 'surgical' day cases. Approximately 1/3 of children in adult wards admitted from the ED (362/1078).

## Paediatric ED Activity

During 2019, there were 15,628 (15,902 and 14,782 during 2017 and 2018, respectively) attendances to the UHG ED up to 16 years of age, c.43 patients reviewed per day. Approximately 2,750 children were admitted directly from the ED to a ward or unit in UHG, c.17.6% of the total ED visits for 2019. Of note, only 1,314 (47.6%) admitted patients were referred by a GP.

## Paediatric Day Unit

The paediatric day unit is located on St Bernadette's ward. In total, 2,604 children were managed on the Day Unit during 2019; 538 episodes were formally coded via the PAS system, the remainder, hand counted from a daily log maintained on the unit. Approximately 10 patients/day throughout the year.

## ICU admissions

There were 62 (60, 2018) children ≤ 16 years of age admitted to the UHG ICU during 2019, only two children >14 but <16. The average age 59 months (range, 0.1-180 months), only 2 neonatal aged patients, see Figure 3 for age breakdown. The average duration of stay 0.77 days (range, 0.14 to 2.14 days).

The Table outlines discharge diagnoses and destination from ICU. Respiratory causes remain the principle reason for ICU admission. The majority of children discharged to St Bernadette's ward, only 19 children (30%) transferred to tertiary services, 9/19 (47%) with the retrieval team.

## Transfers from St Bernadette's to a Tertiary Hospital

During 2019, 37 children (54 during 2018) were transferred to a tertiary hospital directly from St Bernadette's ward. The majority (24) were transferred to Children's Hospital Ireland at Crumlin, 10 to Temple Street, 2 to Beaumont hospital and 1 to Tallaght.

Figure 2. Adult Ward Paed Activity, UHG 2019 - 1,078

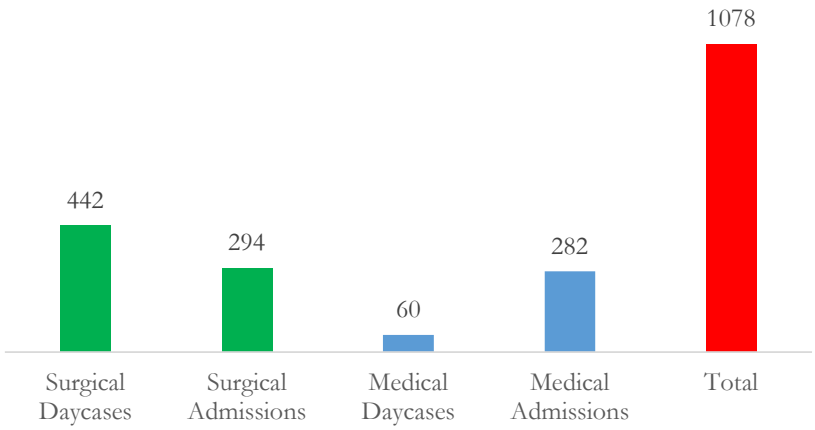
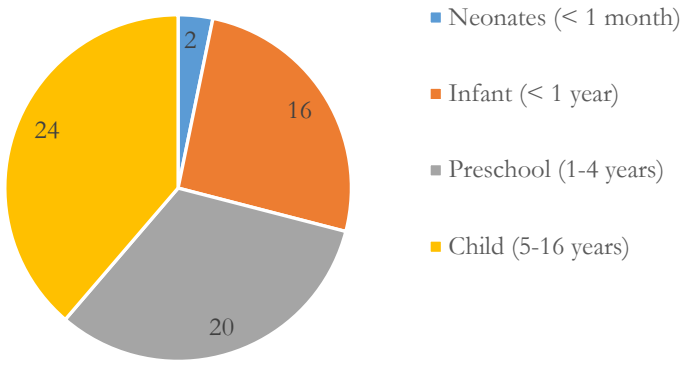



Figure 3. Paediatric ICU admission, by age group, Total, 62




| ICU Discharge Diagnosis and Destination | |
|---|---|
| **Diagnosis** | |
| Respiratory | 34 |
| DKA | 9 |
| Sepsis | 5 |
| Seizure/Status epilepticus | 4 |
| **Other** | 3 |
| **Trauma related** | 3 |
| **Post-surgery** | 2 |
| **Cardiac** | 2 |
| **Paediatric Discharge Destination** | |
| St Bernadette's Ward | 41 |
| Tertiary hospital | 19 |
| Other Ward UHG/Home | 1/1 |

# Section 5: Allied Clinical Services
# *(a) Medical Social Work*

Ms Maeve Tonge Senior Social Work Practitioner

Medical social workers provide support, guidance and counselling as needed at a time of crisis for a family. This is voluntary, non judgemental and non directive. We value self determination and are person centredand holistic in our approach. We will advocate for patients when required.

## Obstetrics & Gynaecology Referrals

All in-patient referrals are accepted online via PAS system with consent. Outpatients requiring Medical Social Work support are accepted on our referral cards again with a patients consent.

## Support and counselling

- Crisis intervention, mediation and counselling for various personal and family difficulties.
- Counselling and support for women at the time of diagnosis of serious illness.
- Antenatal support for parents following diagnosis of fetal abnormality.
- Identification and support for women with anxiety, low mood, depression in ante natal or postnatal stage.
- Bereavement counselling and support for parents and family members following a pregnancy loss including stillbirth, miscarriage, neonatal death and termination of pregnancy.
- Referral and liaison with services and patients linked with drugs services and or mental health services.

## Information and guidance

- Support in relation to parenting and/ or childcare issues.
- Support in relation to immigration issues and integration concerns.
- Involvement in research, training and policy development.
- Liaison, advocacy and support in relation to accessing various services.
- Provision of information regarding social welfare, entitlements, birth registration etc.

## Student Training

Our experienced Medical Social Workers continue to support the Masters in Social Work Programme by acting as Practice Teachers and providing placement opportunities for 1st and 2nd year students from NUIG,TCD, UCD and UCC.

## Committees

Medical Social Workers endeavour to provide active participation on Children's First Committee, Perinatal Mental Health Committee, Traveller Midwifery committee and the Perinatal Bereavement Committee when staffing numbers permit.

## Domestic Violence

A routine enquiry into domestic abuse continues in Maternity Out patients. Should a woman disclose domestic abuse, social workers will respond immediately and counsel her to plan for her safety.

## Crisis Pregnancy & new legislation around abortion

Medical Social Workers support colleagues in the early days regarding the implementation of new legislation that introduced abortion care here under certain guidelines. MSW were involved in the delivery of WHO values training with regard to abortion care. Medical social workers continue to offer supportive,non-biased counselling to women presenting with a crisis pregnancy at any stage of this pregnancy e.g. unplanned pregnancy, or on diagnosis of fetal abnormally. Counselling is offered on all options, including parenting, abortion and adoption, within the relevant legal guidelines. Bereavement support following termination of pregnancy is routinely offered.

## Perinatal Mental Health

Medical Social workers are delighted to welcome the specialised peri natal mental health care Consultant and midwife and have been acutely aware of the increased recognition of the need for support for women experiencing a wide range of stressors in the ante natal and post natal stages. We look forward to working together in meeting the mental health needs of our patients.

## Child protection

Mandatory reporting ensures that we all have a responsibility to protect children. Many staff have adapted to this reporting requirements and will refer directly to Tusla where they have concerns regarding a family. When needed Medical Social Workers can liaise with Tusla to ensure child protection plans are known for unborn babies or children attending paediatrics or the emergency department.

## Paediatric and Neonatal Intensive Care Unit

The Social Worker is an integral part of the multi-disciplinary care team in the Paediatric and Neonatal units focusing on family-integrated care.

## Support available:

- Crisis intervention and counselling to support families coping with life changes associated with illness and hospitalisation, premature birth, diagnosis of long term illness, fetal abnormality
- Enhance coping skills and participation in care, supporting attachment and bonding with caregivers and children
- Information and support to ensure the smooth transition from hospital to home.
- Support with loss and bereavement
- Advocacy and support with accessing community supports and services.
- Consultation and liaison with hospital and community colleagues in relation to child protection and welfare concerns
- Support with parenting or care-giving concerns
- Medical social work co facilitated a Psychosocial support group for parents of children with Cystic Fibrosis with Psychologist Joanne Byrnes.

## Stress Control Programme

- Medical Social workers are part of a team of hospital staff that facilitate a six week programme for patients and staff incorporating basics of a Cognitive Behavioural approach to managing the inevitable stress in our lives.

## Team

Maeve Tonge remains the Senior on the WAC team with clinical work in in FAU, NICU and Paediatrics. In addition she provides Support and supervision to the team of Medical Social Workers and Teen Parent Programme staff. We have had many staff changes again this year and have are immensely grateful to Criona Healy and Triona O Toole for their continued compassion , dedication to their patients. We said goodbye with thanks to Michelle Ruddy and welcomed Patricia luby on a part time basis to our team.

## Conclusion

We are a small team and working closely together, we endeavour to respond to diverse and sensitive need of the families we meet. As always we would like to acknowledge the support from our colleagues across the disciplines in Obstetrics & Gynaecology, Paediatrics and Neo-Natal departments.

# Section 5: Allied Clinical Services
# *(b) Teen Parents Support Programme (TPSP) Galway 2019*

Ms Aileen Davies Programme Leader

## Services:
The Teen parents support programme is located at University Hospital Galway and managed by the Social work Department. It is funded though the HSE West and Tusla Child and Family Agency, under the School Completion Programme. Support is offered in all areas of a young person's life: antenatal care and health in pregnancy, relationships, accommodation, social welfare, education, training, child development, parenting, childcare and any other issue that is of concern to the young parent. Ten similar programmes have been set up nationally. The national Coordinator of all TPSP'S is Margaret Morris based in Treoir, Dublin. Support is offered on a one to one basis, through group activities and through referral to and liaison with other services.

## Client group:
The Teen Parents Support Programme provides services for young people who become parents when they are aged 19 years and under and supports them until their children are two years of age.

This service is open to all young parents living in Galway City and County.

## Referrals:
The majority of referrals come from the outpatient clinic in the Maternity Unit and when young parents are inpatients before and after delivery. Referrals can also be made from outside agencies eg. youth services, Gp's , schools and self referrals.

The number of referrals made to the service in 2019 was 59.

We provide ongoing support for our young parents over a two year period, so our caseload at any one time is 50 - 55 young parents and their children.

## Team structure:
Our team is composed of A Programme leader Aileen Davies (0.8WTE) one project worker Monica Meaney( 1WTE) and one project worker Anita Glynn( 0.6WTE) Our line Manager is Donal Gill Principal social worker and supervision is provided by the Senior Medical Social worker Maeve Tonge for the WAC team and Paediatrics.

## Specific supports:
Individual antenatal classes are provided for the young parents if they wish to avail of them.. The sessions are informal. Partners are welcome to attend. A tour of the labour ward is included.

Sessions are tailor made to meet the unique needs of the young parents and help them to overcome any anxiety or fears they may have in relation to the labour and birth.

## Groups:
We also run Mother and baby groups in a city centre location and provide information sessions on parenting .ie feeding weaning, healthy eating, first aid etc. Peer support is a very vital part of these groups. We also ran two outings for Parents and babies in the Summer to Loughwell farm and another in December to visit Santa, which were a great success. The peer support is invaluable.

## Education
We also provide supports to young parents in education or wishing to return to education with funding from The School Completion Programme.

This funding enables us to provide financial help with fees, books, childcare and transport. This means that young parents can continue to achieve their educational goals and become more independent.

## Outreach
We plan to extend our current service further into the County of Galway by offering an Outreach service to young parents in more rural areas. The two areas we will target are Tuam and Ballinasloe

We will be in a position to do this because we now have a full complement of staff in the programme. This will provide more equitable access to the service for all.

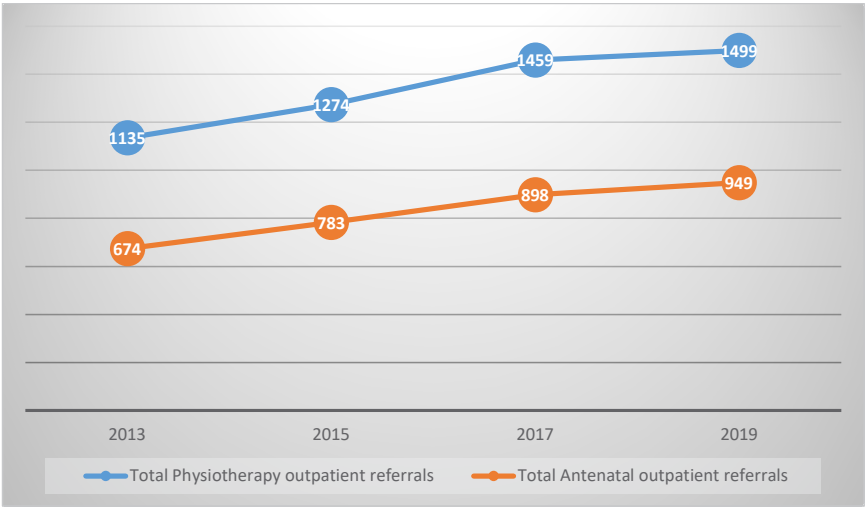
We would like to extend our thanks to our own colleagues in the Social work Dept. and all the Obstetric and Midwifery staff who continue to support our programme.

# Section 5: Allied Clinical Services
# *(c) Physiotherapy Department in Obstetrics & Gynaecology 2019*

Ms Debbie Fallows Senior Physiotherapist

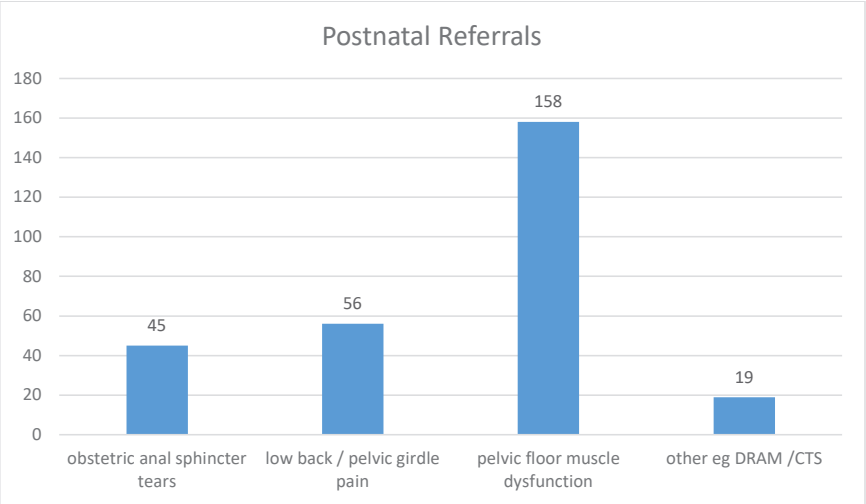
## Introduction

Physiotherapy activity levels continued to increase in 2019. Over the last 5 years, referrals to Physiotherapy have increased by 30%.



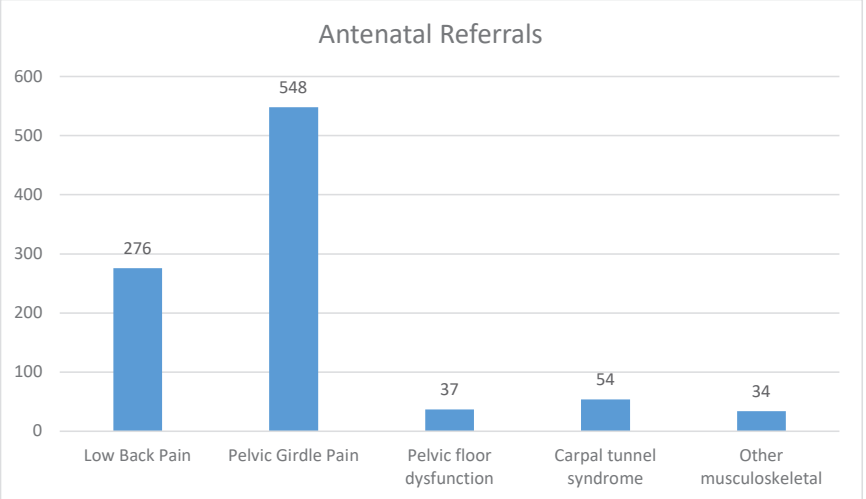

## 1. Postnatal

- A total of 278 postnatal patients were referred to physiotherapy in 2019. The majority of postnatal patients were referred with pelvic floor dysfunction.
- In addition, 778 inpatient postpartum mothers were reviewed and monitored individually following instrumental delivery and /or baby weight >4kgs. These patients represent those at greatest risk of complications due to pelvic floor trauma.
- 45 patients were treated following 3° or 4° perineal tears.



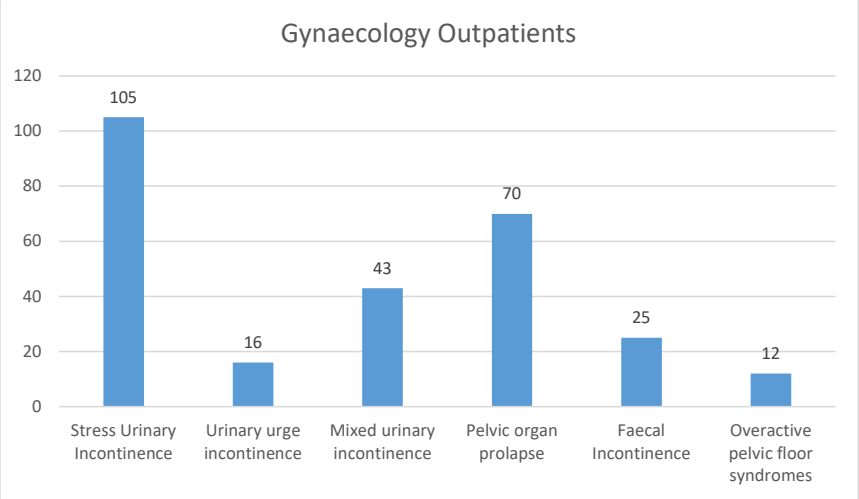

## 2. Antenatal

- A total of 949 antenatal patients were referred for physiotherapy in 2019, representing a further increase of 2.5% from 2018. Due to this continued growth in activity, a weekly exercise-based workshop takes place to help patients manage their pelvic girdle pain.



## 3. Gynaecology

- A total of 271 patients were referred from gynaecology clinics in 2019 (8% more than 2018 figures). Of these, 85 (31%) were seen by a physiotherapist directly from the Urogynaecology or Perineal clinic.




### Group Education Sessions

| Group Physiotherapy sessions | Numbers attending in 2019 |
|---|---|
| Antenatal education session | 1795 |
| Early postnatal education sessions | 578 |
| Postnatal review session | 61 |
| Pelvic Girdle Pain Session | 453 |
| Pelvic Floor Education Sessions | 59 |

# Section 5: Allied Clinical Services
# *(d) Nutrition & Dietetic Department Report*

Ms Mary Connolly Senior Dietician

The Nutrition and Dietetic service to the Women & Children's Directorate comprises an inpatient service to NICU, St Bernadette's, St Monica's, St Catherine's and St Angela's wards and an out-patient service to Diabetes, Cystic Fibrosis, Neonatology and General Paediatrics.

- Ana O'Reilly-Marshall (AORM) – Senior Dietitian Neonatology / Paediatrics (0.8WTE)
- Mary Connolly (MC) – Senior Dietitian Cystic Fibrosis / Paediatrics (0.4WTE)
- Rachael Langan (RL) – Senior Dietitian Paediatric Diabetes (0.5WTE).
- Edel Barrett (EB) – Dietitian Obs & Gynae / General Paediatric OPD

There is a dedicated inpatient dietetic service for Neonatology and Cystic Fibrosis.

Neonatology service continued to generate highest percentage of all inpatient dietetic consultations reflecting the intensive dietetic support required by this long stay patient population.

Dedicated out-patient dietetic services are provided to Diabetes, Cystic Fibrosis, Neonatology and general Paediatrics. All dietetic staff contribute to MDT meetings in each of the specialist areas.

- Newly diagnosed Type 1 Paediatric DM referrals increased by 217% with 26 new patients in 2019 compared to 12 new patients in 2018. These are newly diagnosed Galway patients only and do not include patients who transferred from other centers.
- Four CHOICE structured education courses for children and adolescents with Type 1 Diabetes were delivered jointly by the Senior Diabetes Dietitian Rachael Langan and Clinical Nurse Specialist during 2019.
- Total CF Paediatric patient caseload increased by 7% these new referrals generated from Newborn Screening Service (NBS)
- New dedicated Neonatal outpatient clinics were introduced in 2019 with continued neonatal dietetic support provided as per capacity.
- Weaning and Early pregnancy talks were held in Maternity every 2 weeks.
- In May 2019 the Clinical Psychologist in Cystic Fibrosis along with the Paediatric Social worker the CF Dietitian and CF Physiotherapist completed four sessions of a 'Psychosocial education group for parents of children with CF- providing information, affirmation and social support'.This featured in the Saolta newsletter in September 2019. MC completed a diet sheet as a follow up from this group 'Advice to encourage positive eating behaviors in children with Cystic fibrosis'
- All cystic fibrosis outpatients were reviewed at least 3 monthly as per National Standards Model of care (NCPCF 2019)
- Despite a reduction in clinics delivered, by December 2019 the General Paediatric OPD was on track as per OPD guidelines i.e Priority one patients were seen within 4 weeks of referral
- Waiting lists reduced in General OPD from 103 in December 2018 to 57 in December 2019. 45% reduction by sending opt-in letters.
- Literature-diet sheets, protocols etc were developed and updated in all areas.
- All staff contributed to student training of DIT/TCD BSc Human Nutrition and Dietetic undergraduates and UL MsC
- All staff completed EVOLVE training and commenced using the EHR system for all Paediatric and Neonatal patients
- MC completed training on the DIAMOND system for use in Cystic Fibrosis patients with Diabetes
- AORM completed the GUH Quality in Action Programme and contributed to the development and implementation of the Family Integrated Care QI project in NICU.

# Section 6: Academic Report
# *(a) Obstetrics & Gynaecology*

Professor John Morrison Consultant Obstetrician Gynaecology Clinical Director of Saolta MCAN

## Staff
- **Professor John J Morrison**
  Head of Department / Consultant
- **Dr Geraldine Gaffney**
  Senior Lecturer / Consultant
- **Dr Michael O'Leary**
  Clinical Lecturer / Consultant
- **Dr Susmita Sarma**
  Consultant
- **Dr Katharine Astbury**
  Consultant
- **Dr Tom O'Gorman**
  Consultant
- **Dr Nikhil Purandare**
  Consultant
- **Dr Una Conway**
  Consultant
- **Dr Mark Dempsey**
  Consultant

## Clinical Lecturers/Tutors
- Dr Siobhan Carruthers (Galway)
- Dr Roger Derham (Galway)
- Dr Gillian Ryan (Galway)
- Dr Mehret Berne (Sligo)
- Dr Stephen Sludds (Letterkenny)
- Dr Fiona Kyne (Castlebar)
- Dr Evelyn Burke / Dr Rachel Fallon (Ballinasloe)

## Clinical Teachers in Obstetrics and Gynaecology, affiliated hospitals
- Professor Edward Aboud
  Letterkenny General Hospital, Co. Donegal
- Dr Ulrich Bartels
  Mayo General Hospital, Castlebar, Co. Mayo
- Dr Marie Christine De Tavernier
  Portiuncula Hospital, Ballinasloe, Co. Galway
- Dr Hilary Ikele
  Mayo General Hospital, Castlebar, Co. Mayo
- Dr Murshid Ismail
  Sligo General Hospital, Sligo
- Dr Naveed Khawaja
  Portiuncula Hospital, Ballinasloe, Co. Galway
- Dr Chris King
  Letterkenny General Hospital, Co. Donegal
- Dr Heather Langan
  Sligo General Hospital, Sligo
- Dr Murtada Mohammed
  Mayo General Hospital, Castlebar, Co. Mayo
- Dr Maebh Ni Bhuinneain
  Mayo General Hospital, Castlebar, Co. Mayo
- Dr Vimla Sharma
  Sligo General Hospital, Sligo
- Dr Matt McKernan
  Letterkenny General Hospital, Co. Donegal

## External Examiner
The external examiner for the academic Department of Obstetrics & Gynaecology in 2019 was Professor Sean Daly, Trinity College Dublin.

## Academic Administrator
Ms Breda Kelleher

## Overview
The remit of the Academic Department of Obstetrics & Gynaecology includes undergraduate education, postgraduate education, research and the advance of clinical activity within the department. The undergraduate medical student teaching programme for Obstetrics & Gynaecology is carried out within the Department of Obstetrics & Gynaecology at University Hospital Galway and in the following affiliated hospital academies: Mayo General Hospital, Castlebar, Portiuncula Hospital, Ballinasloe, Sligo General Hospital and Letterkenny Hospital, Donegal. The undergraduate student numbers have increased significantly in recent years. This has resulted in the appointment of dedicated tutors in the affiliated academy sites.

There are a host of postgraduate medical activities ongoing within the Department of Obstetrics and Gynaecology and at GUH. An educational meeting is held in the department every Monday from 1:00pm to 2:00pm. This meeting is available for midwifery staff, postgraduate medical staff, and undergraduate medical students. On the first Monday of every month the subject of the meeting is caesarean section audit. The emergency caesarean sections for the previous month are considered and discussed. On the third Monday of the month, perinatal morbidity and mortality cases for the previous month are discussed. This is held in conjunction with the paediatric and pathology staff. On the fourth Monday of the month a research meeting is held for all staff. This research meeting is presented by internal members of staff and frequently external speakers are invited to present their research from other units. Every Wednesday morning at 8.00am, a case presentation/literature review meeting is held for the Consultants, SpRs, Registrars and SHOs.

Formal one-day education meetings are held every year.

Finally, the staff members in the Academic Department of Obstetrics & Gynaecology are very grateful to all the midwifery and medical staff who assist in recruitment of patients for ongoing research projects.

## Dissemination

### Peer reviewed publications
Ryan GA, Crankshaw DJ, Morrison JJ. Effects of maternal parity on response of human myometrium to oxytocin and ergometrine in vitro. *Eur J Obstet Gynecol Reprod Biol.* 2019 Nov;242:99-102. doi: 10.1016/j.ejogrb.2019.09.006. Epub 2019 Sep 21. PMID: 31580965

Ryan GA, Nicholson SM, Crankshaw DJ, Morrison JJ. Spontaneous Human Myometrial Contractility in the Third Trimester of Pregnancy in Relation to Past Mode of Delivery. *Am J Perinatol.* 2019 Aug 20. doi: 10.1055/s-0039-1694980. Online ahead of print. PMID: 31430820

Ryan GA, Nicholson SM, Crankshaw DJ, Morrison JJ. Maternal parity and functional contractility of human myometrium in vitro in the third trimester of pregnancy. *J Perinatol.* 2019 Mar;39(3):439-444. doi: 10.1038/s41372-019-0312-2. Epub 2019 Jan 17. PMID: 30655596

Hehir MP, Burke N, Burke G, Turner MJ, Breathnach FM, Mcauliffe FM, Morrison JJ, Dornan S, Higgins J, Cotter A, Geary MP, Mcparland P,

Daly S, Cody F, Dicker P, Tully E, Malone FD.
Sonographic markers of fetal adiposity and risk of Cesarean delivery. *Ultrasound Obstet Gynecol.* 2019 Sep;54(3):338-343. doi: 10.1002/uog.20263. PMID: 30887629

Ryan G, O'Doherty K, McAuliffe F, Morrison JJ.
Women with one cesarean: Views on VBAC, ERCD and future RCT regarding mode of delivery. *AJOG* 2019; 220. S616. 10.1016/j.ajog.2018.11.981.

Hayes-Ryan D, Hemming K, Breathnach F, Cotter A, Devane D, Hunter A, McAuliffe FM, Morrison JJ, Murphy DJ, Khashan A, McElroy B, Murphy A, Dempsey E, O'Donoghue K, Kenny LC.

PARROT Ireland: Placental growth factor in Assessment of women with suspected pre-eclampsia to reduce maternal morbidity: a Stepped Wedge Cluster Randomised Control Trial Research Study Protocol. *BMJ Open.* 2019 Mar 1;9(2):e023562. doi: 10.1136/bmjopen-2018-023562. PMID: 30826791

Wemken N, Drage DS, Cellarius C, Cleere K, Morrison JJ, Daly S, Abdallah MA, Tlustos C, Harrad S, Coggins MA.
Emerging and legacy brominated flame retardants in the breast milk of first time Irish mothers suggest positive response to restrictions on use of HBCDD and Penta- and Octa-BDE formulations. *Environ Res.* Epub 2019 Oct 7. PMID: 31629086

Finnegan C, Breathnach F, Dicker P, Fernandez E, Tully E, Higgins M, Daly S, Riordan MO, Dunne F, Gaffney G, Slevin J, Ciprike V.
Investigating the role of early low-dose aspirin in diabetes: A phase III multicentre double-blinded placebo-controlled randomised trial of aspirin therapy initiated in the first trimester of diabetes pregnancy. *Contemp Clin Trials Commun.* 2019 Oct 15;16:100465. doi: 10.1016/j.conctc.2019.100465 PMID: 31701039

## Oral presentations

*SPR Research Medical University Hospital Galway*, Galway June 2019
Spontaneous Myometrial Contractility in the Third Trimester of Pregnancy in Women with a Previous Caesarean Section in Relation to Past Mode of Delivery.
GA Ryan, DJ Crankshaw, JJ Morrison
(Winner of third prize for best Oral Presentation)

*World Congress of the Academy of Human Reproduction, Dublin April 2019*
Women with One Cesarean Delivery: A Multi-center Survey on their Views on Vaginal Birth after Cesarean, Elective Repeat Cesarean & a Future RCT Pertaining to Mode of Delivery.
GA Ryan, KC O Doherty, F McAuliffe, JJ Morrison

## Poster presentations

*World Congress of the Academy of Human Reproduction, Dublin April 2019*

1. Spontaneous Myometrial Contractility in the Third Trimester of Pregnancy in Women in Relation to Previous Vaginal Delivery
   GA Ryan, DJ Crankshaw, JJ Morrison
2. Staffs Views on the Implementation of Termination of Pregnancy Services in Ireland
   GA Ryan, N Whelan, AM Grealish, H Murphy, N Purandare

*Society for Maternal-Fetal Medicine (SMFM), Las Vegas USA February 2019*

1. Women with One Cesarean: Views on VBAC, ERCD and Future RCT Regarding Mode of Delivery.
   GA Ryan, KC O'Doherty, F McAuliffe, JJ Morrison
2. Effects of Parity on Human Myometrial Response to Oxytocin and Ergometrine In Vitro.
   GA Ryan, DJ Crankshaw, JJ Morrison

*University Hospital Galway Registrar Research Day, June 2019*

1. Women with One Cesarean: Views on VBAC, ERCD and Future RCT Regarding Mode of Delivery.
   GA Ryan, KC O Doherty, F McAuliffe, JJ Morrison
2. Effects of Parity on Human Myometrial Response to Oxytocin and Ergometrine In Vitro.
   GA Ryan, DJ Crankshaw, JJ Morrison

## Postgraduate Study Day Lectures

*September 2019*
Title: The IRELAnD Multicentre Study: Investigating the Role of Early Low-dose Aspirin in Pregnancy
Speaker: Dr Fionnuala Breathnach, Consultant Senior Lecturer Maternal Fetal Medicine, RCSI Department of Obstetrics and Gynaecology, Rotunda Hospital, Dublin 1

*November 2019*
Title: Fetal Scalp Stimulation vs Fetal Blood Sampling to assess fetal wellbeing in labour – a multi-centre randomised controlled trial
Speaker: Professor Deirdre Murphy, Obstetrics & Gynaecology Trinity College Dublin /Coombe Women and Infants University Hospital Dublin

## Undergraduate Student Awards

**Henry Hutchinson Stewart Medical Scholarship 2019**
Elizabeth Maher1st prize in Obstetrics & Gynaecology

# Section 6: Academic Report
# *(b) Paediatric Academic Report*

Professor Nicholas M. Allen, on behalf of Academic Dept of Paediatrics

## Introduction

The Academic Department of Paediatrics is part of NUI Galway Medical School, main office located in the Clinical Science Institute, adjacent to University Hospital Galway. The academic team is comprised of Professor, Senior Lecturer, Lecturer, Tutors and Clinical Lecturers. Affiliated hospitals for teaching and clinical experience are integrated with the Medical Academies of NUI Galway, situated in Mayo, Sligo, Letterkenny, and Portiuncula University Hospitals. The majority of paediatric medical students spend one semester of their penultimate medical year attending an academy.

## Remit of the Paediatric Academic Department

**Undergraduate**

With the assistance of the affiliated hospitals (and respective NUIG Medical Academies), it is the goal of the paediatric department to provide an informative and valuable learning experience in a safe and friendly environment. Students are exposed to a wealth of clinical cases and patient interactions during their attachments, with an emphasis of bedside teaching. Teaching is delivered via a variety of modes including bedside tutorials, hands on patient history and examination, out-patient interactions, classroom interactive teaching sessions, podcasts, skills seminars, problem-based learning, and slide-shows.

The curriculum is currently delivered in modular format with two modules, one in each semester. During semester one, students are introduced to basic concepts in the practice of paediatrics, whilst semester two introduces further application of knowledge, in-depth learning and case management. The availability of excellence in clinical exposure and teaching due to expansion into the affiliated hospital academies has enabled increased capacity with delivery of parallel programs at each site.

The assessment process includes an MCQ exam and a case report at the end of module 1, and a written (modified essay questions) paper and OSCE at the end of module two. Formative assessment is an integral component of each semester. Competency-based assessment is also part of the curriculum with the recent introduction of Mini-CEXs. Students actively provide course feedback which is incorporated into curriculum development.

The opportunity for exposure to undergraduate research and paediatric electives are provided outside the teaching curriculum. Undergraduates are also provided with the opportunity to present original research at national and international meetings.

**NCHD education**

Postgraduate education is provided on a daily basis with the assistance of the paediatric teams at University Hospital Galway, with hands on consultant-led teaching (formal small group lectures, simulations, bedside teaching, and supervised Patient Handover). Educational activities include weekly paediatric case presentations, consultant–led lecture series and curriculum (critical appraisal) journal club. The Case Presentation session is an opportunity to review cases with valuable learning points. In addition, all NCHDs are trained in neonatal resuscitation. Monthly perinatal morbidity and mortality meetings are conducted in conjunction with obstetrics/gynaecology and pathology departments. NCHDs are encouraged to become involved in research projects during their period of attachment as well as to present at national/ international meetings. A specialised paediatric handbook (available electronically) is published by the academic paediatric department for use by paediatric NCHDs to assist with the learning experience.

The annual Western Regional Education Network (WREN) meeting in April 2019, took place in the Ardilaun Hotel and featured invited speakers from around Ireland as clinical updates from the Saolta Paediatric Group, and a spectrum of clinical case presentations.

## Academic Staff

- Chair: Professor NM Allen
- Senior Lecturer: Dr E Moylett
- Lecturer: Dr R Geoghegan
- Tutor: Dr. Naveen Malik
- Administration: Ms D Monroe

## School of Medicine, Academy Lecturers

- Dr Mona O'Boyle/Dr. Evelyn McManus – Donegal Academy
- Dr Hilary Greaney/Dr. Ann Murray – Sligo Academy
- Dr Shyam Pathak – Mayo Academy
- Dr Rachel Fallon – Portiuncula Academy

## Clinical Lecturers: University Hospital Galway

- Dr D O'Donovan
- Dr O Flanagan
- Dr M Herzig
- Dr E Ryan
- Dr A Lyons
- Dr Niamh McGrath
- Dr. Johannes Letshwiti

## Mayo University Hospital, Honorary Clinical Lecturers

- Dr (Honorary Prof) M O'Neill
- Dr H Stokes
- Dr AT Elabbas

## Portiuncula University Hospital, Honorary Clinical Lecturers

- Dr P Cahill
- Dr F Neenan
- Dr R Cooke
- Dr P Curran
- Dr J Nelson

## Sligo University Hospital, Honorary Clinical Lecturers

- Dr R Tummaluru
- Dr D Gallagher
- Dr. Bilal Java
- Dr G Harrison

## Letterkenny University, Honorary Clinical Lecturers

- Dr M Thomas
- Dr B Power
- Dr M Azam

## Undergraduate Report

The external examiner for the paediatric examination in 2019 was Professor Jürgen Schwarze, Edward Clark Chair of Child Life and Health, Consultant Paediatrician and Immunologist, University of Edinburgh

**Final Undergraduate Paediatric Results 2018-2019**

A total of 206 students completed the 4MB3 course in 2019:

| Result | % | number of students |
|---|---|---|
| First class (H1) | 8% | 17 |
| Second class (H2) | 40% | 83 |
| Pass | 40% | 82 |
| Fails | 10% | 20 |
| Inc/Def | 2% | 4 |

**National Henry Hutchinson's intervarsity awards in Paediatrics**
Winner: Ashita Dutta, NUI Galway

## Postgraduate

Masters Student Awarded: Dr Hilary Allen De-labelling Beta-Lactam Allergy in Children in a Regional Setting. Primary Supervisor, Dr Edina Moylett; Secondary Supervisor, Dr Marta Vazquez-Ortiz, ICL.

MD Student Awarded: Dr Zakaria Barsoum: Thesis: Rotavirus gastroenteritis: Regional prevalent serotypes correlation with disease severity, nosocomial acquisition, co-infection with other viruses and the impact of vaccine in pre and post vaccination period in one region in Ireland. Supervisor: Dr. Edina Moylett.

PhD Student: Alessia Arbini: Human induced pluripotent stem cell modelling for KCNA2-related developmental encephalopathy and epilepsy. Supervisor: Prof. Nicholas Allen, Co-supervisor: Prof. Sanbing Shen (REMEDI group).

PhD Student: Rachel Stewart: Human induced pluripotent stem cell modelling for KCNQ2-related developmental encephalopathy and epilepsy. Supervisor: Prof. Nicholas Allen, Co-supervisor: Prof. Sanbing Shen (REMEDI group).

## Sample of Research/Audit at University Hospital Galway

Sample of International Peer Review Publications:

- McGlacken-Byrne SM, Dann L, Murphy A, Moylett E. Pain, swelling and irritability in the sun: what is the diagnosis? Arch Dis Child Educ Pract Ed. 2019 Aug 21. pii: edpract-2019-317384.
- Crealey M, Alamin S, Tormey V, Moylett E. Clinical presentation of cashew nut allergy in a paediatric cohort attending an allergy clinic in the West of Ireland. Ir J Med Sci. 2019 Feb;188(1):219-222.
- Lyons A, Allen NM, Flanagan O, Cahalane D. Catatonia as a feature of down syndrome: An under-recognised entity? Eur J Paediatr Neurol [Epub ahead of print].
- Genetic potassium channel-associated epilepsies: Clinical review of the Kv family. Allen NM, Weckhuysen S, Gorman K, King MD, Lerche H. Eur J Paediatr Neurol [Epub ahead of print].
- McGlacken-Byrne SM, O'Rahelly M, Cantillon P, Allen NM. Journal club: old tricks and fresh approaches. Arch Dis Child Educ Pract Ed 2019 pii: edpract-2019-317374.

## Other Abstracts/Research Presentations

- O'Rahelly, Jungbluth H*, Allen NM* (*joint senior authors). Expanding Spectrum of Fetal Acetylcholine Receptor Inactivation Syndrome and novel treatment approach with oral Salbutamol. British Paediatric Neurology Association: Oral Presentation First Prize. Jan 2019 [Publication in progress].
- O'Rahelly M, Hahn, Nguyen CT, Kim DS, Byun SY, Schara U, Henrich M, Leslie J, Vincent A, Jungbluth H, Allen NM (and others). GP230 Fetal acetylcholine receptor inactivation due to maternal myasthenia gravis: an underrecognised, devastating but potentially preventable and treatable disorder. Archives of Disease in Childhood 2019;104:A124.
  - Presented at 1) the International 9th Europaediatrics Congress, Dublin 2019. Presented at 2) the Irish Paediatric Association National Meeting, 2019.
  - Presented at 3) The Word Muscle Society Meeting 2019 P.379 [Abstract published in Oct 2019 Neuromuscular Disorders 29:S192].
- Arbini A, King M, Gorman K, Shen S, Allen NM. Investigation of a human induced pluripotent stem cell model for KCNA2-related epilepsy. Presented at the Children's Health Ireland, Research Day, Temple St. Children's University Hospital, Dublin 1, Dec 13th.
- Gorman K, Forman E, Lynch SA, D, Allen NM, et a. Re-interrogation of whole exome sequencing data in developmental epileptic encephalopathies. Archives of Disease in Childhood 104(Suppl 3) [Presented at 9th Europaediatrics Congress Dublin 2019].
- Hayden J, Dann L, Lynch B, Allen NM. P495 Is narcolepsy incidence increasing or symptoms just better recognised? Archives of Disease in Childhood 2019;104:A351. Presented at the 9th Europaediatrics Congress, Dublin 2019 AND the Irish Paediatric Association National Meeting 2019.
- Sazali H, Browne F, Dvorakova V, Murphy A, Allen NM. GP79 Is it a port-wine stain? vascular birthmark on the face posing a diagnostic challenge. Archives of Disease in Childhood 2019;104:A62 [presented at 9th Europaediatrics Congress, 13–15 June, Dublin, Ireland 2019].
- Allen HI, Vazquez-Ortiz M, Murphy A, Moylett EH. Single Dose Beta-Lactam Oral Challenge In A Low Risk Cohort Of Children: Parental Satisfaction and Possibility of Replicating in Primary Care. EAACI. Oral Poster. Lisbon. June 2019.
- Allen HI, Vazquez-Ortiz M, Murphy A, Moylett EH. De-Labelling Beta-Lactam Allergy Using Tele-Medicine and a Single Dose Protocol in a Low Risk Paediatric Cohort in an Outpatient Setting: A Cost Analysis. Oral Presentation. PAAM. Florence, October 2019.
- Breathnach A, Geoghegan R, Moylett E. Infant Feeding: How Do Irish Parents Plan To Wean On Foot Of Important Advances For Primary Prevention Of Food Allergy? Source Of Funding: Wellcome Trust Biomedical Vacation Scholarship. Oral Presentation. IPA. December 2019.
- Chia, Tiong Ming, Moylett E. Complete Lack of Parental Knowledge and Awareness Regarding Paediatric Vaccine-Preventable Diseases: Potential for Improving Uptake Rates. Oral Presentation. IPA. December 2019.

## Audit

Clinical audit is a key component of clinical activity, some of which is presented to the hospital group, nationally or published as research.

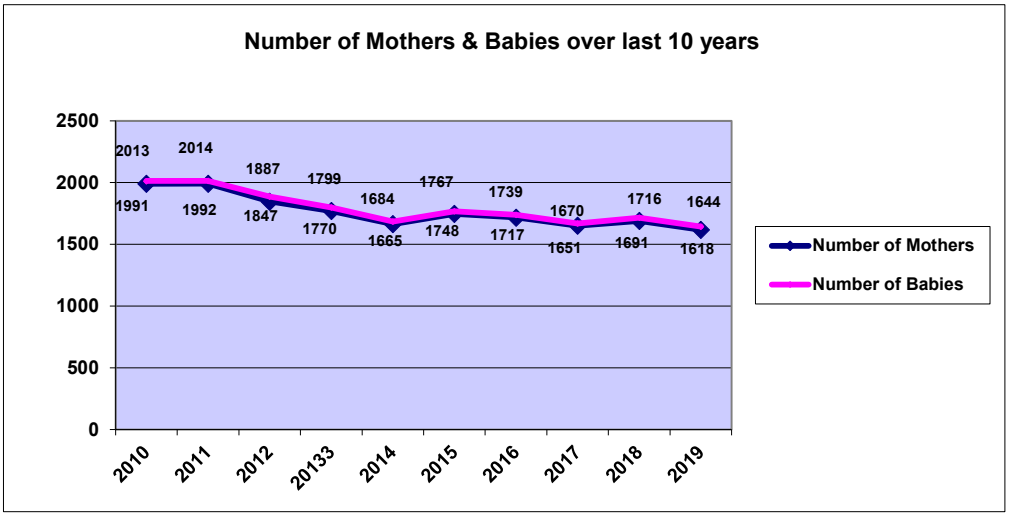
# *Letterkenny University Hospital*

## Section 1: Maternity

## *(a) Statistical Summary*

### Number of Mothers & Babies:

| | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 |
|---|---|---|---|---|---|---|---|---|---|---|
| Number of Mothers | 1991 | 1992 | 1847 | 1770 | 1665 | 1748 | 1717 | 1651 | 1691 | 1618 |
| Number of Babies | 2013 | 2014 | 1887 | 1799 | 1684 | 1767 | 1739 | 1670 | 1716 | 1644 |




| Obstetric Outcomes | Primigravida | Multigravida | Total |
|---|---|---|---|
| Total Number of Mothers | 560 | 1058 | 1618 |
| Total Number of Babies | 569 | 1075 | 1644 |
| >24 weeks or >/= 500g | | | |

| Obstetric Outcomes (Mothers) | Primigravida | % | Multigravida | % | Total | % |
|---|---|---|---|---|---|---|
| | 545 | | 1039 | | 1584 | |
| Induction of Labour | 197 | 35.2% | 252 | 23.8% | 449 | 27.8% |
| Augmentation | | % | | 0.0% | 0 | 0.0% |
| No Analgesia | 12 | 2.1% | 58 | 5.5% | 70 | 4.3% |
| Epidural Rate | | 0.0% | | 0.0% | 281 | 17.4% |
| Episiotomy | | 0.0% | | 0.0% | 280 | 17.3% |
| Caesarean Section | 227 | 40.5% | 372 | 35.2% | 599 | 37.0% |
| Spontaneous Vaginal Delivery | 200 | 35.7% | 639 | 60.4% | 839 | 51.9% |
| Forceps Delivery | 16 | 2.9% | 4 | 0.4% | 20 | 1.2% |
| Ventouse Delivery | 117 | 20.9% | 43 | 4.1% | 160 | 9.9% |
| Breech Delivery | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% |

### Multiples:

| | | | |
|---|---|---|---|
| Total Number of Mothers | 560 | 1058 | 1618 |
| Total Number of Babies | 569 | 1075 | 1644 |
| >24 weeks or >/= 500g | | | |

| Multiple Pregnancies by Year | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 |
|---|---|---|---|---|---|---|---|---|---|---|
| Twins | 22 | 22 | 40 | 29 | 19 | 19 | 22 | 19 | 25 | 26 |
| Total | 22 | 22 | 40 | 29 | 19 | 19 | 22 | 19 | 25 | 26 |

## Perinatal Mortality:

| | Primigravida | Multigravida | Total |
|---|---|---|---|
| Total Number of Mothers | 560 | 1058 | 1618 |
| Total Number of Babies | 569 | 1075 | 1644 |
| >24 weeks or >/= 500g | | | |

| Perinatal Deaths | Total | % |
|---|---|---|
| Stillbirths | 5 | 0.30% |
| Early Neonatal Deaths | 1 | 0.06% |

| Perinatal Mortality Rate | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 |
|---|---|---|---|---|---|---|---|---|---|---|
| Stillbirth rate (per 1,000) | 5.0 | 6.0 | 1.6 | 3.9 | 3.0 | 5.1 | 4.6 | 1.2 | 4.7 | 1.8 |
| Neonatal Death rate (per 1,000) | 2.0 | 1.0 | 3.7 | 2.2 | 0.6 | 2.3 | 1.2 | 0.6 | 0.6 | 0.0 |
| Overall PMR per 1,000 births | 7.0 | 7.0 | 5.3 | 6.1 | 3.6 | 7.4 | 5.8 | 1.8 | 5.2 | 1.8 |

## Parity:

| | Primigravida | Multigravida | Total |
|---|---|---|---|
| Total Number of Mothers | 560 | 1058 | 1618 |
| Total Number of Babies | 569 | 1075 | 1644 |
| >24 weeks or >/= 500g | | | |

| Parity | Number | % |
|---|---|---|
| Para 0 | 465 | 28.7% |
| Para 1 | 522 | 32.3% |
| Para 2 | 357 | 22.1% |
| Para 3 | 154 | 9.5% |
| Para 4 | 65 | 4.0% |
| Para 5 | 25 | 1.5% |
| Para 6 | 13 | 0.8% |
| Para 7 | 7 | 0.4% |
| Para 8 | 4 | 0.2% |
| Para 9 | 1 | 0.1% |
| Para 10 | 1 | 0.1% |
| Total | 1614 | 99.8% |

## Age:

| | Primigravida | Multigravida | Total |
|---|---|---|---|
| Total Number of Mothers | 560 | 1058 | 1618 |
| Total Number of Babies | 569 | 1075 | 1644 |
| >24 weeks or >/= 500g | | | |

| Age | Total | % |
|---|---|---|
| <15 years | 1 | 0.1% |
| 15-19 years | 24 | 1.5% |
| 20-24 years | 162 | 10.0% |
| 25-29 years | 348 | 21.5% |
| 30-34 years | 575 | 35.5% |
| 35-39 years | 415 | 25.6% |
| 40-45 years | 90 | 5.6% |
| >45 years | 3 | 0.2% |
| Total | 1618 | 100.0% |

| Age @ Booking | 2016 | 2017 | 2018 | 2019 |
|---|---|---|---|---|
| 14-19 years | 2.0% | 2.3% | 1.6% | 1.6% |
| 20-24 years | 10.3% | 9.0% | 10.0% | 10.0% |
| 25-29 years | 22.0% | 23.1% | 19.9% | 21.5% |
| 30-34 years | 33.7% | 34.9% | 34.9% | 35.5% |
| 35-39 years | 27.2% | 25.9% | 27.8% | 25.6% |
| 40-44 years | 4.7% | 4.4% | 5.5% | 5.6% |
| 45> | 0.2% | 0.4% | 0.3% | 0.2% |
| Total | 100% | 100% | 0% | 100.0% |

| Gestation at Delivery | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 |
|---|---|---|---|---|---|---|---|---|---|---|
| 24-27 weeks | 11 | 7 | 12 | 11 | 6 | 9 | 9 | 3 | 4 | 0 |
| 28-31 weeks | 11 | 8 | 16 | 9 | 6 | 8 | 12 | 6 | 7 | 19 |
| 32-35 weeks | 39 | 40 | 31 | 40 | 35 | 35 | 32 | 38 | 79 | 38 |
| 36-39 weeks | 379 | 370 | 390 | 364 | 284 | 345 | 317 | 694 | 758 | 54 |
| 40-41 weeks | 1505 | 1514 | 1367 | 1297 | 1281 | 1311 | 1306 | 882 | 817 | 1533 |
| >42 weeks | 46 | 53 | 31 | 49 | 53 | 40 | 41 | 28 | 26 | 0 |
| Total | 1991 | 1992 | 1847 | 1770 | 1665 | 1748 | 1717 | 1651 | 1691 | 1644 |

## Gestation:

| | Primigravida | Multigravida | Total |
|---|---|---|---|
| Total Number of Mothers | 560 | 1058 | 1618 |
| Total Number of Babies | 569 | 1075 | 1644 |
| >24 weeks or >/= 500g | | | |

| Gestation at Delivery | Total | % |
|---|---|---|
| <24 weeks | 0 | 0.0% |
| 24-27 weeks | 0 | 0.0% |
| 28-31 weeks | 19 | 1.2% |
| 32-35 weeks | 38 | 2.3% |
| 36-39 weeks | 54 | 3.3% |
| 40-41 weeks | 1533 | 93.2% |
| >42 weeks | 0 | 0.0% |
| **Total** | **1644** | **100.0%** |

## Birth Weight:

| | Primigravida | Multigravida | Total |
|---|---|---|---|
| Total Number of Mothers | 560 | 1058 | 1618 |
| Total Number of Babies | 569 | 1075 | 1644 |
| >24 weeks or >/= 500g | | | |

| Birth Weights | Total | % |
|---|---|---|
| <1000g | 1 | 0.1% |
| 1000 - 1999g | 22 | 1.2% |
| 2000 - 2999g | 261 | 15.9% |
| 3000 - 3999g | 1099 | 66.8% |
| 4000 - 4499g | 215 | 13.1% |
| 4500 - 4999g | 35 | 2.1% |
| 5000 - 5499g | 4 | 0.3% |
| Unknown | 7 | 0.5% |
| Total Number of Babies | 1644 | 100.0% |

| Birth Weights by year | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 |
|---|---|---|---|---|---|---|---|---|---|---|
| < 500g | 3 | 3 | 4 | 1 | 0 | 1 | 1 | 0 | 0 | 0 |
| 500 - 999g | 4 | 8 | 5 | 5 | 3 | 6 | 4 | 0 | 0 | 1 |
| 1000 - 1999g | 27 | 20 | 32 | 34 | 19 | 18 | 28 | 21 | 25 | 22 |
| 2000 - 2999g | 251 | 256 | 245 | 230 | 196 | 232 | 242 | 220 | 267 | 261 |
| 3000 - 3999g | 1352 | 1360 | 1242 | 1211 | 1146 | 1197 | 1159 | 1142 | 8 | 1099 |
| 4000 - 4499g | 302 | 293 | 295 | 260 | 252 | 260 | 252 | 225 | 1153 | 215 |
| 4500 - 4999g | 52 | 57 | 50 | 51 | 54 | 46 | 43 | 53 | 221 | 35 |
| 5000 - 5499g | 9 | 5 | 4 | 3 | 4 | 5 | 5 | 4 | 40 | 4 |
| >5500g | 0 | 0 | 1 | 1 | 2 | 0 | 0 | 0 | 2 | 0 |
| Not answered | 13 | 12 | 9 | 3 | 8 | 2 | 5 | 5 | 0 | 7 |
| Total Number of Babies | 2013 | 2014 | 1887 | 1799 | 1684 | 1767 | 1739 | 1670 | 1716 | 1644 |

| Induction: | Primigravida | Multigravida | Total |
|---|---|---|---|
| Total Number of Mothers | 560 | 1058 | 1618 |
| Total Number of Babies | 569 | 1075 | 1644 |
| >24 weeks or >/= 500g | | | |

| Induction of Labour | Primigravida | Multigravida | Total | % |
|---|---|---|---|---|
| 2014 | 196 | 254 | 450 | 27.0% |
| 2015 | 199 | 264 | 463 | 26.5% |
| 2016 | 200 | 252 | 452 | 26.3% |
| 2017 | 195 | 173 | 368 | 22.4% |
| 2018 | 196 | 265 | 461 | 27.3% |
| 2019 | 197 | 252 | 449 | 27.8% |

| Perineal Trauma: | Primigravida | Multigravida | Total |
|---|---|---|---|
| Total Number of Mothers | 560 | 1058 | 1618 |
| Total Number of Babies | 569 | 1075 | 1644 |
| >24 weeks or >/= 500g | | | |

| Episiotomy: | Primigravida | Multigravida | Total |
|---|---|---|---|
| Total Number of Mothers | 560 | 1058 | 1618 |
| Total Number of Babies | 569 | 1075 | 1644 |
| >24 weeks or >/= 500g | | | |

| 3rd Stage Problems | Total | % |
|---|---|---|
| Primary PPH (1000ml) | 39 | 2.4% |
| Manual Removal of Placenta | 23 | 1.4% |

| | Total | % |
|---|---|---|
| Shoulder Dystocia | 12 | 0.7% |

| Perineal Trauma | Total | % |
|---|---|---|
| Number of vaginal deliveries | 1019 | |
| Intact | 272 | 26.7% |
| Episiotomy | 280 | 27.5% |
| 2nd Degree Tear | 328 | 32.8% |
| 1st Degree Tear | 114 | 11.2% |
| 3rd Degree Tear | 25 | 2.45 % |
| Total | 1019 | 100.0% |

| Incidence of Episiotomy | Total | % |
|---|---|---|
| 2014 | 346 | 29.9% |
| 2015 | 331 | 27.9% |
| 2016 | 327 | 28.3% |
| 2017 | 291 | 25.2% |
| 2018 | 311 | 28.3% |
| 2019 | 280 | 27.4% |

| B.B.A. | Total |
|---|---|
| 2010 | 7 |
| 2011 | 5 |
| 2012 | 7 |
| 2013 | 3 |
| 2014 | 5 |
| 2015 | 5 |
| 2016 | 7 |
| 2017 | 7 |
| 2018 | 8 |
| 2019 | 4 |

| Anaesthetics Graphs: | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 |
|---|---|---|---|---|---|---|---|---|---|---|
| Number of Women who had Epidurals in Labour | 375 | 372 | 367 | 361 | 379 | 386 | 373 | 338 | 344 | 281 |

| Antenatal Education | Clients | Support Partners | Total Attendance |
|---|---|---|---|
| Weekday Sessions | 161 | 0 | 161 |
| Refresher Sessions | 98 | 30 | 128 |
| Evening Sessions | 155 | 153 | 308 |
| Tours of Maternity Unit | 672 | 655 | 1327 |

| Breastfeeding: | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 |
|---|---|---|---|---|---|---|---|---|---|---|
| Breastfeeding Initiation Rates | 48.5 | 49.7 | 51.1 | 51.2 | 51.1 | 52.9 | 52.9 | 55 | 55.60 | 50.6 |
| Breastfeeding on Discharge | 39 | 39.8 | 41.3 | 41.9 | 40.8 | 42.5 | 43.2 | 44.7 | 45.50 | 43 |

# Section 1: Maternity
# *(b) Director of Midwifery Report*

Ms Evelyn Smith Director Midwifery

## Introduction
The Women &Infant's Directorate in Letterkenny provides care for the needs of the multi-cultural female population of Donegal. The Maternity Unit within the Directorate is founded on the philosophy that childbirth is a normal event. It acknowledges that childbirth is a transformative life event for the whole family rather than an isolated episode. Service and care are planned and delivered around these principles.

## We aim to:
- Build a work environment where each person is valued
- Continue our focus on education through building on the formal affiliations with educational institutions facilitating learning.
- Support continuous performance improvement within the organisation.
- Promote active participation in research and innovation in leading to improved health outcomes for our mothers and Babies.

The Women & Infant's Directorate in Letterkenny University Hospital Group have developed their strategic quality objectives in line with the eight themes of HIQAs national standards for safer better healthcare (2012) and National Standards for safer Better Health Maternity Services (2016)

I am pleased to present the annual report, detailing statistics, activity and outcomes for Women & Infant's Directorate in Letterkenny University Hospital for the year 2018. The publication of this report will serve as source of internal audit, providing us with an opportunity to reflect on the services we offer and the challenges we face.

In 2019, there were 1,618mothers who delivered 1,644 babies, showing an decrease in numbers from 2018.

## Maternity Outpatient Services
There are 4 Consultant Led Gynae Clinics per week which are held in the Obs/Gynae Outpatient Department. There is also 1 Consultant led outreach clinics per fortnight. This service can be accessed through GP referral or Emergency care.

## Gynaecology Inpatient
The Directorate provides a Gynaecology service to women of all ages which are focused on conditions that are specific to the female population. Care is carried out efficiently and effectively through an experienced, skilled, multidisciplinary staff that are sensitive to all aspects of the needs and Health of women, (Physical, Social, Psychological and Spiritual

The Gynae inpatient service works within a compliment of notional beds incorporated into an 11 bedded female/ Gynae ward on level B Gynae Theatre is performed in the main theatre.

## Developments
- Further development of KPIs and Quality Assurance Reports
- HIQA Inspection
- KPI compliance with early dating scans & Anomaly Scans
- Sepsis National Audits completed
- Midwifery Led Team
- Post-Menopausal Bleeding Clinic
- IMEWS training
- Maternity Metrics
- Care Bundle audits
- PROMPT training
- Advanced CTG training
- Neonatal Resuscitation
- Staff training in care of the critically-ill maternity patient
- Upgrade MIR system
- Donegal Breastfeeding Forum
- Sepsis training
- Breast Feeding Volunteers
- Perinatal Mental Health training
- 2 Staff Lactation Consultant

## Achievements
- Appoinment of CMM111
- Butterfly Room' commissioned and completed
- Training provided for Midwives in CNME "Perinatal Loss in Maternity Setting"
- Recent appointment of a Midwifery Tutor based in the CNME
- Further development of KPIs and Quality Assurance Reports
- KPI compliance with early dating scans & Anomaly Scan
- Sepsis National Audits completed
- Midwifery Led Clinic including care of the woman in labour - &Postnatal Home Visit
- Examination of the Newborn-2 of the Midwifery Led Team completed Course
- Post-Menopausal Bleeding Clinic
- New Midwifery Metrics introduced this year
- Advanced CTG training
- Funding for Clinical Skills Facilitator
- Staff training in care of the critically-ill maternity patient
- Funding Sourced IT project-Upgrade MIR system
- Sepsis training
- Perinatal Mental Health training of midwife educator to further meet the demands of vulnerable women and their families.
- Bereavement Training Workshops
- Incorporation of a blended Hypnobirthing model into the antenatal education programme.
- A 'Breastfeeding Peer Support Volunteer Programme'. Two breastfeeding support volunteers from La Leche League offer breastfeeding support on the postnatal ward, on a twice weekly basis. Qualitative feedback continues to be very positive.

I would like to thank all our staff for their support, hard work and commitment to the Service throughout 2019.

# Section 1: Maternity
# *(c) Service Report for Fetal Assessment & Early Pregnancy Clinic*

Ms Geraldine Gallagher Clinical Midwife Specialist

## Service Report for Fetal Assessment and Early Pregnancy Clinic 2019

### Midwife Sonographers:

Geraldine Gallagher CMS
Louise Gallagher CMS
Katriona McCarthy CMS
Student Sonographer: Katie Doohan

Service provided Monday – Friday 8am – 6pm

The Fetal assessment service in Letterkenny University Hospital is provided by Midwife Sonographers who have their Msc in diagnostic imaging ultrasound.

A total of 5378 scans were performed of which 1548 were anomaly scans and 1647 were dating booking scans, 87 of which were late bookers. All pregnant women have an early booking appointment which includes a scan to date the pregnancy and at that stage they are offered an anomaly scan at 20 – 23 weeks gestation. Women with a history of having LLETZ treatment have cervical length measured at 12 weeks gestation.

Other scans performed include fetal wellbeing, growth, placental location, estimated fetal weights.

Serial scans scheduled so as to combine with antenatal appointments for those with high risk pregnancies, multiple pregnancies and known abnormalities.

Abnormalities diagnosed included:

- Total of Referrals sent externally for suspected abnormalities: 37
- 15 Referrals sent for Routine Fetal Echocardiogram due to patient or family history.
- CNS malformations: (Ventriculomegaly. Spina Bifida, Anencephaly, Hydrocephalus)
- Renal Tract malformations: Unilateral kidney, Multicystic kidneys, Hydronephrosis
- CVS malformations: AVSD, VSD, Tetralogy off Fallot, Pulmonary Stenosis.
- Musco-skeletal malformations: Skeletal Dysplasia
- GI malformations: Exomphalus
- Trisomy 21, Trisomy 18.

Total number of RAADP administered in 2019 at 28 weeks was Prophylactic Anti D at 28 weeks was 266

### Early Pregnancy Unit

Early Pregnancy Clinic continues with a morning clinic from 11am – 1pm, Monday – Friday.

Total number of ultrasound scans performed in 2019: 720

This service provides ultrasound for women up to 12 weeks gestation of pregnancy who have been referred by a GP or Emergency department staff with pain or bleeding, or for reassurance scans following a previous poor pregnancy outcome ie early pregnancy loss or Ectopic.

Since the introduction of early dating scans in the Fetal Assessment Unit this has reduced the number of women referred to the Early Pregnancy Clinic for reassurance and dating.

# Section 2: Neonatology
## *(a) Neonatology & Paediatrics*

Ms Kate Greenough Clinical Midwife Manager 2

The staff of the Neonatal unit aim to provide high quality, evidence based, care to neonates in a safe and friendly environment. There were 1644 babies born in Letterkenny University Hospital in 2019, of which 303 were admitted to the neonatal unit. Which represents an admission rate of 18%.

### Indications for Admission include:

- Prematurity
- Hypoglycaemia
- Feeding Issues
- Birth Trauma
- Low Apgars
- IV Fluid Therapy
- IV Antibiotic Treatment
- Respiratory problems
- Sepsis
- Jaundice
- Acidosis
- Seizures
- Substance Abuse
- Congenital Malformations
- Social Reasons

### Baby Weights on Admission 2019

| Weight | No. | % |
|---|---|---|
| < 500gms | 0 | 0.0% |
| 500-1000gms | 3 | 1% |
| 1000-1499gms | 4 | 1.3% |
| 1500-2000gms | 30 | 10% |
| 2000-2500gms | 54 | 17.8% |
| 2500-3000gms | 54 | 17.8% |
| 3000-3500gms | 75 | 24.7 % |
| >3500gms | 83 | 27.4% |
| Total | 303 | 100% |

| Gestation Age of Neonatal Unit Admissions in 2019 | | |
|---|---|---|
| <28wks | 2 | 0.67% |
| 28-31+6wks | 19 | 6.27% |
| 32-36+6wks | 92 | 30.4% |
| >37wks | 190 | 62.7% |
| Total | 303 | 100% |

| General Neonatal Morbidity | |
|---|---|
| CPAP | 64 |
| Ventilation | 13 |
| Respiratory Disorders: RDS/TTN | 170 |
| Congenital malformations | 13 |
| Babies transferred from tertiary centres for ongoing care | 25 |
| Babies were transferred to other hospitals | 26 |
| Neonatal Death | 0 |
| Transferred for Therapeutic Cooling | 1 |

Specialist Services on site include: Audiology and ophthalmology screening. MRI scans and ultrasound facilities.

The multidisciplinary team include a paediatric dietician, the social work team, physiotherapists, radiographers, orthopaedic team and the paediatric link nurse. The staff in the neonatal unit liaises, when necessary, with specialist teams in Dublin. The transport team offer a valuable service, transferring a number of our babies for continuing care and investigations to Dublin hospitals. Communication with the Public Health Nurse team plays an important role in discharge planning.

A staff member is trained to provide CPR training to parents when required, a further member of staff will also be trained to provide this service.

The Neonatal Unit has a core staff of 14.5 WTE. This includes 2 CNMs and a combination of midwives, paediatric nurses and staff nurses with a wide variety of experience and qualifications, training provided includes,

- NRP training
- STABLE study days
- Hand Hygiene and Mandatory Training
- Breastfeeding Study Days
- Study Days relevant to the area of Neonatology
- Child First
- Equipment Training Updates
- Since 2014, the Neonatal Unit has been involved in providing data for the Vermont Oxford Network Database.

# Section 3: Gynaecology
# *(a) Colposcopy*

Ms Regina McCabe Clinical Midwife Specialist in Colposcopy

## Colposcopy Clinic Report

| Staff Complement. | |
|---|---|
| **Consultant Colposcopist** | |
| Prof Edward Aboud | Director Of Colposcopy |
| Dr Sally Philip | Registrar/ Colposcopist |
| Dr Farhat Shireen | Registrar/ Trainee Colposcopist |
| **Colposcopy Nurse** | |
| Ms Charlene Bogan | Staff Nurse/ Trainee Colposcopist |
| **Nurse Colposcopists.** | |
| Ms Regina McCabe | CNS |
| Ms Pat Hirrell | CNM II |
| **Health Care Assistants** | |
| Ms Marjorie Mc Hugh | Full time |
| Ms Donna Black | 0.5 WTE |
| **Office Administrators** | |
| Ms Tanya Graham | Full time |
| Grade IV position | (temporarily filled) |

The Colposcopy service at Letterkenny University Hospital is a consultant led service. There are two fulltime Nurse Colposcopists, Ms Regina McCabe and Ms Pat Hirrell.

All clinicians are British Society Colposcopy & Cervical Pathology (BSCCP) accredited colposcopists. Currently, we have one Senior Registrar, Dr Farhat and Staff Nurse,

Charlene Bogan, undertaking their Colposcopist training with BSCCP.

## Clinic Attendances

First visit attendances showed a marked increase in 2019 on the previous year,

| 2019 | 2018 |
|---|---|
| 793 | 682 |

The Colposcopy clinic LUH is contracted by the National Cervical Screening Programme (NCSP) to see 500 first visits per year. The clinic however, since 2014 exceeded this projection with a big increase of approx 300 more first time attendees in 2019 (793).

The marked increase to the Colposcopy clinic LUH was the result of women requiring examination of the cervix in the wake of the CervicalCheck crisis.

Women were also offered a second free smear test in a bid to re-assure them about the quality of the State's screening process which ultimately resulted in the demand being moved from processing smear tests to seeking Colposcopy examinations.

Women referred to the Colposcopy Unit LUH are offered appointments within the recommended waiting times. We continually facilitate changing of appointments by offering times to suit work and other commitments.

## Summary Of Colposcopy Clinic Activity 2019

| New Referrals | |
|---|---|
| Colposcopy | |
| Attended | Did Not Attend |
| 793 | 41 |
| **Follow Up/Treatment** | |
| Attended | Did Not Attend |
| 1192 | 166 |

## Quality Assurance and MDTs

In 2019 we held CPC/MDT meetings to discuss complex cases requiring team discussion and management planning. These meetings are supported by the Cytopathology laboratory, Histopathology department LUH and Colposcopy clinicians. With the aid of GoToMeeting tele-conferencing, this facilitates live discussion and review of colposcopy/cytology/histology correlation which add greatly to diagnoses and patient management decisions.

The Colposcopy service provision is based upon Quality Standards set out by the National Cancer Screening Service (NCSSP). The Colposcopy Unit LUH continually review our practice against organisational standards such as, system management, staffing, clinical and administrative management and governance structures.

Monthly, quarterly and annual audits of Quality Assurance Standards are submitted in the form of Colp 1 reports to CervicalCheck and to Ms Evelyn Smith. Director of Midwifery, LUH. This measures waiting times for new appointments, type of procedure and result of referral, histology outcomes and waiting time for results.

## CervicalCheck

Women in Ireland have been understandably very worried following the apparent failures in the CervicalCheck programme which first emerged in late 2018-2019.

The Department of Health. HSE set up (RCOG) Expert Panel Review of cervical screening in Ireland. Its aim was to provide women who took part in CervicalCheck, and those who developed cervical cancer, with independent clinical assurance about the timing of their diagnosis and treatment.

Throughout the RCOG review and the recommendations following the Scally enquiry the Colposcopy service in LUH remained under pressure throughout 2019 with increased referrals and the requirement for increased consultation time.

The National Women and infants programme (NWIHP) completed an impact assessment on colposcopy services that identified some immediate resource requirements. Phase 1, Service Development Funding 2019 was made available to Colposcopy clinics nationally to support additional service sessions, to increase capacity and improve waiting times.

Colposcopy LUH received funding for HCA x 1 & Grade IV fulltime clerical support.

## Summary

The Colposcopy team at Letterkenny University Hospital continue to deliver a timely, accessible, quality assured service adhering to the guidelines laid down by CervicalCheck (NCSP) with the aim to reduce the incidence of cervical cancer in Donegal.

# Section 3: Gynaecology
# *(b) Donegal Sexual Assault Treatment Unit (SATU)*

Ms Connie Mc Gilloway Clinical Specialist Nurse, Ms Brídín Bell Clinical Nurse Specialist Sexual Assault Forensic Examination Unit

## Executive Summary 2019 Activity

### Attendance:

- 110 attendances at the Donegal SATU, an increase of 26 (31%) from 2018.
- 96 (87%) reported incidents took place within the Republic of Ireland.
- 14 (13%) reported incidents took place outside the Republic of Ireland.
- Attendance re: Month, Day and Time of Day
- May was the busiest month in 2019 with 13 (14%) cases presenting during this period.
- Tuesday, Thursday and Friday were the busiest days with 54 (48%) patients presenting to SATU
- 79 (72%) incidents occurred between the hours of 20.00 – 07.59hrs.

### Type of Reported Sexual Crime, Assailant, Relationship to Assailant

- 49 (45%) were recent sexual assaults.
- 95 (86%) cases involved a single assailant
- 12 (11%) cases involved multiple assailants
- 28 (20%) cases, the alleged assailant/s was a stranger or unknown
- 65 (48%) cases, the alleged assailant/s was a recent acquaintance, friend or acquaintance.
- 25 (19%) cases, the alleged assailant/s was a person in authority or family member
- 16 (12%) cases, the alleged assailant was an ex-intimate or intimate partner.

### Gender, Age Profile, Referral Source

- 104 (95%) patients were female, 5 (5%) patients were male and 1(1%) was other.
- The mean age was 24 years of age, the youngest < 14 years and the eldest 45 - 55 years of age.
- 47 (43%) patients were referred by An Garda Síochána, 6 (5%) patients were self-referrals and 57 (52%) patients were referred by others; GP, ED, RCC, Domestic Violence Services, Addiction Services, Mental Health Services, Acute Hospitals and 3rd level student services.

### Patients Reporting to An Garda Síochána / Time Frame from Incident to SATU

- 70 (64%) patients reported the incident to An Garda Síochána, of these;
- 49 (70%) reported within 7 days, of these;
- 43 (88%) reported within 72 hours and of these, 25 (58%) reported within 24 hours.

### Patients who had a FCE without initially reporting to An Garda Síochána

- 4 (4%) patients had a FCE without initially reporting to An Garda Síochána of these:
- No patients in 2019 made a formal complaint to An Garda Síochána.
- 2 (50%) patient requested their kits to be retained for another year.

### Psychological Support Worker in Attendance

- 81 (87%) patients had the opportunity to speak to a Psychological Support Worker at the first SATU visit.
- 19 (17%) patients did not have the opportunity to speak to a Psychological Support Worker as there was no one available.
- 14(13%) patients declined a Psychological Support Worker.
- 2 (2%) were supported by an advocate from Domestic Violence Services and Psychiatric services and in these cases RCC were not contacted.

### Physical Trauma

- 33(30%) patients had physical injuries, of these;
- 28 (85%) had superficial trauma, 3 (3%) had injuries were follow-up in hospital was required and
- 2(2%) patients were hospitalised due to injuries.

### Alcohol and Drug Use

- 56 (51%) patients had consumed alcohol in the previous 24 hours of these:
  - 12 (21%) patients had consumed > 6 standard drinks of alcohol.
  - 12 (21%) patients had taken recreational drugs prior to the reported incident.
  - 20 (18%) patients were concerned that drugs were used to facilitate sexual assault.
  - 17 (15%) patients were unsure if drugs were used to facilitate sexual assault.

### Emergency Contraception (EC)

- 41 (39%) female patients presented within 120 hours of the incident; of these;
- 17 (100%) patients were appropriately administered EC in the SATU.

### Sexually Transmitted Infection Prophylaxis and (STI) Screening

- 39 (48%) patients received Chlamydia prophylaxis.
- 70 (64%) commenced Hepatitis B immunisation programme.
- 4 (9%) patient received Post Exposure Prophylaxis (PEP) for HIV.

### Follow-up Appointment for Sexual Health Screening

- 88 (80%) patients who attended the SATU were given an STI review appointment, of these;
- 83 (94%) patients attended first follow-up appointment.
- 7 (6%) patients attended for an appointment elsewhere.
- 2 (2%) patients were SATU to SATU referrals.

### Outcome of Sexual Health Screening and additional Screening at Follow-up

- 81 patients were screened for Chlamydia, of these;
- 4 (5%) patients had a positive result for Chlamydia.
- 55 patients were screened for Bacterial Vaginosis, of these;
- 8 (15%) patients had a positive result for Bacterial Vaginosis.
- 47 patients were screened for Candida Albicans, of these;
- 12 (26%) patients had a positive result for Candida Albicans.

# *Mayo University Hospital Introduction*

Associated Clinical Director Dr Hilary Stokes

Mayo University Hospital is a modern and progressive facility providing a wide and evolving range of services to a steadily increasing population over a wide geographical area. Clinical services provided include General Surgery, General Medicine and it's major subspecialties, Orthopaedics, Paediatrics, Obstetrics & Gynaecology. These are in addition to Renal Dialysis, Oncology services, as well as Palliative care. There is a very active Accident & Emergency department which provides emergency care to all age ranges.

Visiting Consultants to the busy Outpatients Department provide additional regional specialities; giving access to a range of expertise to care for our service users.

Our maternity and neonatal services have a close working relationship, with safe efficient and quality care provision as the shared value. We enjoy an excellent working relationship with the other departments within the hospital and service have access to the huge bank of expertise, knowledge and skills that serve Mayo University Hospital. I wish to acknowledge the hard work and dedication of all staff in their continued contribution to the provision of a high quality, safe service.

Dr Hilary Stokes
Associate Clinical Director for Women's Health & Children,
Mayo University Hospital.

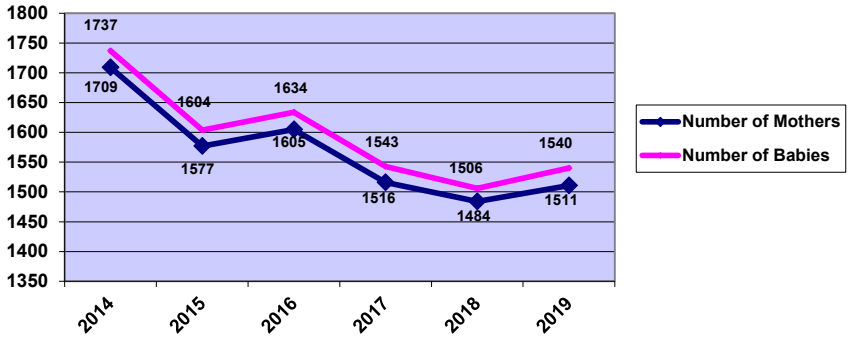
# Section 1: Maternity
## *(a) Statistical Summary*

Ms Andrea McGrail Director of Midwifery

### Number Of Mothers & Babies

| | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 |
|---|---|---|---|---|---|---|
| Number of Mothers | 1709 | 1577 | 1605 | 1516 | 1484 | 1511 |
| Number of Babies | 1737 | 1604 | 1634 | 1543 | 1506 | 1540 |

**Number of Mothers & Babies over last 10 years**




### Obstetric Outcomes:

| | Primigravida | Multigravida | Total |
|---|---|---|---|
| Total Number of Mothers | 484 | 1027 | 1511 |
| Total Number of Babies | 493 | 1047 | 1540 |
| >24 weeks or >/= 500g | | | |

### Obstetric Outcomes (Mothers)

| | Primigravida | % | Multigravida | % | Total | % |
|---|---|---|---|---|---|---|
| | 484 | | 1027 | | 1511 | |
| Induction of Labour | 176 | 36.4% | 224 | 21.8% | 400 | 26.5% |
| Caesarean Section | 246 | 50.8% | 341 | 33.2% | 587 | 38.8% |
| Spontaneous Vaginal Delivery | 108 | 22.3% | 622 | 60.6% | 730 | 48.3% |
| Operative Vaginal Delivery | 130 | 26.8% | 64 | 6.2% | 194 | 12.8% |

| | | |
|---|---|---|
| Episiotomy | 211 | 14.0% |
| Epidural Rate | 401 | 26.5% |

### Multiples:

| | Primigravida | Multigravida | Total |
|---|---|---|---|
| Total Number of Mothers | 484 | 1027 | 1511 |
| Total Number of Babies | 493 | 1047 | 1540 |
| >24 weeks or >/= 500g | | | |

| Multiple Pregnancies by year | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 |
|---|---|---|---|---|---|---|
| Twins | 28 | 27 | 29 | 27 | 22 | 29 |
| Total | 28 | 27 | 29 | 27 | 22 | 29 |

## Perinatal Mortality:

| | Primigravida | Multigravida | Total |
|---|---|---|---|
| Total Number of Mothers | 484 | 1027 | 1511 |
| Total Number of Babies | 493 | 1047 | 1540 |
| >24 weeks or >/= 500g | | | |

| Perinatal Deaths | Total | % |
|---|---|---|
| Stillbirths | 7 | 0.45% |
| Early Neonatal Deaths | 3 | 0.19% |

| Perinatal Mortality Rate | 2019 |
|---|---|
| Stillbirth rate (per 1,000) | 4.5 |
| Neonatal Death rate (per 1,000) | 1.9 |
| Overall PMR per 1,000 births | 5.2 |
| Corrected PMR per 1,000 births | 0.6 |

Inductions:

| | Primigravida | Multigravida | Total |
|---|---|---|---|
| Total Number of Mothers | 484 | 1027 | 1511 |
| Total Number of Babies | 493 | 1047 | 1540 |
| >24 weeks or >/= 500g | | | |

| Induction of Labour | Primigravida | | Multigravida | | Total | % |
|---|---|---|---|---|---|---|
| 2015 | 208 | 39.8% | 197 | 18.7% | 405 | 25.7% |
| 2016 | 179 | 33.0% | 184 | 17.3% | 363 | 22.6% |
| 2017 | 196 | 39.3% | 197 | 26.4% | 393 | 31.3% |
| 2018 | 201 | 39.8% | 205 | 20.9% | 406 | 27.4% |
| 2019 | 176 | 36.4% | 224 | 21.8% | 400 | 26.5% |

## Perineal Trauma

| | Primigravida | Multigravida | Total |
|---|---|---|---|
| Total Number of Mothers | 484 | 1027 | 1511 |
| Total Number of Babies | 493 | 1047 | 1540 |
| >24 weeks or >/= 500g | | | |

| Perineal Trauma | Total | % |
|---|---|---|
| Number of vaginal deliveries | 924 | 60% |
| Episiotomy | 211 | 23% |
| 3rd Degree Tear | 12 | 1.3% |

## Episiotomy

| | Primigravida | Multigravida | Total |
|---|---|---|---|
| Total Number of Mothers | 484 | 1027 | 1511 |
| Total Number of Babies | 493 | 1047 | 1540 |
| >24 weeks or >/= 500g | | | |

| Incidence of Episiotomy | Total | % |
|---|---|---|
| 2019 | 211 | 23.0% |

## 3rd Stage

| | Primigravida | Multigravida | Total |
|---|---|---|---|
| Total Number of Mothers | 484 | 1027 | 1511 |
| Total Number of Babies | 493 | 1047 | 1540 |
| >24 weeks or >/= 500g | | | |

| 3rd Stage Problems | Total | % |
|---|---|---|
| Primary PPH (1000ml) | 108 | 7.1% |
| Manual Removal of Placenta | 17 | 1.1% |

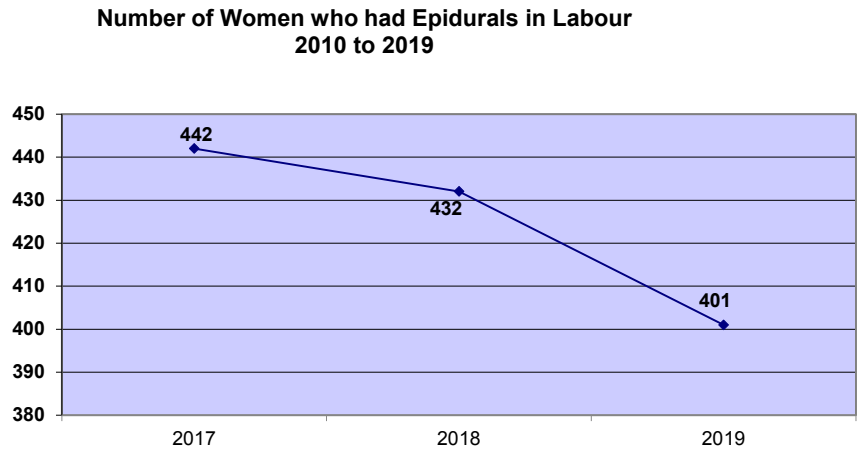
## Robson Groups

| | Primigravida | Multigravida | Total |
|---|---|---|---|
| Total Number of Mothers | 484 | 1027 | 1511 |
| Total Number of Babies | 493 | 1047 | 1540 |
| >24 weeks or >/= 500g | | | |

| Robson Groups | n-CS | n-Women | % |
|---|---|---|---|
| Group 1 - nullip singleton cephalic term spont labour | 63 | 236 | 26.7% |
| Group 2 - nullip singleton cephalic term induced or pre-labour CS | 116 | 205 | 56.6% |
| Group 3 - multip singleton cephalic term spont labour | 11 | 402 | 2.7% |
| Group 4 - multip singleton cephalic term induced or pre-labour CS | 47 | 235 | 20.0% |
| Group 5 - previous CS singleton cephalic term | 252 | 293 | 86.0% |
| Group 6 - all nulliparous breeches | 23 | 24 | 95.8% |
| Group 7- all multiparous breeches | 21 | 24 | 87.5% |
| Group 8 - all multiple pregnancies | 20 | 29 | 69.0% |
| Group 9 - all abnormal lies | 8 | 8 | 100.0% |
| Group 10 - all preterm singleton cephalic | 26 | 55 | 55.0% |
| TOTAL | 587 | 1511 | |

## Anaesthetics Graphs

| | 2017 | 2018 | 2019 |
|---|---|---|---|
| Number of Women who had Epidurals in Labour | 442 | 432 | 401 |




## Antenatal Education Sessions:

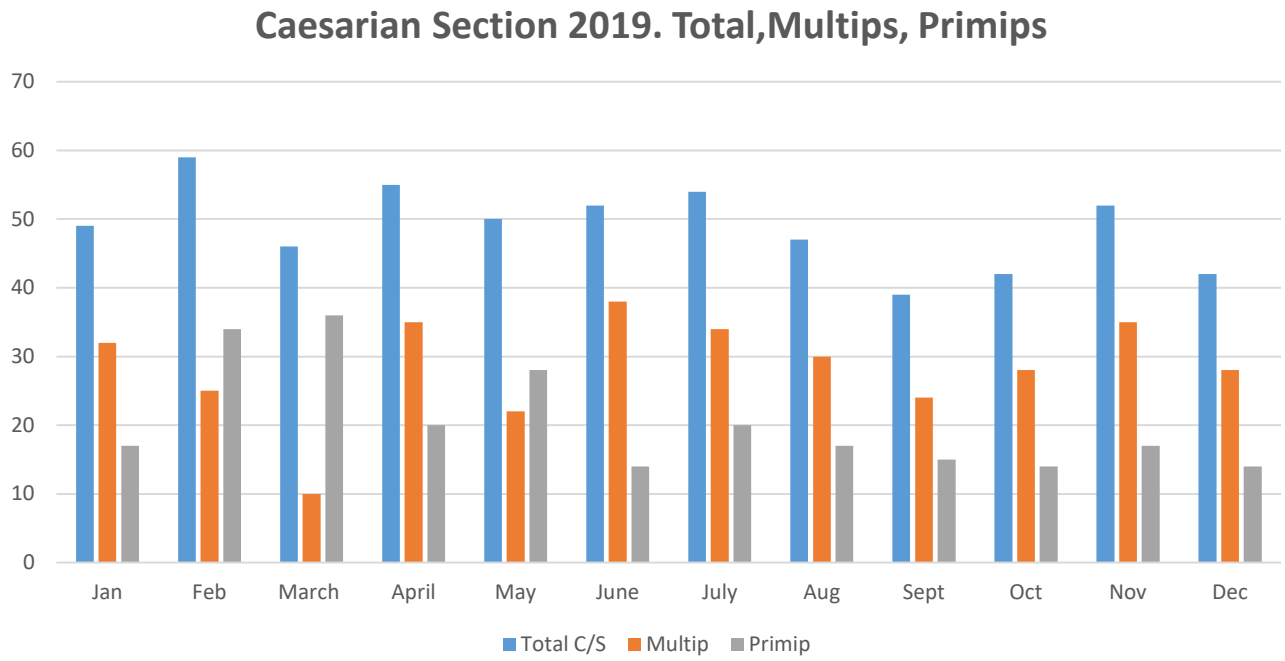
### Attendance at Antenatal Education Sessions

| Antenatal Education | Clients | Classes |
|---|---|---|
| Weekday Sessions | 565 | |
| Multiple Birth Classes | | 13 |
| Breastfeeding Classes | 185 | |
| Specailised Educational Need Classes | | 20 |
| One to One sessions | | 50 |

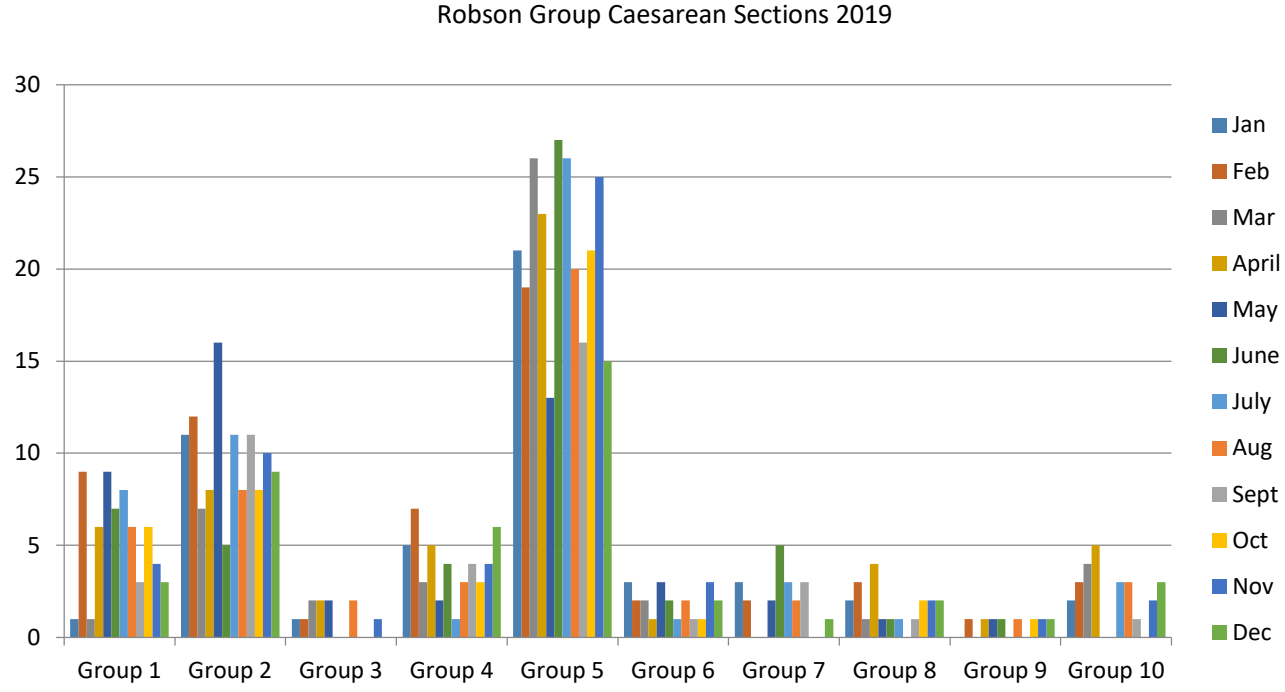
### Breastfeeding:

| | 2019 |
|---|---|
| Breastfeeding Initiation Rates | 1002 |
| Breastfeeding on Discharge | 530 |

## MUH Deliveries in 2019



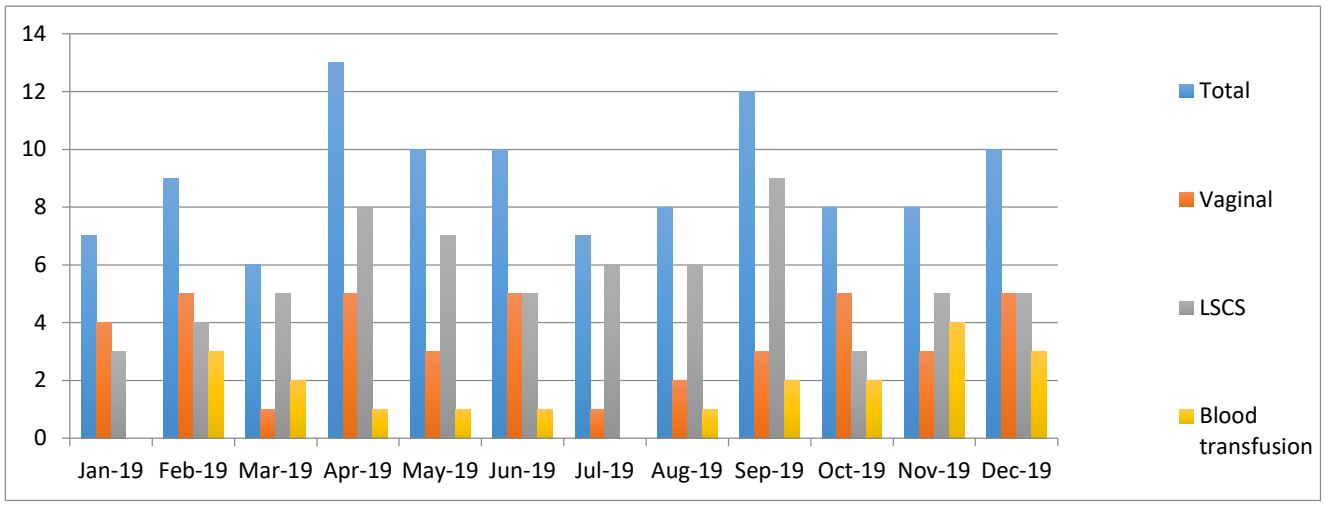

| Parity | Jan | Feb | March | April | May | June | July | Aug | Sept | Oct | Nov | Dec | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Total | 49 | 59 | 46 | 55 | 50 | 52 | 54 | 47 | 39 | 42 | 52 | 42 | 587 |
| Multip | 32 | 25 | 10 | 35 | 22 | 38 | 34 | 30 | 24 | 28 | 35 | 28 | 341 |
| Primip | 17 | 34 | 36 | 20 | 28 | 14 | 20 | 17 | 15 | 14 | 17 | 14 | 246 |




| Jan | Feb | Mar | April | May | June | July | Aug | Sept | Oct | Nov | Dec | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 0 | 0 | 1 | 4 | 0 | 0 | 2 | 0 | 1 | 1 | 3 | 0 | 12 |

**2019.**

**Primary PPH ≤ 1000 Mls**




Total : 106

Primary PPH following Vaginal Delivery: 42

Primary PPH following LSCS: 66

Require Blood Transfusion: 20

# Section 1: Maternity
# *(b) Director of Midwifery Report*

Ms Andrea McGrail Director of Midwifery

Mayo University Hospital is a busy modern facility providing a wide range of services. It has 309 inpatient beds and 23 day patient beds. The services provided include General surgery, General Medicine, Orthopaedics, Renal Dialysis, Accident and Emergency, Oncology, Paediatrics Obstetrics and Gynaecology and Palliative care.

Visiting Consultants to the busy outpatients department provide additional regional specialities; giving access to a range of expertise to care for our service users.

Our maternity and neonatal department have an excellent working relationship with the other departments within the hospital and have access to the huge bank of expertise, knowledge and skills that serve Mayo University Hospital.

The Maternity Day ward is up and running and is proving very successful and gives some women who require monitoring the opportunity to be managed as outpatients.

We continue to have a peer review safety meeting Mon – Friday on Maternity ward meeting room. This is attended by Day / Night staff Obstetricians Midwives and students. All cases in the previous 24 hours are discussed, patients that were seen out of hours in ED or labour ward. The day's work is discussed and any high risk patients staffing issues or other concerns addressed. Any women attending with a known fetal abnormality is mentioned so all staff are reminded and familiar with their situation when they present in our department.

On Thursday we are joined by the Paediatric team and all babies' that required SCBU admission in the previous week are discussed. We also have input from the ultrasound perinatal staff to give us updates on any women that have had problems detected on ultrasound.

In 2019 we updated and reconfigured the CTG recording and archiving system the Obs Trace Vue. This involved a huge amount of work from the staff with development and reviewing new forms. We also had to revert to the old system of paper documentation while the transition took place. Thankfully the transition to the new system was successful. A few minor issues ironed out and I would like to thank all involved.

The staff of WHC has continued to work hard throughout 2019 to provide families with a positive experience and safe quality care.

The women's and children's Department are supported by a team of allied health professionals and I would like to thank these staff for their hard work and commitment to our service in 2019. These include, social work Dept, physio and pharmacy

In 2018, 1,540 babies were delivered to 1511 women at MUH, showing a slight increase in numbers from 2018. Our delivery rate by caesarean sections continues to increase in line with national trends.

# Section 1: Maternity
# *(c) Maternity Ward Annual Report 2019*

Ms Mary Sammon & Ms Maureen Hannon Clinical Midwife Managers 2 Maternity Ward

The Maternity ward continues as a mixed antenatal/ postnatal unit consisting of 26 beds.

The Midwives rotate through labour ward, antenatal and postnatal. Midwifery team members working in postnatal /antenatal include CMM midwives student midwives and HCAs trained in midwifery modules.

We have two ward managers and currently 22 staff working as part of a large team.

The Antenatal/Postnatal ward provides a 24-hour service where staffs endeavour to provide holistic and evidence based care to mothers and newborn babies

The unit is staffed by Midwives providing antenatal/postnatal care, breastfeeding and artificial feeding support, parenting support, education and teaching and preparation for home.

The multisdiplinary team working as part of the ward include Obstetricians, Paediatricians, Physiotherapists, Social workers, Antenatal educators and Newborn Hearing screening.

We also work closely with health care professionals in the community on discharge from the ward a summary of care is generated by midwifery staff and forwarded to the Public Health Office and General Practitioners.

# Section 1: Maternity
## *(d) Early Pregnancy Unit Report*

Ms Priscilla Fair Clinical Nurse Managers 2

The Early Pregnancy Unit is situated on the first floor. It operates Monday to Thursday mornings from 08.00-10.30 and Fridays until 13.00.

The majority of referrals come via GP letter which are triaged by EPU staff and patient given appropriate appointment. Women who have recurrent miscarriage, previous ectopic pregnancy or previous molar pregnancy can self-refer directly to unit for an early reassurance ultrasound.

In patients in hospital with early pregnancy problems are referred by consultant on duty and the patient is seen on the morning of referral.

| No. | | Jan. | | Feb. | | Mar. | | Apr. | | May | | June | | July | | Aug. | | Sept. | | Oct. | | Nov. | | Dec. | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | N | R | N | R | N | R | N | R | N | R | N | R | N | R | N | R | N | R | N | R | N | R | N | R |
| 1 | Total Attendances in the EPU | 51 | 38 | 65 | 33 | 47 | 42 | 48 | 52 | 57 | 51 | 47 | 38 | 44 | 51 | 41 | 41 | 38 | 37 | 47 | 41 | 48 | 44 | 46 | 37 |
| | TOTAL No. 1 | 89 | | 98 | | 89 | | 100 | | 108 | | 85 | | 95 | | 82 | | 75 | | 88 | | 92 | | 83 | |
| 2 | Total Viable Intrauterine Pregnancies diagnosed | 34 | | 39 | | 29 | | 31 | | 31 | | 18 | | 24 | | 25 | | 25 | | 26 | | 20 | | 30 | |
| 3 | Total Complete Miscarriages Diagnosed | 13 | | 7 | | 7 | | 13 | | 15 | | 5 | | 9 | | 10 | | 11 | | 13 | | 7 | | 9 | |
| 4 | Total Incomplete Miscarriages Diagnosed | 5 | | 6 | | 7 | | 4 | | 5 | | 7 | | 4 | | 5 | | 7 | | 5 | | 6 | | 3 | |
| 5 | Total Missed Miscarriages | 7 | | 9 | | 12 | | 9 | | 13 | | 15 | | 8 | | 15 | | 8 | | 12 | | 6 | | 8 | |
| | Medical | 2 | | 5 | | 1 | | 4 | | 5 | | 8 | | 4 | | 2 | | 3 | | 6 | | 1 | | 1 | |
| | Surgical | 2 | | 3 | | 6 | | 3 | | 3 | | 4 | | 2 | | 7 | | 3 | | 2 | | 0 | | 0 | |
| | Conservative | 3 | | 1 | | 6 | | 2 | | 9 | | 3 | | 2 | | 6 | | 2 | | 4 | | 5 | | 7 | |
| 6 | Total Ectopic Pregnancies Diagnosed | 1 | | 3 | | 1 | | 2 | | 0 | | 1 | | 1 | | 5 | | 2 | | 1 | | 2 | | 1 | |
| 7 | Total Pregnancies of Unknown Location Diagnosed | 9 | | 4 | | 4 | | 8 | | 10 | | 9 | | 16 | | 3 | | 16 | | `14 | | 20 | | 11 | |
| 8 | Total Molar Pregnancies Diagnosed | 0 | | 1 | | 1 | | 0 | | 0 | | 0 | | 1 | | 0 | | 0 | | 1 | | 0 | | 0 | |
| 9 | Total Miscarriage Misdiagnosis Errors | 0 | | 0 | | 0 | | 0 | | 0 | | 0 | | 0 | | 0 | | 0 | | 0 | | 0 | | 0 | |
| 10 | Total Number of written complaints | 0 | | 0 | | 0 | | 0 | | 0 | | 0 | | 0 | | 0 | | 0 | | 0 | | 0 | | 0 | |
| 11 | Total CIS Forms submitted in the First Trimester | 0 | | 0 | | 0 | | 0 | | 0 | | 0 | | 0 | | 0 | | 0 | | 0 | | 0 | | 0 | |
| 12 | No. of Cases reported to CIS | 0 | | 0 | | 0 | | 0 | | 0 | | 0 | | 0 | | 0 | | 0 | | 0 | | 0 | | 0 | |
| 13 | Total No. of Pregnancies Unknown Viability | 6 | | 11 | | 8 | | 14 | | 13 | | 8 | | 14 | | 8 | | 7 | | 13 | | 11 | | 13 | |
| 14 | Total No. of BHCG Levels Recorded | 18 | | 18 | | 23 | | 24 | | 24 | | 21 | | 27 | | 12 | | 20 | | 16 | | 26 | | 15 | |

# Section 1: Maternity
# *(e) Anaesthetics Report*

Dr Ciara Canavan, Consultant Anaesthetist

## Overview
In 2019 the Department of Anaesthesia at Mayo University Hospital provided anaesthesia services for 587 patients undergoing Caesarean Section, 28 patients in theatre for instrumental delivery, 67 patients for ERPC, 23 for post partum haemorrhage,17 for manual removal of placenta, 3 for cervical cerclage, 12 for management of ectopic pregnancy, 32 for perineal repair and 401 labour epidurals.

Staff consist of 7 Consultants, 6 Registrars and 6 SHOs. 6 of these NCHDs rotate to MUH from the College of Anaesthesiologists SAT training scheme. MUH is recognised for Obstetric Anaesthesia training at SAT 1 and SAT 3 level.

A Consultant Anaesthetist covers the Elective Obstetric and Gynaecology Theatre during the day and is also on call for any Obstetric emergencies with an SHO on call who is not rostered for any elective theatre and provides the epidural service and emergency delivery suite anaesthesia cover.

There is a named Obstetric lead Consultant Anaesthetist who has a role in education, audit, training and policy implementation.

## Services Provided
The Department provides a 24/7 epidural for labour analgesia service, pre assessment of all patients for Elective Caesarean section and aims to provide a weekly High Risk Antenatal Anaesthesia Clinic for all patients meeting OAA/AAGBI criteria for referral antenatally by the Obstetricians or Midwives once Consultant numbers increase.

In 2019 there were 1511 deliveries at MUH. Of these 401 (26% of all mothers ) had an epidural for labour which is a lower percentage than last year. 587 (38.8%) had a Caesarean section of whom 246 were primiparous and 341 were multiparous.

## Operative Anaesthesia
General anaesthesia was provided for 32 women (5.4% of all Caesarean sections) and either spinal or epidural anaesthesia was provided for the remainder for Caesarean Section delivery. The reasons for GA section included: failure of regional anaesthesia, no time to give a regional anaesthetic, bleeding disorder, cord prolapse, patient request and antepartum haemorrhage. 3 patients required general anaesthesia as a technique due to previous negative experience with regional anaesthesia, coagulation disorders, patient request and the remainder had GA due to failure of regional technique or patient instability.

Epidural analgesia was complicated by 4 recognised dural punctures (1%), 2 patients required a blood patch for post dural puncture headache (one of whom required two blood patches).

Remifentanil PCA guidelines were reviewed and updated in 2016 and the technique was used for one patient who was unsuitable for epidural analgesia in 2019.

Early skin to skin, “gentle caesarean section”, and improved family centred practice in theatre is being practiced by the obstetricians in suitable cases. This includes the partner and baby remaining in theatre with the mother for a much longer period, initiation of beast feeding and minimising separation of families.

Critical care admissions included 12 Obstetric patients who require HDU care in the combined HDU/ICU ward. Reasons for admission included post partum haemhorrhage and pre eclampsia.

113 patients were managed in the High Observation area of the Delivery suite for one to one midwifery care and observations.

## Audit
Post natal follow up at 24 hours of all patients who receive anaesthesia care has allowed us to document complications and side effects, audit our practice and assess patient satisfaction since 2006.

## Education
The Department is actively involved in teaching on the PROMPT course locally, continuing education with the midwifery competency module for management of epidurals on delivery suite and Departmental education sessions on all aspects of Obstetric Anaesthesia care.

## Aims for 2020
The Saolta Epidural policy will be implemented superceding our current policy.

To formalise the High Risk Antenatal clinic with a dedicated Consultant session allocated.

## Aims to implement recommendations of National Maternity Strategy
To increase our Consultant Anaesthetist staffing levels to allow for 24/7 exclusive Consultant cover for Delivery Suite and High Risk antenatal clinic.

To continue to campaign for a dedicated Obstetric Emergency Theatre for urgent operative delivery during daytime hours.

All senior staff to attend MOET course.

# Section 1: Maternity
# *(f) Obstetrics Ultrasound*

Ms Maura McKenna Clinical Midwife Manager 2 Obstetric Ultrasound

The Obstetric Ultrasound Department in Mayo University Hospital is divided into two areas -

### 1. Early Pregnancy Unit
Mon-Thursday 8.00-10.30
Fri- 8.00 – 12.30

EPU cares for women in pregnancy up to 12 weeks gestation.

### 2. Perinatal Unit
Mon- Thursday 08.30-18.00
Fri 07.00-17.00

There is also a satellite Perinatal clinic every Tuesday from 08.30-17.00hrs in Ballina.

Both areas are staffed by midwives and midwife sonographers.

The Early Pregnancy Unit has the added benefit of Clerical support.

### Figures for 2019:
- 1084 scans performed in the Early Pregnancy Unit.
- 4516 scans performed in the Perinatal Unit this included 1299 mothers had booking scan and 1146 routine second trimester anomaly ultrasound examinations
- 700 scans performed in Ballina.

In total 6400 scans were performed by the Obstetric Ultrasound Team in Mayo University Hospital

### About the Scans and Service offered
Ultrasound examinations are performed both abdominally (TAS) and vaginally (TVS).

The following is a list of ultrasound examinations performed
- Booking/Dating Scans
- Cervical length scans.
- Second trimester detailed routine anatomy scans.
- Growth scans
- Biophysical Profiles.
- Doppler studies.
- Fetal well being.
- Multiple pregnancies.

### Endrocrine service
From January to December 2019 188 Diabetic mothers attended the Thursday morning Endocrine Antenatal Clinic.

Surveillance for mothers with Diabetes is practised as per the DIP study and these women are offered scans at 12 weeks, 22 weeks, 28 weeks, 32 weeks, 36 weeks and 38 weeks. Mothers with other endocrine conditions are also seen at this clinic and are offered further ultrasound surveillance. .

These scans include growth, biophysical profile and umbilical artery Doppler studies.

Surveillance for routine multiple pregnancy (usually Twins) pregnancy is as followed.

For Dichorionic diamniotic twin pregnancies women are offered scans every 4 weeks up to , 28 weeks, every 2 weeks up to 36 weeks, and weekly up to delivery

For Monocorionic diamniotic twin pregnancies women are offered scans every 3 weeks up to 24 weeks and every 2 weeks to 34 weeks and weekly then until delivery. These twins have the added monitoring on Middle cerebral artery Doppler's.

In 2019 there were twins delivered at MUH, not including 1 late miscarriages
27 sets of DCDA
09 set of MCDA

### Fetal Abnormalities
Fetal abnormalities are diagnosed and managed within the Perinatal Unit.

We have a direct referral pathway with the National Maternity Hospital, Holles Street.

They see any patients we refer within 72 hours and we are very grateful for their unending support.

In 2019 we referred 71 women to fetal medicine in the National Maternity Hospital, and the Coombe Hospital.

These Fetal abnormalities ranged from Hydronephrosis to fatal fetal abnormalities. All women were given follow up appointments here in Mayo University Hospital.

These numbers do not include direct referrals made by Consultant.

### Further Training
Spring 2019 Aisling Gill, Siobhan Ryan, Jenny Corcoran and Maura Mckenna attended Maynooth University Master classes in supporting unplanned pregnancy ran by the CNME at Castlebar.

October 2019 the BMUS study day in London was attended by Maura Mckenna CMM2 Perinatal Ultrasound

Each Staff member within both EPU and the Perinatal Unit has continued to maintain their professional competencies throughout 2019 by attending mandatory study and local study days.

# Section 1: Maternity
# *(g) Antenatal Education Report*

Ms Frances Burke Clinical Midwife Manager 2 & Ms Maura McKenna Clinical Midwife Manager 2

## Service Provision

The primary service provision is twice weekly blocks of four classes monthly for first-time parents.

This continues to provide education on natural birthing and on deviations from the normal pathway. Hypnobirthing techniques continue to play a role in providing sound relaxation practice and we strongly encourage parents to learn how to relax in pregnancy in preparation for birthing.

Second time parents are welcome to join all sessions and partners are encouraged to attend also.

Other classes provided include:
- Breastfeeding
- Twins
- One-to-one advocacy, education, young parents and special needs.

The Education Service includes a strong advocacy supporting role and links closely with the Pregnancy Counselling Service and the Social Work Department. This is essential for the support of vulnerable women and their families.

We continue to link with community partners in end of life services for babies, specialist nursing services and charity groups such as Feiliceain.

As we await the launch of the National Antenatal Education standards we continue to provide family focused classes and educate expectant women and their birth partners on issues relating to a variety of topics on pregnancy, birth and life after delivery.

We are delighted to share the "mychild.ie" site information with new parents and give each family at booking the pregnancy book. This is a great resource and we have ensured families attending classes have copies of the booklet.

## Attendance at antenatal classes

- Blended Classes = 565 Women and Partners
- Twins classes = 13 families
- Breastfeeding classes = 185 women
- Special need education for poor outcome = 20 visits
- One-to-one Sessions = 50

## Breastfeeding

The Education Service runs a separate breastfeeding antenatal class. This provides parents with good preparation for breastfeeding their babies.

This is now one of the most popular classes and concentrates on the early feeding patterns.

We continue to update our skill to ensure best practice is maintained in this area. Part of our role ensures promotion of breastfeeding for breastfeeding awareness week and keeping to the Baby Friendly Health Initiative as a guide to best practice. We continue links with the Association of Lactation Consultants.

National Breastfeeding Awareness Week 2019 was celebrated with a breast feeding awareness day in Mayo University Hospital.

Information stands were available in the main foyer and on Maternity ward in the hospital for staff and members of the public.

One-to-one breastfeeding support has been given by phone, paediatric and maternity ward visits, A&E and office. It is recognised that this service needs better resourcing to improve support within the hospital setting; business cases have been submitted to further this position.

## Conclusion

The education service experienced its own challenges with practice hours reduced. We continuously redesign and review our practices to meet parent's needs. We look forward to 2020 for a better resourced service.

# Section 2: Neonatal & Paediatrics
## *(a) Special Care Baby Unit Statistics*

Ms Joan Falsey Clinical Midwife Manager 2 Special Care Baby Unit & Ms Irene McNicholas Clinical Nurse Midwife 1

| Infants admitted by gestational age group | |
|---|---|
| Gestation (weeks) | Total Admissions |
| Less than 32 | 5 |
| 32 - 36 | 47 |
| 37 weeks and over | 252 |
| **TOTAL** | **304** |

| Total admissions from source | |
|---|---|
| Theatre | 107 |
| Delivery Suite | 72 |
| Maternity Unit | 95 |
| Other hospital | 28 |
| Paediatric Ward | 0 |
| Social Admission | 2 |
| **TOTAL** | **304** |

| Birthweight | |
|---|---|
| Less than 1500g | 7 |
| 1501 – 2000g | 14 |
| 2001g – 2500g | 33 |
| Over 2500g | 250 |
| **TOTAL** | **304** |

| Reasons for Admission | |
|---|---|
| Prematurity | 86 |
| Respiratory | 69 |
| Suspected sepsis | 30 |
| Gastrointestinal | 1 |
| Hypoglycaemia | 47 |
| Neurological (Passive cooling) | 1 |
| Cyanotic Episodes | 3 |
| Low birth weight/IUGR | 6 |
| Infant of Insulin dependent diabetic | 2 |
| Congenital Abnormalities | 4 |
| From paediatric ward | 0 |
| Hypothermia | 2 |
| Maternal treponoma pallidum | 0 |
| Cardiac | 2 |
| Social Reasons | 4 |
| Confirmed bactermia on blood cultures | 0 |
| Jaundice for phototherapy | 18 |
| Poor feeding | 8 |
| Drug dependent mother | 3 |
| Observation post instrumental delivery | 9 |
| Meconium Aspiration | 2 |
| Hyponutraemia | 2 |
| Fall from bed on post natal ward | 1 |
| Maternal placental abruption | 1 |
| | 1 |
| | 1 |
| | 1 |
| **TOTAL** | **304** |

| Very Low Birthweight 400g – 1500g | |
|---|---|
| Born in MUH & kept in MUH | 1 |
| Born in MUH & transferred to Regional Centre | 1 |
| Born in Regional centre & transferred back to MUH | 5 |
| **TOTAL** | **7** |

| Gestational Age of Very Low Birthweight admitted to SCBU | |
|---|---|
| 22 -24+6 WEEKS | 0 |
| 25 – 26+6 WEEKS | 1 |
| 27 – 28+6 WEEKS | 2 |
| 29 – 31+6 WEEKS | 3 |
| 32 WEEKS AND OVER | 1 |
| **TOTAL** | **7** |

| Birthweight of Very Low Birthweight admitted to SCBU | |
|---|---|
| Less than 501g | 0 |
| 501 – 750g | 2 |
| 751 – 1000g | 0 |
| 1001 – 1250g | 4 |
| 1251 – 2500g | 1 |
| **TOTAL** | **7** |

| From the above total of 11 babies, 4 were born in Regional Centres following in utero transfer from MGH | |
|---|---|
| Less than 501g | 0 |
| 501 – 750g | 2 |
| 751 – 1000g | 0 |
| 1001 – 1250g | 4 |
| 1251 – 1500g | 1 |
| **TOTAL** | **7** |
| Neonatal Deaths = 0 | |

| Neonatal Transfers to Regional Centres | |
|---|---|
| Transfers by National Neonatal Transport Team | 9 |
| Transfers by SCBU staff | 8 |
| **TOTAL** | **17** |

| Neonatal Transfers from Regional Centres | |
|---|---|
| Transfers by National Neonatal Transport Team | 0 |
| Transfers by SCBU staff | 18 |
| **TOTAL** | **18** |

| ROP Screening | |
|---|---|
| Eye Checks in UCHG | 4 |
| Eye Checks in Dublin | 1 |
| Eye Checks in Sligo | 0 |
| **TOTAL** | **5** |

| Cardiac Investigations | |
|---|---|
| Cardiac Echo in UCHG | 0 |
| Cardiac Echo in Dublin | 1 |
| **TOTAL** | **1** |

| |
|---|
| List of CONGENITAL ABNORMALITIES = 4 |
| Trisomy 21 x 2 |
| Cleft Lip and palate x1 |
| Ebstein Anomoly x 1 |

| | |
|---|---|
| Number of babies delivered in MUH IN 2019 | 1540 |
| Number of babies delivered in MUH in 2019 | 1511 |

Percentage of infants delivered that were admitted to SCBU – 19.7%

# Section 2: Neonatal & Paediatrics
# *(b) Paediatric Ward Report*

Ms Ann Doherty Clinical Nurse Manager 2

There are 27 beds on the paediatric ward, where children & young people (CY&P) up to the age of 16 years are admitted under general paediatrics as well as a number of specialties, including orthopaedics and general surgery.

Total admissions (unscheduled care) for 2019: 1306. This number is representative of an unselected group from all specialties. 222 of this total number were admitted from the short stay, rapid access unit on the paediatric ward, the Paediatric Decision Unit (PDU).

## Paediatric Decision Unit

The Paediatric Decision Unit (PDU) opened in late August 2017 within the footprint of the existing ward. It continues to operate from this location. The PDU provides a short stay service for the assessment, observation and treatment of C&YP, for up to 6 hours, with a consequent reduction in unnecessary overnight admissions. The aim is to provide safe and efficient, high quality care to both the unscheduled and scheduled care cohorts of children attending MUH, Dept of Paediatrics.

It has improved patient flow through the ED, and ensures that C&YP access care in an appropriate environment, in a timely manner with reduced risk of unnecessary overnight stay in hospital. Service user feedback is strongly positive.

There are 6 PDU beds, including one isolation cubicle. It is staffed by two experienced paediatric nurses and a paediatric registrar, with senior decision maker involvement to ensure rapid turnaround and maintain the flow. Within the 6 hour observation period if it is likely that the child requires ongoing treatment in hospital he / she will be transferred from the PDU to an inpatient bed.

Planned reviews and assessments form part of the daily activity, with a consequent reduction of footfall onto the main paediatric ward.

## Unscheduled Care

A total of 8750 children who presented to the ED in 2019. Of this total number, 1633 children in the mild to moderately unwell category were referred directly from triage to the PDU and then either admitted or discharged to home within 6 hours from time to presentation.

Mean conversion rate was 13.5%. The mean conversion rate has decreased from 16.4% in 2018, to a mean of 13.5% in 2019 (median 15%).

Activity in the PDU increased by 8.2% between 2018 and 2019.

## Scheduled Care

933 children attended the PDU, for scheduled care, in 2019. This number represents a significant increase in activity of 18.1%, from 2018.

See breakdown below.

- 'Shared Care ' patients with tertiary centres requiring infusions or reviews
- Children with complex needs requiring rapid access / review
- Faltering growth
- Infants with excessive crying / poor feeding
- Children requiring joint review with dietician
- Children requiring early consultant review post discharge
- GP referrals for urgent assessment / evaluation (variety of presenting complaints)

2019 has seen an expansion and development of the PDU service. It is now operational 24 hours, 7 days, where previously it was operational Monday to Friday 0900-2200 only.

There is now a more direct pathway of referral for GPs. Referring GPs can now contact the consultant paediatrician on call via a 'hot line', for urgent, or same day assessment.

## Paediatric Outpatient Service

The paediatric department has a well-structured and functioning OPD with 5 consultations rooms. There are clinics occurring in the Enable Ireland 'Safari Club', Therapy Centre which are multidisciplinary in nature. The Department provides outreach services to Ballina and Belmullet.

The clinic structure has developmental clinics, along with general and subspecialty clinics. In total, there are 38 clinics per month.

The clinics provided are outlined in Table 3.

**Table 3**

| Clinic Provision by the Paediatric Service | | | |
|---|---|---|---|
| Asthma 3/month | Constipation 2/ month | Diabetes 2/month | Down Syndrome 1/Month |
| Cystic Fibrosis 2/month | Complex care 2/ month | Complex needs community (preschool + school age) 2 / month | Autism Assessment 4/ month (Autism Forum for multidisciplinary discussion - monthly) |
| General Clinics 14/month | Outreach Ballina 5/month | Outreach Belmullet 1/month | |

A deficiency had been highlighted in the Paediatric Diabetes Service with no dedicated CNS or Dietitian and there is an absence of a Paediatric Pump service. There are 105 children in the paediatric diabetic service, 4 aged <5 years. The provision of a pump service had been highlighted as a requirement. In 2019, Mayo children with Diabetes are now accessing a regional service and outreach clinics at MUH provided by Dr Niamh McGrath, Paediatric Endocrinologist.

The clinical diabetes service is supported by dietetic services (0.1 wte) and the adult Clinical Nurse Specialist, with minimum dedicated time. The service requires dedicated paediatric dietetic (0.5wte) and clinical nurse specialist input (1.3wte) to be compliant the National recommendations.

The Asthma clinic is support by a clinical nurse specialist and all children have pulmonary function testing performed at the clinic once they are over 5 years.

## ICU

Paediatric patients continue to be admitted to the adult ICU. Patient numbers are small, totalling 10 patients in 2018. The majority clinical conditions which necessitate admission include DKA, Status Epilepticus and respiratory diagnoses. The National Paediatric Retrieval Service team facilitates transfer of ventilated patients to a tertiary ICU, and is operational on 5 days per week, 0800-1600.

## Emergency Department (ED)

Paediatric patients represent 21% of all ED attendances in the ED. Total paediatric attendance was 8750, and increase of 9.2% compared to 2018.

Our services see those children and adolescents with medical conditions as the first point of contact post triage which is at variance with ED Service provision for paediatric patients in other Saolta Hospitals, where initial assessment of paediatric patients is completed by ED doctors. With the extension of Paediatric services to 16, this will result in an increased workload for the Paediatric services. The impact of this increased burden has not yet been assessed.

The non-separation of paediatric patients from adults in the ED continues to be a problem and is at variance with national recommendations. The introduction of the PDU during it's has lessened but not eliminated this difficulty. The ED requires significant modification to its footprint to address the separation of children from adults.

# Section 3: Gynaecology
# *(a) Ambulatory Gynae Unit (AGU)*

Ms Priscilla Fair Clinical Nurse Manager 2

It has been another busy year for the Ambulatory Gynae Unit (AGU) at Mayo University Hospital. Total numbers of women attending the unit increased slightly. The unit continues to be the first operational ambulatory gynae service of its kind in the Saolta Group and is amongst the leading units in the country .

The unit is shared with other essential services including the Early Pregnancy Service (EPU), Colposcopy and Cytology Service and the Termination of Pregnancy service which was introduced January 2019.

AGU is located on the first floor adjacent to Surgical G Ward. During the past year the AGU (including all services) has been staffed by three part times midwives, one full time Colposcopy clinical nurse specialist and one part- time nurse. An additional Clinical Nurse Manager and one full time Midwife/Nurse has also been allocated to the department with the introduction of the Termination of Pregnancy Service (TOP). There is a total of two full time clerical officer who registers all the women attending the services and one part time clerical officer who is assigned to colposcopy services only. Extra clerical cover was appointed to the AGU this year with the introduction of the Termination of Pregnancy service . This has helped the clerical for the AGU with the increased numbers of women attending the unit as whole.

## One Stop Clinic

Outpatient and Ambulatory hysteroscopy clinics provide a means for delivering both diagnostic and therapeutic procedures for common gynaecology conditions in a safe, convenient and cost effective environment. Advances in endoscopic technology have facilitated the movement of gynaecological interventions from expensive inpatient services requiring general anaesthesia and theatre facilities to a convenient office based setting.

Clinics are undertaken by a specialist team of five consultants and their teams Monday- Thursday. There are currently five ambulatory clinic sessions per week, one gynae outpatient clinic, and two colposcopy clinics. EPU has a daily two hour emergency morning service (Mon- Friday) On average 8-10 patients are booked for each ambulatory gynae session. TOP Service is scheduled on a daily basis including scans, consultations and providing the Surgical option of Manual Vaccum Aspiration in the department.

## Reasons for referral to the unit include:

- Heavy or irregular periods
- Fibroids or polyps
- Postmenopausal bleeding
- Infertility
- Bleeding between periods
- Removal or insertion of an Intrauterine contraceptive device
- Vulval skin abnormalities

## Service Provision

Diagnostic procedures performed include trans-vaginal scans, hysteroscopies, endometrial, cervical and vulval biopsy sampling and blood investigations. Therapeutic interventions include insertion of intrauterine systems. A typical day will involve women of reproductive age and older attending the unit to be reviewed for the reasons as outlined above. In the majority of cases treatment options can be offered or the very least the woman can be reassured in most instances that their symptoms are not serious .The catchment area of these referrals have increased with % of women attending and being referred from Co. Galway and Co.Roscommon. Off course these ambulatory gynae clinics take place for one half of a day but the other services like EPU, Colposcopy, Cytology and Terminatoin of Pregnancy are intertwined into the service provision of the entire unit and demand equally as much planning and time as the ambulatory clinics.

A total of 1366 women were seen in ambulatory gynae clinics last year, being made up of new and review appointments. New patients comprised of 1017 and review patients were 349 (these figures are only the women attending the Ambulatory Gynae Clinic sessions)

Of these women that attended the clinic a total of;

- 1098 Transvaginal Scans were performed
- 150 Hysteroscopies
- 9 Operative Hysteroscopies
- 535 Biopsies (including cervical polypectomies, endometrial and labial)
- 218 Mirena insertions
- 105 Mirena removals

## Advances of treatments

In February 2017 a new procedure 'The Truclear moscillator' was introduced. This system provides a minimally invasive option for women suffering from uterine bleeding due to abnormalities such as polyps and fibroids. Tissue can be removed for analysis. Its advantages include an incisionless procedure, no electricity inside the uterus minimal recovery time as the majority of procedures can be done while the woman is awake. An operative hysteroscope is used to introduce the moscillating device into the uterus.

Endometrial ablation and the Thermablate system we use is a thermal balloon device intended to ablate the endometrial lining of the uterus in women suffering from excessive uterine bleeding due to benign causes and for whom childbearing is complete.

In total there were 9 operative procedures completed in the AGU in 2019. Total moscillating time of a polyp may take as little as 11 secs. Women attending for this procedure are given pre meds half hour before the procedure and are recovered for half hour post procedure. A total of two hours, which is significantly less time than attending for a traditional day case procedure.

## Challenges for the service

The mix of the five services is a challenge at times to waiting times for the women attending the unit as certain clinics may 'run' over their designated times.

- At present women check in on a corridor adjacent to the unit. The waiting area room is very small however we have put new bench chairs on a corridor to ensure comfort and safety for the patient while waiting for their appointment.
- It is hoped that a new bereavement room will be made available to the unit as the room that was initially addressed is now been modified into a new clinical operating room.
- Due to the increased services cleaning is an issue proposals for additional Multi Task attendant has been submitted as contract cleaning outside of clinics times has not been sanctioned for the unit
- Space is an issue for Stores and sterile equipment. An Ergonomic assessment was carried out and have made recommendations.

In conclusion when a woman is first told that she has a gynaecological condition that requires investigation at a clinic her reaction is one of anxiety. The staff of the AGU understand and recognise these feelings of fear and anxiety and deal with each woman in a sensitive and professional manner. The AGU provides a fast and efficient means to diagnosis and provide treatment for the women attending the clinic in particular reducing hospital visits. Risks associated with general anaesthesia can be eliminated and also disruption to work and family life.

## Ambulatory Gynae statistics 2019

| | JAN | | FEB | MAR | APR | MAY | JUN | JUL | AUG | SEP | OCT | NOV | DEC | TOTAL |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | AMB/ GYN | GY OPD | AMB/ GYN | AMB/ GYN | AMB/ GYN | AMB/ GYN | AMB/ GYN | AMB/ GYN | AMB/ GYN | AMB/ GYN | AMB/ GYN | AMB/ GYN | AMB/ GYN | |
| **TVS** | 67 | | 84 | 102 | 84 | 109 | 74 | 107 | 89 | 93 | 108 | 98 | 83 | **1098** |
| **Hysteroscopy – Diagnostic** | 8 | | 8 | 13 | 12 | 19 | 8 | 10 | 12 | 9 | 19 | 20 | 12 | **150** |
| **Hysteroscopy – Operative** | 0 | | 0 | 3 | 0 | 0 | 1 | 0 | 1 | 1 | 0 | 3 | 0 | **9** |
| **Biopsy** | 22 | | 36 | 57 | 28 | 46 | 47 | 58 | 44 | 56 | 54 | 55 | 32 | **535** |
| **Mirena – In** | 15 | | 16 | 14 | 9 | 14 | 12 | 24 | 16 | 17 | 24 | 26 | 31 | **218** |
| **Mirena – Out** | 7 | | 9 | 7 | 9 | 8 | 5 | 8 | 8 | 9 | 12 | 11 | 12 | **105** |
| **Bloods taken** | | | | | | | 9 | 11 | 17 | 20 | 24 | 24 | 16 | **121** |
| **NEW** | 78 | | 83 | 92 | 62 | 86 | 64 | 83 | 86 | 107 | 102 | 102 | 72 | **1017** |
| **REVIEW** | 16 | | 18 | 27 | 14 | 24 | 31 | 31 | 21 | 32 | 36 | 45 | 54 | **349** |
| **DNA** | 17 | | 14 | 18 | 17 | 14 | 18 | 15 | 32 | 33 | 22 | 4 | 12 | **216** |

# Section 3: Gynaecology
# *(b) Colposcopy Service*

Ms Ita Lynskey Clinical nurse Manager 2, Dr Ulrich Bartels Consultant Obstetrician & Gynaecologist

There were 1475 appointments issued by the Colposcopy clinic in 2019, of which 675 were first appointments. 470 new patients attended. The DNA (Did-Not-Attend) rate was 9.8% amongst first visits and 13% for follow up appointments. Our over-all DNA rate was 11.4%, This rate is slightly above the target set by Cervical Check at 10%. However we are pleased that the service of reminders by text message which was commenced 30th November 2015 to the Colposcopy service in Mayo University Hospital has continued to prove successful.

The waiting times for a Colposcopy appointment at the clinic is 1 - 2 week in respect of urgent referral, 4 weeks for high grade cell changes on smear results and within 8 weeks for low grade cell changes on smear results. This is within the target standard set by Cervical Check.

As a result of the Cervical Check Screening crisis of April 2018 which also affected the year 2019, our Colposcopy service continued to receive a large volume of calls from worried concerned women as a result of the media coverage. There was also a delay of smear results been processed by laboratories thus delaying in obtaining results to the Colposcopy service. This added to the anxiety and concern for women. The HSE and Cervical Check programme has reiterated its deepest apologies to women for any worry caused by this situation. Cervical Check continued to update their website with key information regarding the Cervical Check crisis for women and health professionals which was most helpful. As a result we were able to reassure women, alleviate their concerns, while assuring them of the effectiveness of cervical screening programme.

Combined Cytology and High Risk HPV test continues to be provided by Med Lab Pathology up until April 2019. Then the Coombe Laboratory Pathology, Dublin took over this roll. For all women post treatment at six months and if negative are discharged for follow up by GP for 1 smear test in 12 months. The management of low grade abnormalities continues with Combined Cytology and High Risk HPV test. If negative, patient are discharged for routine recall as part of Cervical Check Guidelines 2015. All this has helped greatly in the management of follow up women and has led to a reduction in the number of review appointments at the Colposcopy Service. Women attending Colposcopy Service are now more aware of HPV as a major cause of cervical cancer.

**Colposcopy Procedures 2019**

| Histology Result | Diagnostic Punch | Excision | Other | Total |
|---|---|---|---|---|
| Cervical Cancer | 1 | 3 | | 4 |
| Adenocarcinoma in situ / CGIN | 2 | 2 | 0 | 4 |
| CIN3 | 8 | 59 | 0 | 67 |
| CIN2 | 28 | 38 | 0 | 66 |
| CIN 1 | 57 | 22 | 0 | 79 |
| CIN Uncertain Grade | 1 | 0 | 0 | 1 |
| VAIN 3 | 0 | 0 | 0 | 0 |
| VAIN 2 | 0 | 0 | 0 | 0 |
| VAIN 1 | 0 | 0 | 0 | 0 |
| VIN 3 | 0 | 1 | 0 | 1 |
| VIN 2 | 0 | 0 | 0 | 0 |
| VIN 1 | 0 | 0 | 0 | 0 |
| HPV / cervicitis only | 47 | 5 | 0 | 52 |
| No CIN / No HPV (normal) | 93 | 13 | 0 | 106 |
| Inadequate | 3 | 0 | 0 | 3 |
| Result not Known | 0 | 0 | 0 | 0 |
| Other | 0 | 0 | 0 | 0 |
| **Total** | **240** | **143** | **0** | **383** |

Histology services continue to be provided by Mayo University Hospital laboratory. A total of 383 biopsies were preformed of which 240 were diagnostic cervical punch biopsies. There were 143 excision biopsy (LLETZ treatment. 83.2% of the LLETZ treatment had CIN on the histology which meets Cervical Check standard (>80%). There were 5 new cases of cervical cancer seen in the Colposcopy clinic in 2019. 3 were Squamous cell carcinoma of the cervix and 2 were Adenocarinoma.

Multi-Disciplinary Team meetings between the clinical staff from the Colposcopy service, Histology laboratory and Med Lab Laboratory were held regularly using the Go-to-meeting software. Monthly, quarterly and annual Colposcopy activity reports were generated and submitted to Cervical Check.

Training and ongoing professional development of both medical, and nursing continues within the Colposcopy service. One of the Doctors has commenced her Colposcopy training to obtain accreditation as a BSCCP Colposcopist . Practice nurses from the primary care services continue to attend the Colposcopy clinic as part of their cervical screening smear takers course given by Cervical Check. Quality cervical smear-taking training is central to an effective national screening programme. Ongoing clinical education continues both to the Medical and Midwifery students who attend the Colposcopy clinic as part of their professional training from UCHG.

# Section 4: Allied Clinical Services
# *(a) Medical Social Work Department Report*

Ms Ann Doherty Senior Medical Social

## Team
The Medical Social Work Department of Mayo University Hospital comprises of 3.8 WTE posts which includes a Principal Medical Social Worker and a Clerical Officer. Our team provides a medical social work service across all ages and all hospital divisions. We have a duty system in operation to cover high priority cases across the hospital. The Medical Social Work Department of Mayo University Hospital supports the emotional and social well-being of patients and their families attending the Women & Children's Health Division from initial referral through to patient discharge.

## Standards pertaining to Professional Practice
Every Social Worker is registered with CORU.

## Obstetrics and Gynaecology
As part of our support to women and children we often provide individual counselling and practical advice around issues such as domestic violence, rape, teenage pregnancy, mental health and relationship issues or where there are drug or alcohol misuse concerns.

Emotional support is also offered when a pregnancy is complicated by foetal anomaly. When a baby in Mayo University Hospital is diagnosed with a very severe foetal abnormality that is going to lead to death of the baby at birth or very shortly afterwards, we offer non directive counselling support throughout the pregnancy and advise of and liaise with supports in the community to enable parents navigate the daily challenges inherent with having such a sad diagnosis.

## Special Care Baby Unit
On the Special care Baby Unit we regularly support families whose baby is admitted either due to prematurity or health problems.

We are aware of the impact of difficult diagnoses for families and counselling support is offered. Information and support are provided to ensure the smooth transition of a baby from hospital to home.

Crisis intervention and counselling to support families coping with life changes associated with illness and hospitalisation, premature birth, diagnosis of long term illness, fetal abnormality. We work closely with families to enhance coping skills and participation in care, supporting attachment and bonding with caregivers and children.

## Paediatrics
We work as part of the multidisciplinary care team on the Paediatric Ward focusing on family-centred care. We offer crisis intervention and counselling to support families coping with life changes associated with illness and hospitalisation. Our Department offers advocacy and support with accessing community supports and services.

As we are all designated officers under child protection legislation we are all responsible for the protection of children identified as either suffering or likely to suffer, significant harm as a result of abuse or neglect. Medical social workers assist staff fulfil their obligations under mandatory reporting legislation.We attend pre-birth case conferences and liaise with Tusla social workers regarding child protection care plans for new born infants. Assessments are also made where there are concerns in relation to underage sexual activity.

The MSW Department has active representation on the Saolta Children First Implementation Committee, as well as the hospital's committee on Children First.

## Emergency Department
Our Social Workers in the Women and Children's Directorate have responsibility to provide support to the Emergency Department where reasonable grounds for concern exist regarding the protection and welfare of children, under 18 years of age.

## Student Training
Our experienced Social Work team continues to provide support to the Masters in Social Work Programme by acting as practice Teachers and providing placement opportunities for 1st and 2nd year students from NUIG.

## Training
Our Department collaborates with colleagues from the Centre of Nursing and Midwifery Education in the design and provision of inter-professional education programmes to support professionals and as such The MSW for Women and Children provides yearly education and training in the Centre of Nursing and Midwifery Education on:

- Domestic and Sexual Abuse Disclosure
- Bereavement and Loss in early Pregnancy
- Receiving and Responding to Disclosures of Domestic Violence and Sexual Abuse in Pregnancy.
- Childhood Bereavement and Loss; Empowering Families and Health Care Professionals.
- The MSW is currently collaborating with the CNME around the development of an inter-professional training day called 'Creating Memories: Loss in Pregnancy and Childhood Master class.

## Stress Control Programme
Our Principal Medical Social Worker Seamus Moran co-facilitates a six week programme for patients and staff incorporating basics of a Cognitive Behavioural approach to managing the inevitable stress in our lives.

## Conclusion
As always we would like to acknowledge the support and inter-disciplinary relationship we have with our colleagues in Obstetrics & Gynaecology, Maternity, Labour, Special Care Baby Unit, the Ante natal department, Ante natal education, Chaplaincy and Paediatrics that ensures a consistant and integrated approach in the delivery of a high quality of care and compassion to our patients and their families. We would also like to acknowledge the close working interdisciplinary relationship with community services that enable a continuity of care for our clients from hospital to community. A special mention to our colleagues in the Centre of Nursing and Midwifery Education Mayo/Roscommon whom we partner with in some areas of work; a professional partnership built on the foundations of understanding and respecting one another's complimentary expertise, to achieve best outcomes.

# Section 4: Allied Clinical Services
# *(b) Physiotherapy Report*

Ms Ogechi Nsoedo Senior Physiotherapis

## Women's Health Physiotherapy

Women's Health physiotherapy is a specialist clinical area and all urogynaecological referrals from the county are treated in Mayo University Hospital. Referral levels remained consistent with a total number of 414 referrals received for outpatient care in 2019.

The service was delivered by 0.4WTE Senior Physiotherapist and 0.5 staff physiotherapist.

In 2019, there were significant waiting lists due to delay in replacement of our senior Women's health physiotherapist who was on secondment as the physiotherapy Manager. Our pelvic floor group education classes continued to help manage the waiting lists.

In total there were 298 new patients seen and 897 interventions delivered by the physiotherapy department in Mayo University Hospital.

The Post Natal education programme has been running successfully for three years in the local Primary Care Centre. This education is a two part programme which addresses the health and well-being needs of new mums in line with the National Maternity Strategy. The feedback on the content, timing and location of the education has remained positive.

The physiotherapy service was unable to deliver on the antenatal education programme throughout 2019.

## Paediatric Physiotherapy Service.

This service is currently being delivered by a staff physiotherapist 0.8WTE

### The inpatient service includes:

- Paediatric ward,
- Special Care Baby Unit
- Maternity ward
- Cystic Fibrosis service to inpatients (Delivered by a Senior -CF and ICU),

### The outpatient service includes:

- Follow up on referrals from maternity ward and SCBU e.g. Foot anomalies (Talipes Calcanoevalgus/ Equinovarus), Obstetric Brachial Plexus Lesions, Torticollis and Developmental issues.
- Developmental Delay referrals from Consultants, Public Health Nurses.
- Paediatric Normal Variance referrals across Co Mayo.
- Physiotherapy referrals for all paediatric musculoskeletal and orthopaedic referrals aged 0-12 years across Co Mayo.
- Exercise testing/ shuttle testing
- CF outpatients, CF clinics and annual assessments to meet standards of international best practice.
- Asthma clinics
- Liaison with PCCC paediatric services regarding transfer of appropriate infants and children to other services.

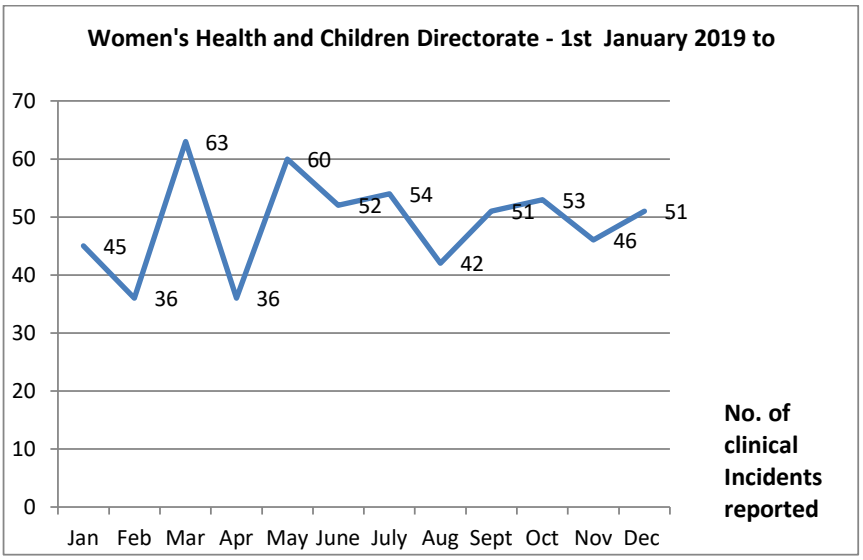
There were 398 referrals received for outpatient paediatric physiotherapy in 2019.

| 2019 | New patients seen | Physiotherapy treatments |
|---|---|---|
| Inpatient Paediatric | 88 | 323 |
| Outpatient Paediatric | 469 | 847 |
| CF outpatients | 41 | 46 |
| Asthma Clinic | 272 | 272 |
| Paediatrics (Maternity Ward) | 29 | 31 |

# Section 4: Allied Clinical Services
## *(c) Quality & Patient Safety Department*

Women's Health and Children Directorate meetings continue to be held on a monthly basis in Mayo University Hospital with a set Agenda for review and discussions at these meetings to include Patient Experience and Midwifery Standards, Positive feedback, Complaints, Incidents, Risk Register items, scheduled care, unscheduled care, Key performance Objectives and Achievements, Resources finance report and appropriate actions taken as agreed at these meetings.

**Women's Health and Children Directorate – 1st January 2019 to 31st December 2019**



# Section 5: Academic Report
# *(a) Women's & Children's Directorate Academic Report*

Prof Michael B O'Neill Consultant Paediatrician
Associate Clinical Lead NDTP for Saolta Group (MUH, SUH, LUH)

## Introduction

Both undergraduate and postgraduate education for trainees in Obstetrics and Paediatrics is provided at Mayo University Hospital. At an undergraduate level, medical students from NUIG attend the Medical Academy based in Castlebar, for 4-week rotations during the Academic year.

The Departments of Paediatrics and Obstetrics also offer rotations to students from UCD as well. These rotations reflect 25% of the student's clinical expose to these specialties. Both departments also accept, on an individual request basis, medical students from German universities which number 2 to 3 students in each department per year.

At a postgraduate level the Department of Paediatrics has 7 SHOs (of whom 3 are Basic Specialist Trainees from the National Paediatric Program, 2 are Family Practice trainees, 1 International paediatric trainee and 1 stand-alone post). This year Mayo University Hospital has taken a lead role in training the first international paediatric trainee from the Kingdom of Saudi Arabia. The Paediatric complement of NCHDs is modified depending on trainee numbers and preferences. The Registrar complement is 7 (2 SPR and 5 Registrars).

The Department of Obstetrics maintains a complement of 6 SHO (of whom 2 are BST and4 are Family Practice trainees). There are 6 registrars (2 SPRs and 4 Registrars) and 1 associate specialist.

The educational component consists of structured educational Handover rounds both in Obstetrics and Paediatrics on a daily basis. These structured handovers facilitate both enhanced patient care in terms of safety, and continuity of care (in an environment where being European Working Time Directive Compliant is required), while providing clinically relevant education in terms of decision making. In the Paediatric service with the advent of the Paediatric Decision Unit (PDU), in conjunction with the inpatient service and introduction of the SAFE program, the handover process has been furthered refined to now include a Safety Huddle.

### The Paediatric Educational timetable

| Monday | Tuesday | Wednesday | Thursday | Friday |
|---|---|---|---|---|
| X ray conference 2/month Dr M Browne 8.30-9.00 am | Emergency Department Drills by Liz Casey 8.00-9.00 am Weekly | Paediatrics Dr O'Neill 8.00-9.00 am Weekly | Perinatal Meeting Weekly Paediatric Consultant Group 8.00-8.30 am | Dr Stokes 9.30 -10.00 Journal Club, Case presentations, Community paediatric topics |
| Educational Handover Round 9.00-10.00 All Consultants in attendance | Educational Handover Round 9.00-10.00 All Consultants in attendance | Educational Handover Round 9.00-10.00 All Consultants in attendance | Educational Handover Round 9.00-10.00 All Consultants in attendance | Educational Handover Round 9.00-9.30 All Consultants in attendance. |
| Monday 1.00-2.00pm Dr Stokes Tutorial (1/month) | | SPR Tutorial 1.00-2.00pm Dr O'Neill (3/month) | | Dr O'Neill 12.30 -1.00pm Clinical Slides (2/month) |
| | GP half day release weekly | | BST day release 8 per year SPR day release 8 per year | |

### The Obstetrical Educational timetable

| Monday | Tuesday | Wednesday | Thursday | Friday |
|---|---|---|---|---|
| Educational Handover Round 8.00-9.15 All Consultants in attendance | Educational Handover Round 8.00-9.00 All Consultants in attendance | Educational Handover Round 8.00-9.00 All Consultants in attendance | Educational Handover Round 8.00-9.00 All Consultants in attendance | Educational Handover Round 8.00-9.15 All Consultants in attendance |
| | | | | Structured Teaching for BST and SPR trainees 10.30-12.00 |
| | | | Obstetric Drills 15.30-16.00 | |
| | | GP half day Release | | |

## Academic and Educational outputs for 2019

### A) Department of Paediatrics.

#### Prof Michael O'Neill

1) Associate Dean Basic Specialist Training Paediatrics RCPI
2) NDTP Clinical Lead Saolta (for Mayo University Hospital, Sligo University Hospital and Letterkenny University Hospital)
3) International Paediatric Residency Training Lead Program RCPI (member)
4) Clinical Lead Department of Paediatrics Mayo University Hospital
5) Examiner for MRCPI (Paediatrics)

#### Dr Hilary Stokes

1) Associate Clinical Director Women's and Children Mayo University Hospital
2) Head of Department, Paediatrics, Mayo University Hospital

#### Dr Asaad Elabbas

1) Strand Lead Paediatrics Mayo Medical Academy, Mayo University Hospital

### B) Department of Obstetrics and Gynaecology

#### Dr Méabh Ni Bhuinneain

1) Dean of Medical Education, Mayo Medical Academy, MUH
2) National Specialty Director Obstetrics (BST), RCPI
3) Member - Severe Maternal Morbidity Review Group, National Perinatal Epidemiology Centre
4) Member - ESTHER Ireland Steering Group, HSE Global Health Program

#### Dr Ulrich Bartels

1) Lead Colposcopist (MUH)
2) Member of the consultant board of the Irish Doctors for the Environment www.ide.ie

#### Dr Hilary Ikele

1) Clinical lead – Department of Women's Health, Mayo University Hospital
2) Member Executive Council Institute of Obstetrician and Gynaecologist RCPI

### C) Obstetrical Anaesthesia (Dept of Anaesthesia)

#### Dr Michelle Duggan

1) Lead Consultant Obstetrical Anaesthesia
2) Perioperative medicine and Critical Care strand Lead
3) Examiner College of Anaesthetists
4) Anaesthesia editor Irish Journal of Medical Science

#### National Presentations

1. Ali, M.E., Salama, M., **O'Neill, M.B.** Lumbar puncture performance and the paediatric patient, one hospital's experience. Euro paediatrics Dublin June 2019
2. Canty, N., Elbadry, M., Reidy, B., Stokes, H., **O'Neill, M.B.** Incident Reporting and the non-consultant hospital doctor in a general hospital. Euro paediatrics Dublin June 2019
3. Canty, N., Branaghan, A. O'Halloran,E., **O'Neill, M.B.** Partial Trisomy. Euro paediatrics Dublin June 2019
4. Kasha,S., Hamid A., Fox, B., **O'Neill, M.B.**, Antenatal corticosteroid therapy;to determine the level of adherence to protocol in preterm neonates.
5. Branaghan, A. O'Halloran,E., Canty, N., **O'Neill M.B., Stokes, H.,** Children with eating disorders presenting to non-tertiary paediatric units in Ireland – a case series. Euro paediatrics Dublin June 2019
6. O'Halloran,E., Branagan, A., Canty, N., **O'Neill M.B., Stokes, H.,**Conversion disorder, don't be mistaken, don't be misled. Euro paediatrics Dublin June 2019
7. Hassan, M., **O'Neill, M.B,** O'Halloran, E., Jaralla, H., McDonnell, C. When less is more: a case of adrenal suppression secondary to topical corticosteroid overuse. Euro paediatrics Dublin June 2019
8. Canty, N., Branaghan, A. O'Halloran,E., **Stokes, H., O'Neill, M.B.** In pursuit of a wandering spleen. Euro paediatrics Dublin June 2019
9. **Stokes H.,** Hamid, A., Kasha, S., Branagan, A., Leukaemia cutis: a rare manifestation of acute lymphoblastic leukaemia. Euro paediatrics Dublin June 2019
10. Salama, M., Stanciu, C., Ullah, B., **Leshwiti, J.,** and Antibiotic Stewardship: determining the extent of E.Coli resistance to co-amoxiclav in children with urinary tract infection in Mayo University Hospital. Euro paediatrics Dublin June 2019
11. Deliu. A.G., Cotter, M., **Letshwiti, J.B.** Rare case of severe thrombocytopenia at birth associated with rhesus disease of the newborn. Euro paediatrics Dublin June 2019

#### Invited National Presentations

1. **O'Neill M.B.** Clinical Incidents and the NCHD: Moving from Inaction to Enaction. National Treasury Management Agency (States Claims Agency) .Dublin November 2019-

# *Portiuncula University Hospital*

## Section 1: Maternity

## *(a) Statistical Summary*

| | Primigravida | Multigravida | Total |
|---|---|---|---|
| Total Number of Mothers | 510 | 999 | 1509 |
| Total Number of Babies | 517 | 1012 | 1529 |
| >24 weeks or >/= 500g | | | |

**Obstetric Outcomes:**

| | Primigravida | Multigravida | Total |
|---|---|---|---|
| Total Number of Mothers | 510 | 999 | 1509 |
| Total Number of Babies | 517 | 1012 | 1529 |
| >24 weeks or >/= 500g | | | |

| | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 |
|---|---|---|---|---|---|---|---|---|---|---|
| Number of Mothers | 2150 | 2106 | 2026 | 2017 | 1946 | 1853 | 1779 | 1644 | 1584 | 1590 |
| Number of Babies | 2186 | 2148 | 2055 | 2052 | 1982 | 1883 | 1817 | 1664 | 1602 | 1529 |

| Obstetric Outcomes (Mothers) | Primigravida | % | Multigravida | % | Total | % |
|---|---|---|---|---|---|---|
| | 510 | | 999 | | 1509 | |
| Induction of Labour | 183 | 35.9% | 228 | 22.8% | 411 | 27.2% |
| Augmentation | 20 | 3.9% | 28 | 2.8% | 48 | 3.2% |
| No Analgesia | 10 | 2.0% | 84 | 8.4% | 94 | 6.2% |
| Epidural Rate | 296 | 58.0% | 287 | 28.7% | 583 | 38.6% |
| Episiotomy | 189 | 37.1% | 80 | 8.0% | 269 | 17.8% |
| Caesarean Section | 216 | 42.4% | 369 | 36.9% | 585 | 38.8% |
| Spontaneous Vaginal Delivery | 159 | 31.2% | 571 | 57.2% | 730 | 48.4% |
| Forceps Delivery | 23 | 4.5% | 1 | 0.1% | 24 | 1.6% |
| Ventouse Delivery | 112 | 22.0% | 56 | 5.6% | 168 | 11.1% |
| Breech Delivery | 0 | 0.0% | 2 | 0.2% | 2 | 0.1% |

| Obstetric Outcomes (Babies) | Primigravida | % | Multigravida | % | Total | % |
|---|---|---|---|---|---|---|
| Spontaneous Vaginal Delivery | 159 | 30.8% | 573 | 56.6% | 732 | 47.9% |
| Forceps Delivery | 23 | 4.4% | 1 | 0.1% | 24 | 1.6% |
| Ventouse Delivery | 112 | 21.7% | 57 | 5.6% | 169 | 11.1% |
| Breech Delivery (Singleton) | 0 | 0.0% | 2 | 0.2% | 2 | 0.1% |
| Breech Delivery (1st Twin) | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% |
| Breech Delivery (2nd Twin) | 1 | 0.2% | 1 | 0.1% | 2 | 0.1% |
| Caesarean Section (Babies) | 222 | 42.9% | 378 | 37.4% | 600 | 39.2% |
| **Total** | **517** | **100.0%** | **1012** | **100.0%** | **1529** | **100.0%** |

**Multiples:**

| | Primigravida | Multigravida | Total |
|---|---|---|---|
| Total Number of Mothers | 510 | 999 | 1509 |
| Total Number of Babies | 517 | 1012 | 1529 |

| Multiple Pregnancies | Primigravida | % | Multigravida | % | Total |
|---|---|---|---|---|---|
| Twins | 7 | 1.4% | 13 | 1.3% | 20 |

| Multiple Pregnancies by year | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 |
|---|---|---|---|---|---|---|---|---|---|---|
| Twins | 36 | 42 | 29 | 35 | 36 | 30 | 38 | 19 | 18 | 20 |
| **Total** | **36** | **42** | **29** | **35** | **36** | **30** | **38** | **19** | **18** | **20** |

| Perinatal Mortality | Primigravida | Multigravida | Total |
|---|---|---|---|
| Total Number of Mothers | 510 | 999 | 1509 |
| Total Number of Babies | 517 | 1012 | 1529 |
| >24 weeks or >/= 500g | | | |

| Perinatal Deaths | Primigravida | Multigravida | Total | % |
|---|---|---|---|---|
| Stillbirths | 0 | 8 | 8 | 0.52% |
| Early Neonatal Deaths | 0 | 0 | 0 | 0.00% |

| Perinatal Mortality Rate | 2015 | 2016 | 2017 | 2018 | 2019 |
|---|---|---|---|---|---|
| Stillbirth rate (per 1,000) | 4.8 | 6.1 | 5.4 | 6.2 | 5.2 |
| Neonatal Death rate (per 1,000) | 2.1 | 1.1 | 0.6 | 0.0 | 0.0 |
| Overall PMR per 1,000 births | 6.9 | 7.2 | 6.0 | 6.2 | 5.2 |

| Parity: | Primigravida | Multigravida | Total |
|---|---|---|---|
| Total Number of Mothers | 510 | 999 | 1509 |
| Total Number of Babies | 517 | 1012 | 1529 |

| Parity by year | 2015 | 2016 | 2017 | 2018 | 2019 |
|---|---|---|---|---|---|
| 0 | 35.0% | 31.4% | 32.2% | 34.4% | 33.8% |
| 1,2,3 | 62.0% | 65.0% | 63.7% | 61.8% | 62.6% |
| 4+ | 3.0% | 3.6% | 4.1% | 3.8% | 3.6% |

| Parity | Number | % |
|---|---|---|
| Para 0 | 510 | 33.8% |
| Para 1 | 519 | 34.4% |
| Para 2 | 311 | 20.6% |
| Para 3 | 114 | 7.6% |
| Para 4 | 31 | 2.1% |
| Para 5 | 14 | 0.9% |
| Para 6 | 3 | 0.2% |
| Para 7 | 3 | 0.2% |
| Para 8 | 3 | 0.2% |
| Para 9 | 1 | 0.1% |
| Para 10 | 0 | 0.0% |
| **Total** | **1509** | **100.0%** |

| Age: | Primigravida | Multigravida | Total |
|---|---|---|---|
| Total Number of Mothers | 510 | 999 | 1509 |
| Total Number of Babies | 517 | 1012 | 1529 |
| >24 weeks or >/= 500g | | | |

| Age | Primigravida | % | Multigravida | % | Total | % |
|---|---|---|---|---|---|---|
| <15 years | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% |
| 15-19 years | 7 | 1.4% | 2 | 0.2% | 9 | 0.6% |
| 20-24 years | 56 | 11.0% | 28 | 2.8% | 84 | 5.6% |
| 25-29 years | 99 | 19.4% | 131 | 13.1% | 230 | 15.2% |
| 30-34 years | 192 | 37.6% | 284 | 28.4% | 476 | 31.5% |
| 35-39 years | 129 | 25.3% | 402 | 40.2% | 531 | 35.2% |
| >40 years | 27 | 5.3% | 152 | 15.2% | 179 | 11.9% |
| **Total** | **510** | **100.0%** | **999** | **100.0%** | **1509** | **100.0%** |

| Age @ Booking | 2015 | 2016 | 2017 | 2018 | 2019 |
|---|---|---|---|---|---|
| <15 years | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% |
| 15-19 years | 2.1% | 0.9% | 1.4% | 1.1% | 0.6% |
| 20-24 years | 7.8% | 7.8% | 8.3% | 6.2% | 5.6% |
| 25-29 years | 17.0% | 14.6% | 15.9% | 15.6% | 15.2% |
| 30-34 years | 37.5% | 30.9% | 35.3% | 32.0% | 31.5% |
| 35-39 years | 29.9% | 36.4% | 32.8% | 34.3% | 35.2% |
| >40 years | 5.7% | 9.4% | 6.4% | 10.8% | 11.9% |
| **Total** | **100.0%** | **100.0%** | **100.0%** | **100.0%** | **100.0%** |

| Origin: | Primigravida | Multigravida | Total |
|---|---|---|---|
| Total Number of Mothers | 510 | 999 | 1509 |
| Total Number of Babies | 517 | 1012 | 1529 |
| >24 weeks or >/= 500g | | | |

| County of Origin | 2015 | 2016 | 2017 | 2018 | 2019 |
|---|---|---|---|---|---|
| Sligo | | | 0.1% | | 0.0% |
| Leitrim | 0.5% | 0.4% | 0.5% | 0.5% | 0.2% |
| Mayo | | | 0.3% | 0.5% | 0.1% |
| Roscommon | 20.7% | 21.7% | 20.5% | 21.1% | 25.1% |
| Cavan | | | | 0.3% | 0.0% |
| Galway | 33.9% | 35.1% | 35.8% | 35.2% | 33.9% |
| Longford | 1.3% | 1.5% | 1.8% | 1.5% | 1.8% |
| Dublin | | 0.1% | | | 0.1% |
| Westmeath | 20.5% | 18.8% | 20.3% | 21.2% | 17.4% |
| Offaly | 15.4% | 16.1% | 15.2% | 13.6% | 17.0% |
| Clare | 0.5% | 0.6% | 0.7% | 0.5% | 0.4% |
| Meath | | | 0.1% | | 0.0% |
| Tipperary | 5.5% | 5.2% | 4.2% | 4.5% | 3.8% |
| Others | 1.7% | 0.5% | 0.50% | 1.1% | 0.3% |
| **Total** | **100.0%** | **100.0%** | **100.0%** | **100.0%** | **100.0%** |

| Gestation: | Primigravida | Multigravida | Total |
|---|---|---|---|
| Total Number of Mothers | 510 | 999 | 1509 |
| Total Number of Babies | 517 | 1012 | 1529 |
| >24 weeks or >/= 500g | | | |

| Gestation at Delivery | Primigravida | % | Multigravida | % | Total | % |
|---|---|---|---|---|---|---|
| <24 weeks | 1 | 0.2% | 0 | 0.0% | 1 | 0.1% |
| 24-27 weeks | 0 | 0.0% | 3 | 0.3% | 3 | 0.2% |
| 28-31 weeks | 0 | 0.0% | 4 | 0.4% | 4 | 0.3% |
| 32-36+6 weeks | 25 | 4.9% | 45 | 4.5% | 70 | 4.6% |
| 37-40 weeks | 375 | 73.5% | 800 | 80.1% | 1175 | 77.9% |
| 41 weeks+ | 109 | 21.4% | 147 | 14.7% | 256 | 17.0% |
| **Total** | **510** | **100.0%** | **999** | **100.0%** | **1509** | **100.0%** |

| Gestation at Delivery | 2017 | 2018 | 2019 |
|---|---|---|---|
| <24 weeks | 0 | 1 | 1 |
| 24-27 weeks | 1 | 3 | 3 |
| 28-31 weeks | 3 | 4 | 4 |
| 32-36+6 weeks | 73 | 84 | 70 |
| 37-40 weeks | 1201 | 1219 | 1174 |
| 41 weeks+ | 366 | 273 | 256 |
| **Total** | **1644** | **1584** | **1509** |

| Birth Weight: | Primigravida | Multigravida | Total |
|---|---|---|---|
| Total Number of Mothers | 510 | 999 | 1509 |
| Total Number of Babies | 517 | 1012 | 1529 |
| >24 weeks or >/= 500g | | | |

| Birth Weights | Primigravida | % | Multigravida | % | Total | % |
|---|---|---|---|---|---|---|
| <500g | 1 | 0.2% | 0 | 0.0% | 1 | 0.1% |
| 500 - 999g | 1 | 0.2% | 2 | 0.2% | 3 | 0.2% |
| 1000 - 1999g | 8 | 1.5% | 12 | 1.2% | 20 | 1.3% |
| 2000 - 2999g | 96 | 18.6% | 151 | 14.9% | 247 | 16.2% |
| 3000 - 3999g | 344 | 66.5% | 695 | 68.7% | 1039 | 68.0% |
| 4000 - 4499g | 57 | 11.0% | 124 | 12.3% | 181 | 11.8% |
| 4500 - 4999g | 10 | 1.9% | 28 | 2.8% | 38 | 2.5% |
| 5000 - 5499g | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% |
| **Total Number of Babies** | **517** | **100.0%** | **1012** | **100.0%** | **1529** | **100.0%** |

| Birth Weights by year | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 |
|---|---|---|---|---|---|---|
| < 500g | 6 | 12 | 3 | 0 | 1 | 1 |
| 500 - 999g | 4 | 2 | 1 | 2 | 2 | 3 |
| 1000 - 1999g | 23 | 19 | 26 | 15 | 20 | 20 |
| 2000 - 2999g | 263 | 256 | 256 | 225 | 250 | 247 |
| 3000 - 3999g | 1302 | 1247 | 1210 | 1130 | 1067 | 1039 |
| 4000 - 4499g | 319 | 276 | 272 | 241 | 220 | 181 |
| 4500 - 4999g | 59 | 61 | 46 | 46 | 37 | 38 |
| 5000 - 5499g | 5 | 7 | 2 | 5 | 5 | 0 |
| >5500g | 2 | 3 | 1 | 0 | 0 | 0 |
| **Total Number of Babies** | **1983** | **1883** | **1817** | **1664** | **1602** | **1529** |

| Inductions: | Primigravida | Multigravida | Total |
|---|---|---|---|
| Total Number of Mothers | 510 | 999 | 1509 |
| Total Number of Babies | 517 | 1012 | 1529 |
| >24 weeks or >/= 500g | | | |

| Induction of Labour | Primigravida | % | Multigravida | % | Total | % |
|---|---|---|---|---|---|---|
| 2009 | 228 | 26.6% | 238 | 17.7% | 466 | 20.9% |
| 2010 | 225 | 27.4% | 217 | 16.3% | 442 | 20.2% |
| 2011 | 227 | 29.5% | 200 | 14.9% | 427 | 19.9% |
| 2012 | 221 | 30.4% | 240 | 18.4% | 461 | 22.4% |
| 2013 | 233 | 32.0% | 279 | 22.0% | 512 | 25.0% |
| 2014 | 232 | 33.0% | 256 | 21.0% | 488 | 25.0% |
| 2015 | 224 | 35.0% | 260 | 21.0% | 484 | 26.0% |
| 2016 | 183 | 32.8% | 274 | 22.4% | 457 | 25.7% |
| 2017 | 202 | 38.5% | 254 | 22.7% | 456 | 27.7% |
| 2018 | 215 | 39.4% | 213 | 20.5% | 428 | 27.0% |
| 2019 | 203 | 39.8% | 256 | 25.6% | 459 | 30.4% |

| Perineal Trauma: | Primigravida | Multigravida | Total |
|---|---|---|---|
| Total Number of Mothers | 510 | 999 | 1509 |
| Total Number of Babies | 517 | 1012 | 1529 |
| >24 weeks or >/= 500g | | | |

| Perineal Trauma | Primigravida | % | Multigravida | % | Total | % |
|---|---|---|---|---|---|---|
| Number of vaginal deliveries | 294 | | 633 | | 927 | |
| Intact | 139 | 47.3% | 193 | 30.5% | 332 | 35.8% |
| Episiotomy | 190 | 64.6% | 80 | 12.6% | 270 | 29.1% |
| 2nd Degree Tear | 54 | 18.4% | 196 | 31.0% | 250 | 27.0% |
| 1st Degree Tear | 19 | 6.5% | 107 | 16.9% | 126 | 13.6% |
| 3rd Degree Tear | 8 | 2.7% | 10 | 1.6% | 18 | 1.9% |
| **Total** | **410** | | **586** | | **996** | |

| Episiotomy: | Primigravida | Multigravida | Total |
|---|---|---|---|
| Total Number of Mothers | 510 | 999 | 1509 |
| Total Number of Babies | 517 | 1012 | 1529 |
| >24 weeks or >/= 500g | | | |

| Incidence of Episiotomy | Total | % |
|---|---|---|
| 2015 | 350 | 29.8% |
| 2016 | 315 | 28.0% |
| 2017 | 339 | 32.2% |
| 2018 | 302 | 29.9% |
| 2019 | 270 | 29.2% |

| BBA – 3rd Stage - Dystocia: | Primigravida | Multigravida | Total |
|---|---|---|---|
| Total Number of Mothers | 510 | 999 | 1509 |
| Total Number of Babies | 517 | 1012 | 1529 |
| >24 weeks or >/= 500g | | | |

| B.B.A. | Primigravida | % | Multigravida | % | Total | % |
|---|---|---|---|---|---|---|
| 2009 | 0 | 0.0% | 6 | 45.0% | 6 | |
| 2010 | 1 | 0.1% | 8 | 1.0% | 9 | |
| 2011 | 1 | 13.0% | 1 | 0.1% | 2 | |
| 2012 | 0 | 0.0% | 5 | 0.4% | 5 | |
| 2013 | 1 | 0.1% | 7 | 0.5% | 8 | |
| 2014 | 0 | 0.0% | 5 | 0.4% | 5 | |
| 2015 | 0 | 0.0% | 7 | 0.6% | 7 | |
| 2016 | 0 | 0.0% | 3 | 0.2% | 3 | |
| 2017 | 0 | 0.0% | 5 | 0.4% | 5 | |
| 2018 | 2 | 0.4% | 7 | 0.7% | 9 | 0.6% |
| 2019 | 2 | 0.4% | 3 | 0.3% | 5 | 0.3% |

| 3rd Stage Problems | Primigravida | % | Multigravida | % | Total | % |
|---|---|---|---|---|---|---|
| Primary PPH (1000ml) | | 0.0% | | 0.0% | 47 | 3.1% |
| Manual Removal of Placenta | 13 | 2.5% | 23 | 2.3% | 36 | 2.4% |

| | Primigravida | % | Multigravida | % | Total | % |
|---|---|---|---|---|---|---|
| Shoulder Dystocia | 1 | 0.2% | 1 | 0.1% | 2 | 0.1% |

| Robson Groups: | Primigravida | Multigravida | Total |
|---|---|---|---|
| Total Number of Mothers | 510 | 999 | 1509 |
| Total Number of Babies | 517 | 1012 | 1529 |
| >24 weeks or >/= 500g | | | |

| Robson Groups | n-CS | n-Women | % |
|---|---|---|---|
| Group 1 - nullip singleton cephalic term spont labour | 44 | 232 | 19.0% |
| Group 2 - nullip singleton cephalic term induced or pre-labour CS | 139 | 243 | 57.2% |
| Group 3 - multip singleton cephalic term spont labour | 9 | 348 | 2.6% |
| Group 4 - multip singleton cephalic term induced or pre-labour CS | 45 | 259 | 17.4% |
| Group 5 - previous CS singleton cephalic term | 248 | 290 | 85.5% |
| Group 6 - all nulliparous breeches | 20 | 20 | 100.0% |
| Group 7- all multiparous breeches | 29 | 34 | 85.3% |
| Group 8 - all multiple pregnancies | 15 | 22 | 68.2% |
| Group 9 - all abnormal lies | 9 | 9 | 100.0% |
| Group 10 - all preterm singleton cephalic | 27 | 52 | 51.9% |
| **TOTAL** | **585** | **1509** | |

| | | |
|---|---|---|
| Outcome for women who went into Spontaneous/Induced Labour after 1 previous Caesarean Section | SVD | 18 |
| | Ventouse | 10 |
| | Forceps | 1 |
| | Total VBAC | 29 |
| | Emergency C.S. | 37 |

# Section 1: Maternity
# *(b) Director of Midwifery*

Ms Deirdre Naughton Director of Midwifery, Ms Anne Regan Associated Director of Midwifery,
Ms Melinda O'Rourke Interim Clinical Midwife Manager 2

## Introduction

The Women and Children's Directorate team in Portiuncula Hospital are pleased to present an overview of the clinical activity and services provided on site for 2019. A strong spirit of teamwork and the provision high quality evidence-based care has been the driving force of each member of the Maternity team throughout 2019. We take this opportunity to thank the dedicated team working within the department for their continued hard work and resilience in this difficult current climate.

## Clinical Activity

In 2019 we saw the reduction of births from 2018 of 4.7% with 1529 babies born to 1509 mothers; there has been a nationally consistent drop in birth rate observed in PUH since since 2009 has been a drop in birth rates year on year since 2009. This is in keeping with a reduction in birth trends nationally. We have the highest incidence in multiple births reported in 3 years albeit a modest increase at 20 births. It is noteworthy this is half of the number of incidences of twins born in PUH in 2011.

The mode of delivery for the majority of women was normal vaginal delivery at 48.5% with the caesarean section rate at 38.8%, a slight rise for the 2018 rate. Instrumental delivery rates for first time mothers are reduced by 4.4% from 2018; however it remained consistent with other years for the multigravida group. Our induction rate is reduced by 2.4% for primagravidas and increased by 4.3% for multigravidas. The age of which mothers are delivering is steadily increasing with 11.9% of women over the age of 40. The group of mothers aged between 35 and 39 years make up the highest proportion of deliveries at 35.2%. There are also an increasing number of diabetic women from 132 in 2018 to 147 diagnosed in 2019. There a continuing drop in the rate of women achieving vaginal birth following one previous caesarean section with 28 in 2019 compared with 59 in 2017 which requires further investigation.

The rate of primary postpartum haemorrhage of over 1000mls has markedly decreased from 7.3% in 2018 to 3.1% in 2019. Interestingly the rate of manual removal of placenta has increased from 0.8% to 2.4% in 2019. We have seen the rate of 3rd and 4th degree tears stay the same as well as the rate of episiotomy being unchanged. The number of babies born before arrival to the hospital has dropped from 9 babies in 2018 to 5 in 2019 and the number remains low in relation to overall births.

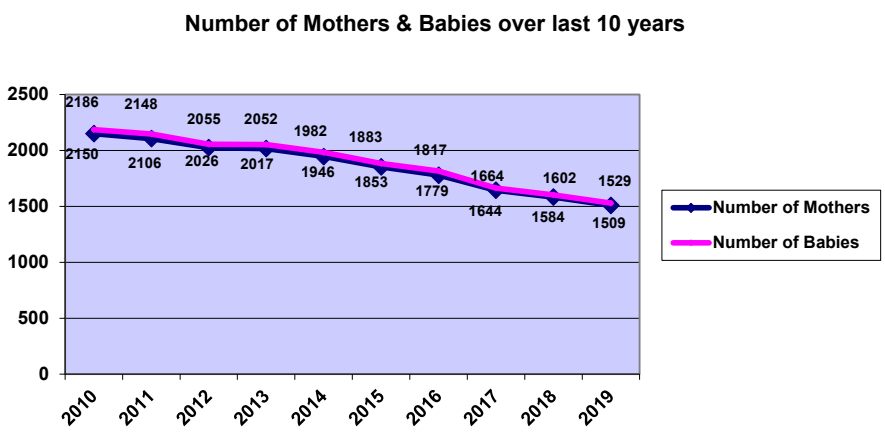
Birth weight and gestation at delivery are relatively unchanged, continuing the trend for reducing numbers in the >4000g category by 2% in 2019. The perinatal mortality rate was reduced from previous years to an overall perinatal mortality rate of 5.2 per 1,000 births a decrease from a rate of 6.2 per 1,000 births in 2018. When reviewing woman and infants born at Portiuncula Hospital we note that around 40% originate from outside the Saolta hospital group.

## Academic Achievements

- Two Midwives completed the Certificate in Nurse/Midwife Prescribing in NUIG.
- One SCBU Nurse completed the Neonatal Resuscitation Provider Trainer Course
- One SCBU Nurse is undertaking the Clinical Educator Postgraduate Diploma.
- A number of Midwives completed a Venepuncture and Cannulation Train-the-Trainer Course.
- One Midwife completed the eHealth Programme GMIT.
- One Midwife is undertaking a Masters in Obstetric Ultrasound UCD.

## Quality Initiatives

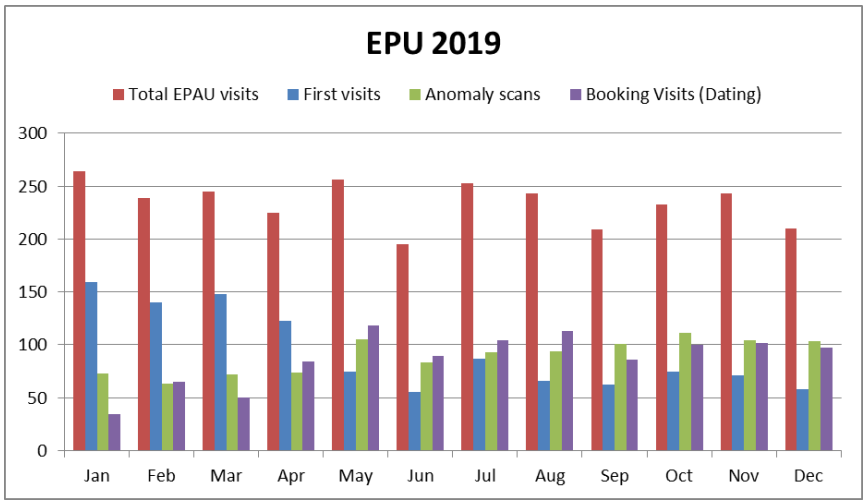
December 2019 saw the launch of our Maternity Euroking IT System as a quality improvement initiative. This IT system improves the standardisation and quality of data captured within our Maternity services. The Euroking also allows for greater efficiency and accessibility of statistics in regards to auditing clinical activity.




# Section 1: Maternity
# *(c) Early Pregnancy Unit (EPU) / Fetal Assessment Unit*

Ms Sheila Melvin Staff Midwife

EPU was established in early 2008 and is combined with the Fetal Assessment Unit, providing scheduled appointments as well as emergency and inpatient referrals. Ultrasound scans are performed by two clinical specialist sonographers, two midwife sonographers, two part time clinical specialist radiographers as well as a number of NCHDs. A fifth midwife is currently working in the unit whilst doing a Masters in Ultrasound. The unit is supported by one staff midwife and two clerical officers with the services of the Bereavement CMS available on request. The recently refurbished unit boasts 3 new scanning rooms along with new scanners and patient viewing monitors.




In 2019, a total of 6411 ultrasound scans were performed, including 2815 early pregnancy assessments, 1042 booking scans (dating) and 1076 detailed anomaly scans. Other scans included first visits and fetal assessment scans including, but not limited to; growth, dopplers, estimated fetal weights and placental location. Referrals to the unit come from GP services, A&E, antenatal clinic and the maternity ward.

# Section 1: Maternity
## *(d) The Bereavement Support Service*

Ms Joanne Kelly

The Loss of a baby at any stage during pregnancy or after birth is a tragic event and totally devastating for the parents and family concerned. Providing an empathetic, sensitive and caring environment to support couples and their families following a pregnancy loss is an integral part of the maternity service provided at Portiuncula Hospital.

In 2018 a designated bereavement Support Midwife was appointed, who is trained to care for and support women and families who suffer the loss of a baby. The bereavement support midwife offers immediate and long-term emotional support, information and practical guidance to couples who:

- Experience a miscarriage
- Experience a stillbirth or neonatal death
- Have an ongoing pregnancy with a poor prognosis
- Choose to have a termination of pregnancy for Abnormalities
- Have a subsequence pregnancy

The Bereavement support midwife understands that the parents of a baby who has died will be faced with many difficult decisions. She works closely with the multidisciplinary team to ensure joined up care for bereaved couples. She is someone consistent to whom parents can relate, and can explain all options and choices at a time of great difficulty and sadness. For Families, the bereavement support midwife is an identifiable person who can be contacted whenever they have questions or requests, or simply want to talk.

It is not possible for one individual to manage all issues relating to bereavement in a maternity unit. It is therefore important to ensure that all relevant staff members are equipped with the necessary knowledge to adequately respond to, and care for bereaved parents. To facilitate this we provide up to date bereavement care training for staff and best practice policies and procedures, to ensure that families and staff, are optimally supported.

The bereavement multidisciplinary team meets every two months with service user representatives invited. This facilitates shared decision making for all perinatal bereavement care.

In April 2019 the pregnancy loss website www.infantandpregnancyloss.ie was launched. This is a welcomed national online resource service for patients and staff.

Portiuncula hospital along with its Saolta group representatives are working on the national pathways of care for pregnancy loss and hope to develop a Saolta pregnancy loss pathway document. This will ensure that the care for women is standardised throughout the Saolta group in line with national recommendations.

Portiuncula hospital joined in the light up your building for pregnancy loss awareness day on the 15th of October 2019 staff gathered to light a candle in remembrance which was left in the front reception area of the hospital. In addition the hospital lit up blue and pink to raise awareness of pregnancy loss and the devastation it causes to families.

# Section 1: Maternity
## *(e) The Teen Support Programme*

The Teen Support Programme (TPSP) Outreach Service Galway provides services for young people who become Parents whilst aged 19 years or under. This service will provide support until their child reaches 2 years of age. This service is available to all young parents living in both Galway City and County. The programme is centrally located in University Hospital Galway and has an outreach service in Portiuncula University Hospital. It is managed by the Social Department and funded by the HSE West and Tulsa Child and Family Agency under the School Completion Programme.

Referrals are made from the Antenatal Services, Midwives and Social Work Department in Portiuncula Hospital. Since the service commenced 12 young people have been referred. The benefits of Midwifery lead care to the Teenagers are an individualised Ante Natal care package that provides a familiar face for the client. We also offer a tour of the Maternity Ward and the Labour Ward.

Our team is composed of Mary Finn (Social Worker) and Joanne Kelly (Staff Midwife) and complemented by the Ante Natal Midwifery team.

# Section 1: Maternity
# *(f) Community Midwives / Supported Care Antenatal Clinic*

Ms Aisling Dixon Clinical Midwife Manager 2, Ms Priscilla Neilan Quality Midwife Clinical Midwife Manager 3

This is the second annual report of the antenatal midwifery clinics since its introduction into the service at the end of 2017. The service has now completed two years as part of antenatal care provision and is accepted as a permanent and integral part of antenatal maternity care at Portiuncula Hospital.

Much of this success has been down to the support of the midwifery and obstetric staff within the hospital. The service has had the support of midwifery management from the onset and collaboration and support from the obstetric team with the midwives within the midwifery led service has enabled a safe and seamless review and transfer of care within the model of care pathways.

2019 has seen the addition of two midwives in a part time capacity to the team on a permanent basis. They share a passion for the philosophy of normality, expertise in midwifery, constant professionalism, willingness and flexibility which is integral to the success of the service. As each midwife works part of the week on the labour/postnatal ward, this means for some mothers it will increase their chances of further continuity of care throughout labour and or the postnatal period.

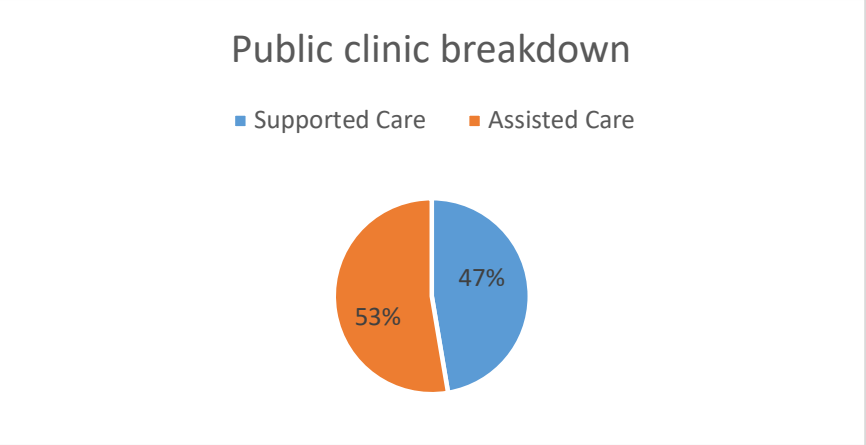
Central to the service is the mothers and babies whom we attend, their support for the service, their positive experiences and feedback is out greatest motivator. We look forward to the continued progress of the service into the intrapartum and post natal period with the aim of excellent user experiences throughout the continuum and optimal health outcomes for mothers and babies.

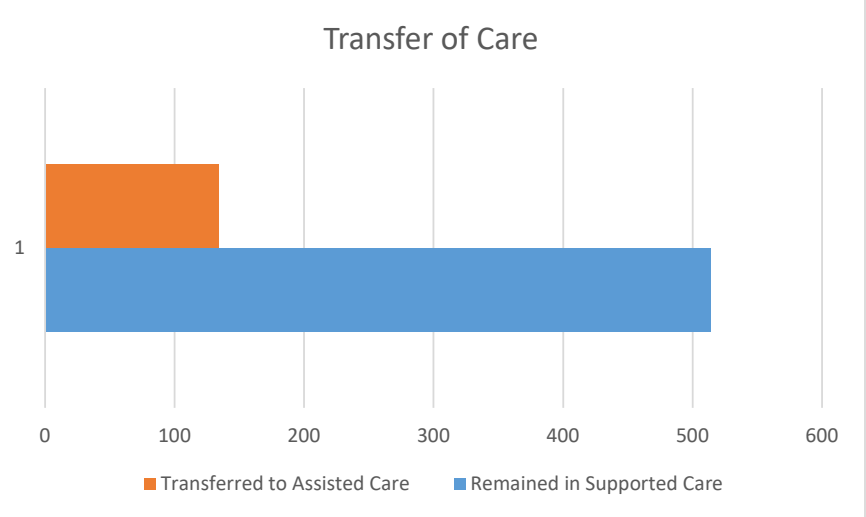
10 Antenatal clinics are facilitated on a weekly basis, mainly within the Outpatient department in Portiuncula but 3 are in the outreach site of Athlone and Loughrea. 4 of these clinics are run alongside an obstetric clinic where review and escalation can be facilitated.

## Antenatal Care pathways

A breakdown of Public Patients attending Portiuncula Maternity Service:

| | N | % |
|---|---|---|
| Supported Care | 648 | 47.3% |
| Assisted Care | 721 | 52.7% |
| Total | 1369 | 100% |



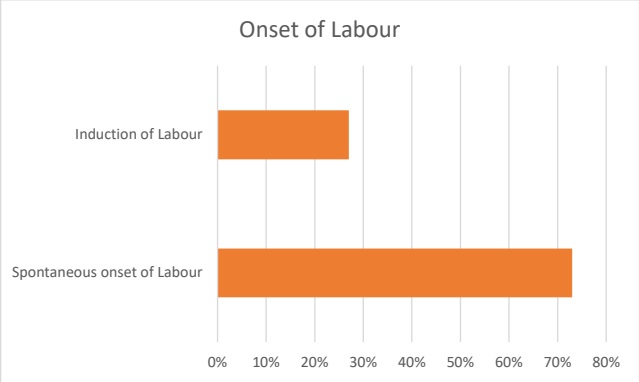



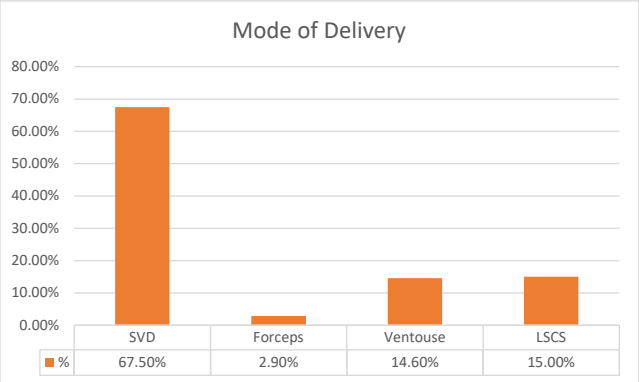

Major reasons for transfer out of the service are outlined below, other reasons include PV bleeding, Large for Gestational age, fetal abnormality, obstetric cholestasis and review for mode of birth.

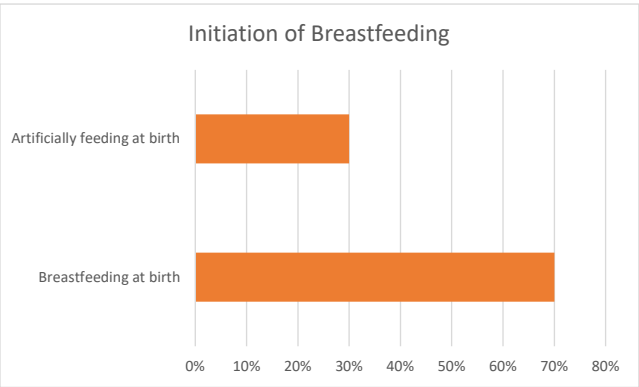
## Reasons for transfer

| | |
|---|---|
| SFD/IUGR | 19.40% |
| Liquor volume abnormality | 6.00% |
| Gestational Diabetes | 13.00% |
| Hypertensive | 9.70% |
| Placenta previa/low lying | 3.70% |
| Malpresentation | 8.20% |
| Transferred/Moved | 9.70% |

## Labour and Birth Outcomes:




## User experience feedback:

Over all experience of the Midwifery Clinics in Portiuncula clients reported their experience on a scale of 1 (Poor) and 10 (Excellent)

A high satisfaction rate (99.5%) of women felt they had enough time to discuss questions/concerns they may have had during their pregnancy visits with the midwife and 96.7% of mothers would recommend the midwifery Clinic to their friends and family.

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|
| 0.00% | 0.00% | 0.00% | 0.53% | 4.34% | 2.72% | 3.30% | 9.81% | 17.90% | 61.40% |

# Section 1: Maternity
# *(g) Specialised Antenatal Clinic Data 2019*

The specialised antenatal model of care commenced providing care in Portiuncula University Hospital in January 2019, the current clinic runs for 1 session per week and has a direct referral pathway to the Fetal medicine department in UHG.

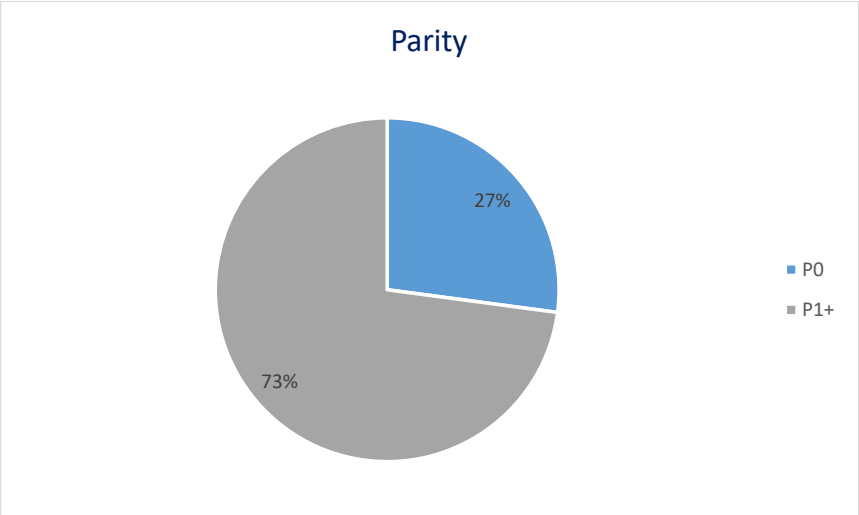
In total 59 mothers were referred to the Specialised Clinic in PUH in 2019. This is 3.8 % of all women who delivered in PUH in 2019 (n=1529). The profile and clinical outcomes for this patient cohort is described below. The aim for 2020 is to continue to ensure that all women who meet the criteria for referral are managed via this pathway.

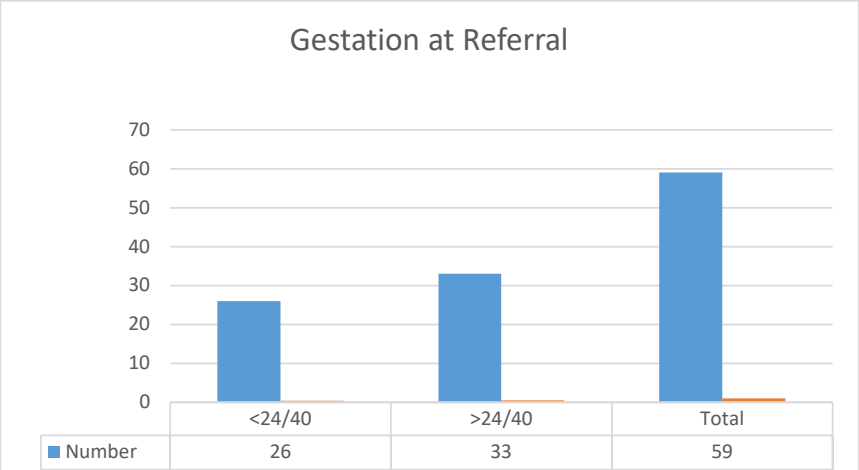
## Parity
Most of the women (75%) who were referred to SC were multiparous women.

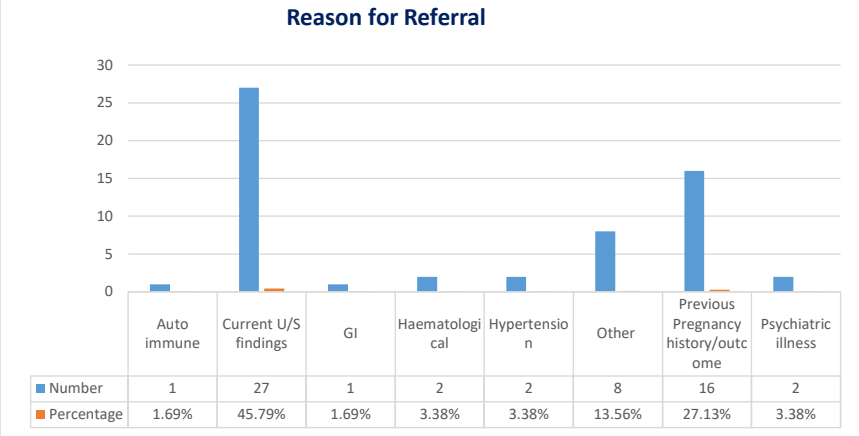
## Gestation at referral
A large number (44.06%) were referred early in the pregnancy or booking with the remainder referred as risk arose.

## Reasons for referral
The reasons for referral were multi factorial, with current ultrasound findings the most common contributor (46%) and previous pregnancy history or outcome the next at 27%. the previous history outcomes are listed below.

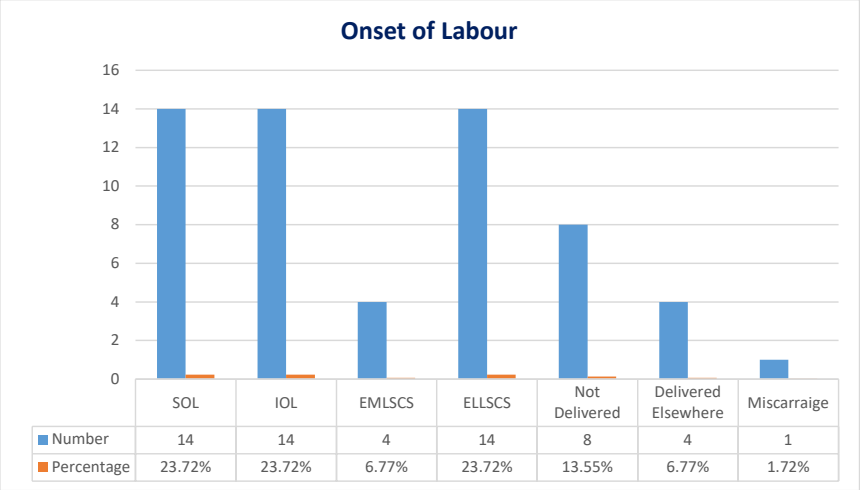
## Onward referral
37% of the women were referred to assisted care which demonstrates the bidirectional flow of this clinic, with almost half remaining in SC (49%). The reasons for tertiary referral included opinion, shared care and takeover of care as appropriate

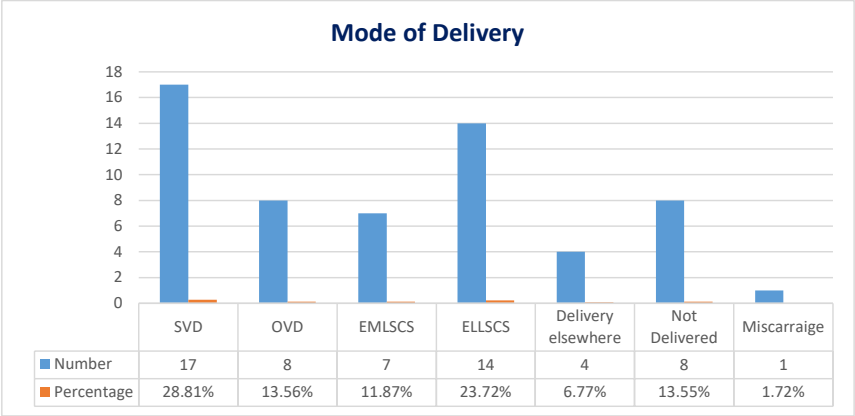


## Delivery details




## Mode of delivery

The rate of LSCS is 35% which surprisingly dips below the average rate for Portiuncula in 2019 which was 39%.

## Infant Outcome

| Admission to SCBU | |
|---|---|
| Yes | 16 |
| No | 28 |
| RIP | 2 |
| Delivered Elsewhere | 4 |
| Not Delivered | 8 |
| Miscarriage | 1 |

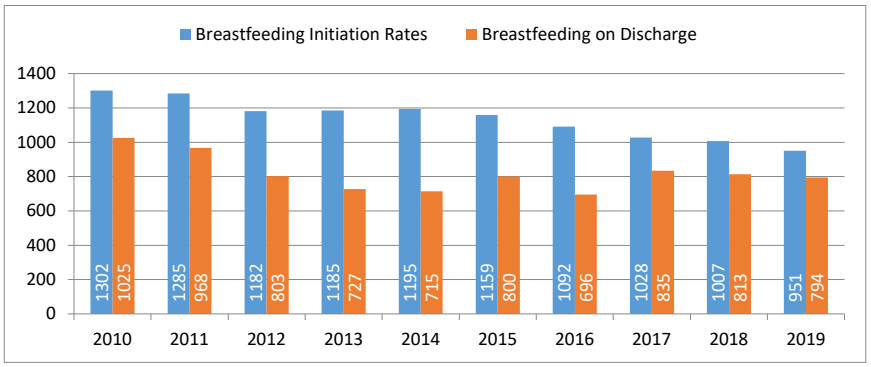
| Babies Condition | |
|---|---|
| IUD (Know abnormality) | 1 |
| ENND (Know abnormality) | 1 |
| Ventriculomeagaly | 1 |
| Cephalhaematoma | 1 |

| Mothers Condition | |
|---|---|
| Post-Partum Haemorrhage | 1 |
| 3rd Degree Tear | 3 |
| Hypertension/Pre-eclampsia | 2 |

# Section 1: Maternity
# *(h) The Breastfeeding Report*

Ms Melinda O'Rourke, Clinical Midwife Manager 2, IT W&C Services

2019 saw our breastfeeding initiation rate maintained at 63.03%. This is due to the dedication of all our staff who work within the Maternity Services at Portiuncula Hospital. It was particularly challenging as the position of CMM2 in Breastfeeding was vacant from May until December of 2019. The rate of exclusive breastfeeding from birth to discharge decreased from 39% to 37.40%. The rate of any breastfeeding on discharge was a slight decrease at 15.17%, as calculated from the total % of deliveries. However the rate of skin-to-skin rose by an impressive 3.52% to an overall rate of 84.22%. This rise is attributed to the education and supports that have been put in place to ensure that all mother and babies receive the optimum time for skin-to-skin.




National Breastfeeding week 2019 was celebrated in Portiuncula Hospital on October 1st. We were delighted to welcome our guest speaker Ms Maria Casey. Staff from Maternity (Midwives, Doctors, Social worker, Laboratory and Clerical staff) attended a talk by Maria who is a Breastfeeding Counsellor and the author of the 'Mammy Diaries'. Maria's publication gives an in-depth insight into pregnancy and motherhood in modern Ireland and is based on almost three years' worth of interviews with Irish mothers. The talk was inspirational, crediting the midwives in Portiuncula with all the hard work they do to support women who choose to breastfeed their babies. The gathering highlighted the important of the daily contribution of our staff in providing the necessary support to promote and protect breastfeeding.

# Section 1: Maternity
# *(i) Hypnobirthing Report*

Ms Carmel Cassidy and Ms Melinda O'Rourke, Clinical Midwife Manager 2, IT W&C Services

Hypnobirthing classes have been available at Portiuncula University Hospital for over two years. The two-day course is held over a weekend for Mothers and their Birthing Partners. There are currently 11 Midwives actively involved in facilitating the weekend classes, 189 couples attended this course in 2019.

The aim of the Hypnobirthing classes is to prepare mentally for birth, in the context of birth being a normal event and not something to be frightened of. Hypnobirthing gives couples the coping tools which help in the understanding and the appreciation of the physiological process of birth. This enables women to prepare for birth using breathing and relaxation techniques, massage and positive visualisations.Women and their Birthing Partners who attended the Hypnobirthing classes report to feeling more informed, in control and empowered and prepared for labour after the course.

The Hypnobirthing weekend has been a huge success and is very popular with our service users.

# Section 1: Maternity
# *(j) Annual Report Practice Development*

Ms Deirdre Naughton, Director of Midwifery, Ms Carmel Connolly Clinical Placement coordinator and Ms Deirdre Munro Practice Development Midwife

- **Midwifery Practice Development Co-ordinator - Deirdre Naughton** (1 wte Sept 2017 - July 2019)
- **Clinical Placement Co-ordinators (CPC's) - Carmel Cronolly** (0.5 wte 2007)
- **Clinical Skills Facilitator - Deirdre Munro** (0.5 wte Nov 2019)

## Goal of the Midwifery Practice Development

- The goal of the Midwifery Practice Development in Portiuncula is to play a proactive role in empowering, motivating and supporting staff and students alike in practice. The underlying drivers in this process is through the application of specialist knowledge, implementation of best practice, and provision of support for practice-based education and continuing professional development. Supporting staff through access to education and research opportunities enhances their knowledge and promotes the use of current, evidence based practice which helps provide a quality patient service.
- The CPC is responsible for co-ordinating the clinical components of the Undergraduate B.Sc. Midwifery Programme ensuring an optimal clinical learning environment. In 2017 we supported over forty eight Midwifery students in Portiuncula for their clinical maternity experience. Their placements included Postnatal/ Antenatal ward, Labour ward, Out-patients department, and Theatre and Special Care Baby unit. In addition, we supported twelve undergraduate General Nursing students and three Public Health Nurse Students during their maternity placement in PUH.
- The role of the clinical skills coordinator is to role is to support staff by overseeing the preceptorship/ induction of staff, with particular emphasis on newly trained staff and those who need extra support. It plays a pivotal role in education provision within the Maternity department both in a clinical and classroom settings.
- The clinical sites are audited for suitability for students in conjunction with NUIG and a new site has recently been approved for students; Midwifery led Supportive care antenatal clinics. We have strong partnership networks, promoting engagement and sustaining collaborative relationships with clinical staff and the School of Nursing and Midwifery, NUIG.

## Policy Development

- The challenge to provide up to date evidence to support practice and the wish to improve service through innovation provides the impetus for policy development. We work and liaise closely with Practice development in University Hospital Galway in the development of clinical practice policies, guidelines and care pathways. We have established a local monthly Midwifery Policy procedure, guideline and audit meeting. We also actively participate and attend the Group PPGA meeting which is held bimonthly. The purpose of our meetings is to facilitate consistency and evidence based information through standardisation of PUH midwifery policies, procedures, guidelines and audits. it is also to ensure quality and transparency through a multidisciplinary team approach, respectful of the diversity of opinion

## Audit

- Audit of midwifery practice is an essential element in the provision of care to women at PUH in order to evaluate and review current practices. The Midwifery Practice Development Team perform clinical and non-clinical audits on an on-going basis and they are fed back via PPGA and education committee meetings

## Education

- An Education Committee meeting is held monthly. The purpose of these is to facilitate consistency and quality of education for staff in the Maternity Unit, PUH. We always aim to ensure that all staff are fully informed of all available training opportunities and staff development.
- We have an annual plan for mandatory midwifery education including CTG training, PROMPT, NRP and Breastfeeding.
- We provide on-going ward based education on new guidelines and initiatives.
- Portiucula University Hospital (PUH) held their 'Whose Shoes' Service user engagement event for maternity services on 1st March 2019 in the Shearwater hotel in Ballinasloe. 'Whose Shoes' is a maternity experience workshop that brings together women and maternity staff to share experiences and learning. We wanted to facilitate the opportunity for the women who use our service here in PUH and the staff that provide it, to come together in an informal and relaxed way and talk about their experiences. The event was funded and supported by the NMPDU (Nursing Midwifery Planning and Development Unit). The feedback from everyone was extremely positive and enlightening. The feedback was excellent with women welcoming the collaborative inclusive approach.
- National Breastfeeding week 2019 was celebrated in Portiuncula hospital on Tuesday 1st Oct. Staff from maternity (midwives, doctors, social worker, laboratory and clerical staff) attended a talk by Maria Casey who is a Breastfeeding counselor, and the author of the Mammy Diaries, which gives an in-depth insight into pregnancy and motherhood in modern Ireland based on almost three years' worth of interviews with Irish mothers
- We held a successful, well attended study day in 20th November 2019 led by international authors Soo Downe and Sheena Byrom entitled 'Roar behind the silence'. Midwives from all Saolta hospitals were in attendance and it was exceptionally well evaluated. This conference explored the premise that kindness, compassion and respect in maternity care improves safety, efficiency, effectiveness, experience and staff morale.
- We facilitated on site train the trainer for venepuncture and cannulation. The trainers are now facilitating regular onsite training for staff.
- We celebrated International day of the midwife by having a display of new initiatives in PUH including midwifery led supportive care antenatal clinic, hypnobirthing classes and implementation of the bereavement standards.

# Section 1: Maternity
# *(k) Ballinasloe Crisis Pregnancy Support Service*

Ms Caroline McInerney Layng – Principal Social Worker

The beginning of 2019 represented a remarkable transformation in Ireland with the introduction of abortion care services. Our service continued to provide a client centred, non-directive, non-judgemental counselling service where all options are discussed.

The service responded to 77 women presenting with a crisis pregnancy in 2019 with the majority of referrals from the maternity unit, ante natal clinics and the early pregnancy unit. The profile of clients attending the service was varied, with a wide ranging age group from 14 years to 44 years, presenting with different social issues. Addiction, mental health, financial stress, health complications and relationship issues continue to be the prevalent issues. The service also responded to a number of service users who availed of post termination counselling.

## Key Achievements throughout the year:

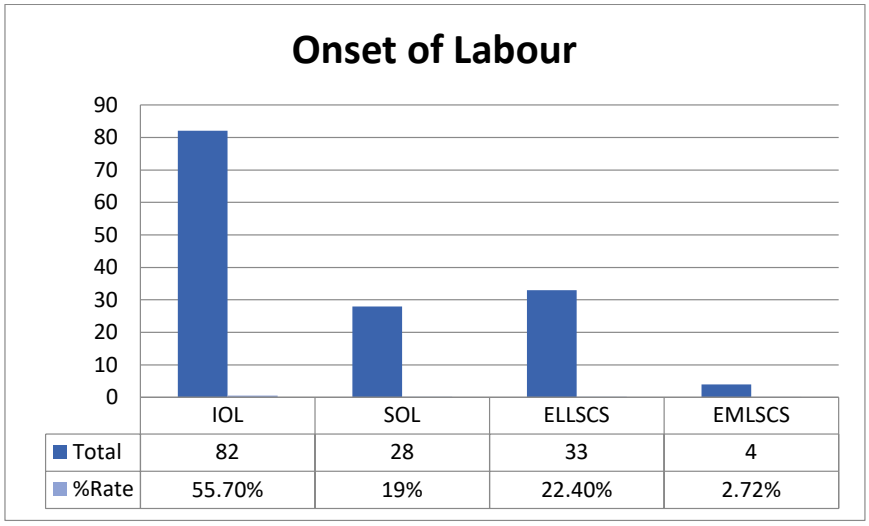
- Annual information campaign in October
- Participation in the Athlone Institute of Technology Health Fair in February
- GP Training Scheme – provision of training in December
- Students on clinical placements availed of master classes in Crisis Pregnancy Counselling in NUI Maynooth
- NCHD Induction
- Teen Parenting Service

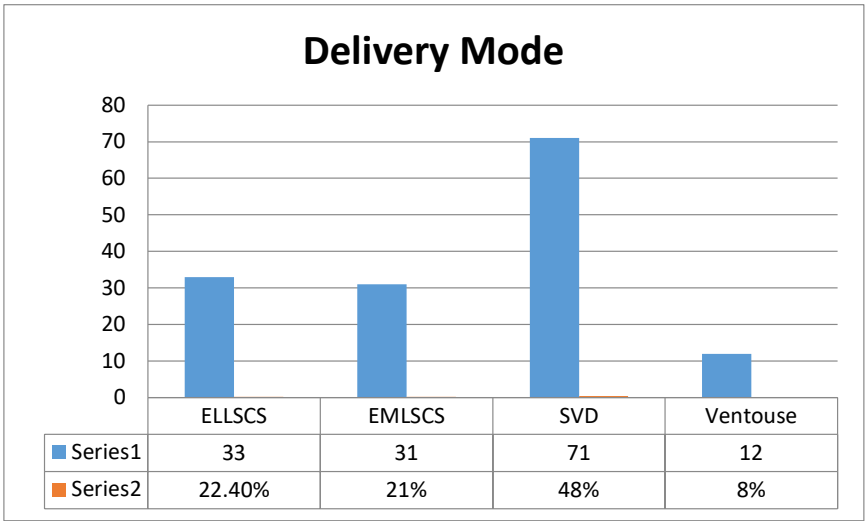
I would like to thank the HSE Sexual Health & Crisis Pregnancy Programme for their continued funding and support. I would also like to thank the social work department, Hospital management and the clinical staff in maternity, Ante Natal & EPU, who support us in providing a quality service.

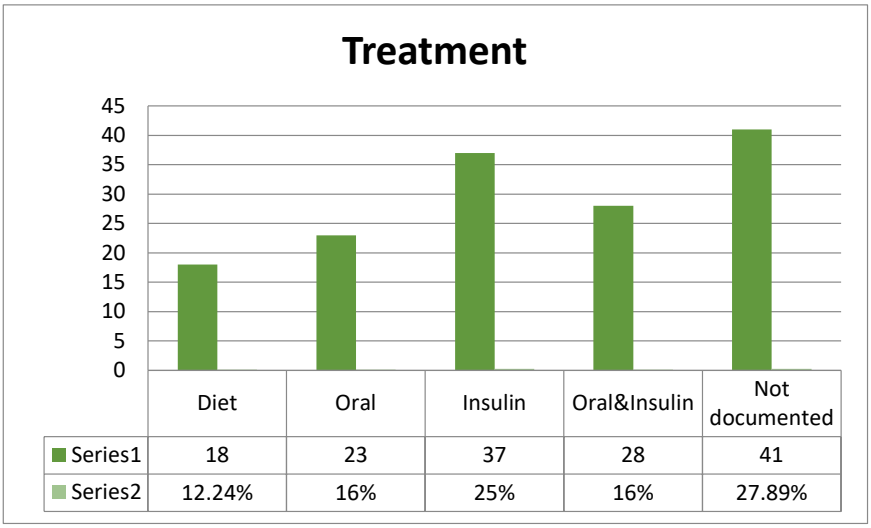
# Section 1: Maternity
# *(l) Gestational Diabetic Data*

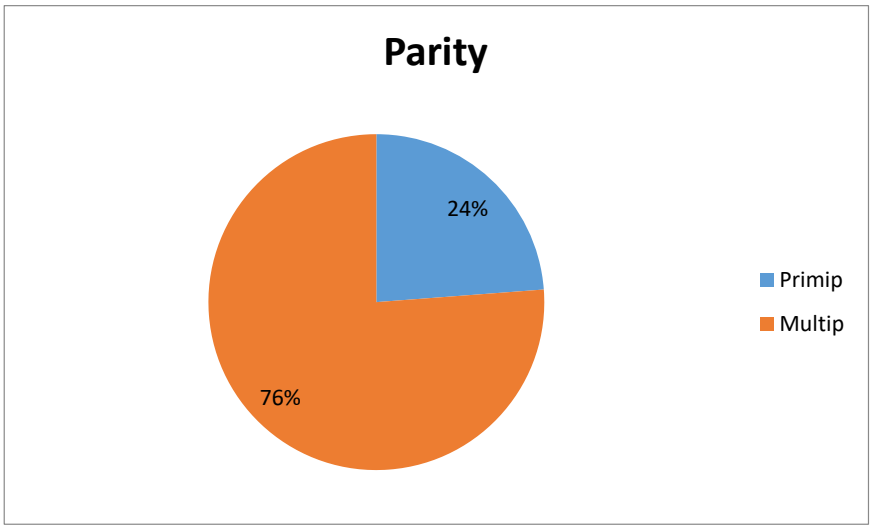
Dr Marie Christine DeTavernier, Consultant Obstetrician and
Ms Melinda O'Rourke, Clinical Midwife Manager 2, IT Women's & Childrens Services

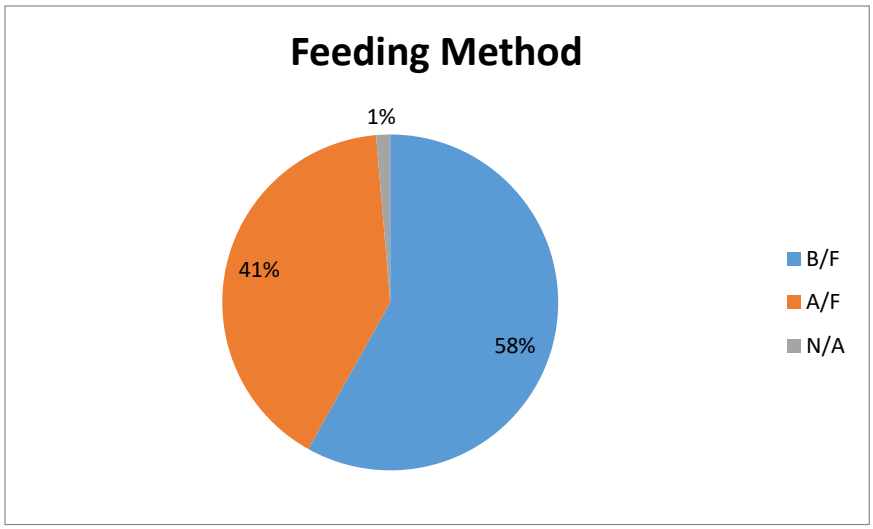
The Diabetic Clinic is held weekly on Tuesday mornings. It is managed by Dr Aaron Liew, endocrinologist; Dr Maire-Christine de Tavernier, Consultant Obstetrician; Ms Hilda Clarke, Clinical Nurse Specialist in Diabetics; the Midwifery team in the Antenatal Outpatients and the Sonographer team in the Fetal Assessment Unit. 147 women were recorded as having Gestational Diabetes in their pregnancy at the time of delivery, data on those women can be found below.



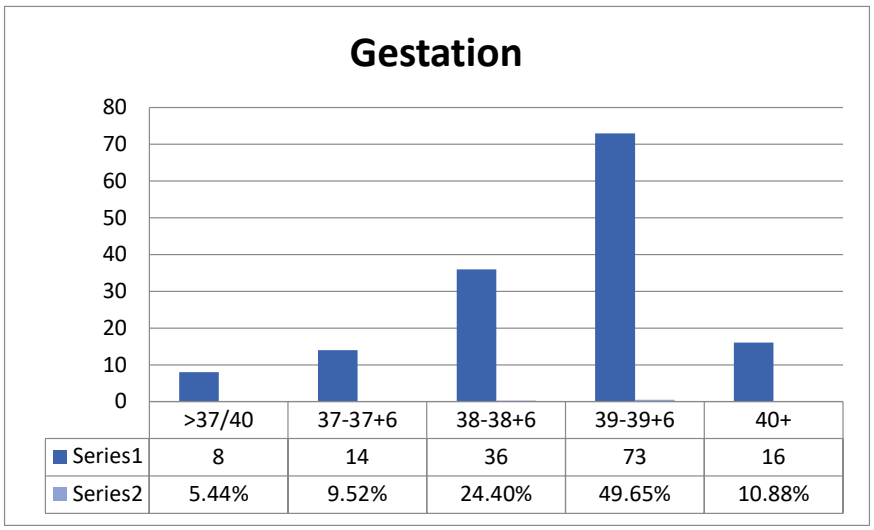



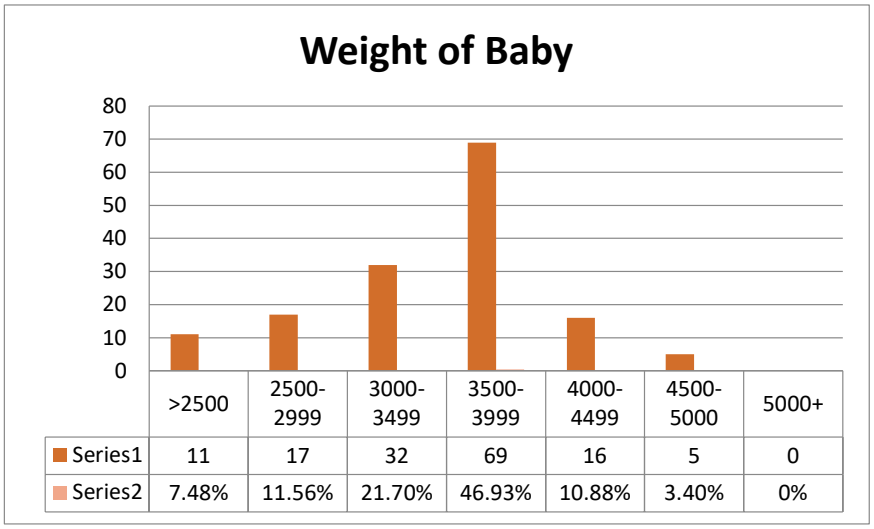


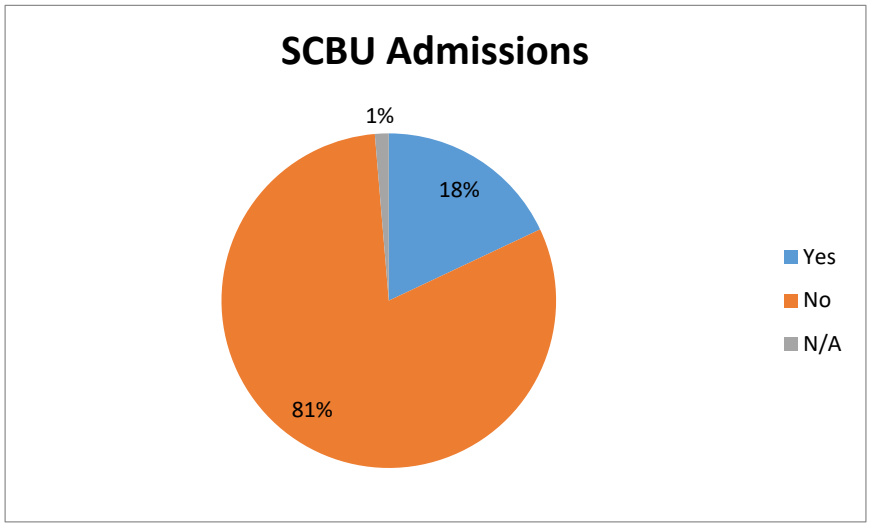




*N/A applies to stillborn baby

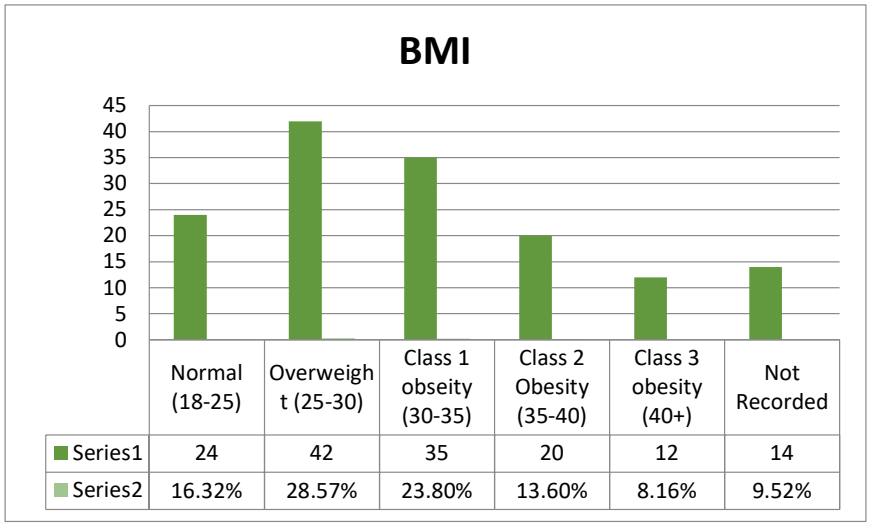



| | >37/40 | 37-37+6 | 38-38+6 | 39-39+6 | 40+ |
|---|---|---|---|---|---|
| Series1 | 8 | 14 | 36 | 73 | 16 |
| Series2 | 5.44% | 9.52% | 24.40% | 49.65% | 10.88% |




*N/A applies to stillborn baby



# Section 2: Neonatal & Paediatrics
# *(a) Neonatal Clinical Report*

Dr Regina Cooke Consultant Paediatric Consultant

During the year 2019, a total of 1529 infants were born at Portiuncula Hospital. 260 infants were admitted to the NICU for neonatal care following birth. This represents 17% of babies born at the hospital. In addition, 11 infants were admitted for ongoing care following initial care in a regional or tertiary unit.

The majority of infants (76.5% of babies) admitted to the NICU were >37 weeks gestation. We aim to transfer mothers who require delivery of an infant <32weeks gestation and <1.5 kg to a regional or tertiary centre antenatally. Occassionally, this is not possible. In 2019, 4 infants <32 weeks gestation were born at our hospital.

Each year a number of babies are transferred from our unit to tertiary paediatric or neonatal services after birth for investigations or specialised care. In 2019, 23 babies were transferred.

### Gestational Age of NICU (Inborn) Admissions 2018

| Gestation at delivery | N | % |
|---|---|---|
| <28 weeks | 2 | 0.76% |
| 28-31+6 weeks | 2 | 0.76% |
| 32-36+6 weeks | 57 | 21.9% |
| >37 weeks | 199 | 76.5% |
| **Total** | **260** | |

### Source of Admission (Including Transfers In) 2018

| Source of admission | N | % |
|---|---|---|
| Delivery Suite | 53 | 19.6% |
| Theatre | 101 | 37.2% |
| Post natal ward | 106 | 39.1% |
| Tertiary Unit | 11 | 4.0% |
| **Total** | **271** | |

### Transfers Out For Tertiary Services (Diagnosis) (1)

| Reason for Transfer | |
|---|---|
| Prematurity | 3 |
| Cardiac | 3 |
| HIE/Therapeutic Hypothermia | 4 |
| Surgical | 2 |
| Sepsis/meningitis | 1 |
| Respiratory | 4 |
| Metabolic | 1 |
| Endocrine (Hypoglycaemia) | 2 |
| Other | 3 |
| Total | 23 |

### Transfers Out For Tertiary Services (Destination) (2)

| | |
|---|---|
| University Hospital Galway | 3 |
| OLCHC | 3 |
| CUH, Temple Street | 5 |
| NMH, Holles St | 3 |
| CWH | 5 |
| Rotunda | 1 |
| **Total** | **20** |

### Birth Weight of NICU (Inborn) Admissions 2016

| Birth wt. | N | % |
|---|---|---|
| <1000g | 1 | 0.38% |
| 1001-1500g | 1 | 0.38% |
| 1500-2500g | 77 | 29.6% |
| 2500-4500g | 180 | 69.2% |
| >4500g | 1 | 0.38% |
| **Total** | **260** | |

### Reason For Admission

| REASON FOR ADMISSION | N | % |
|---|---|---|
| Preterm <37weeks | 61 | 22.5% |
| Respiratory Distress | 60 | 22.1% |
| Hypoglycaemia | 15 | 5.5% |
| Jaundice | 28 | 10.3% |
| LBW | 30 | 11% |
| Sepsis/ Rule out Sepsis | 20 | 7.3% |
| Retrotransfer | 11 | 4.0% |
| Other | 46 | 16.9% |
| **Total** | **271** | |

### Admission Rates, Transfers, Retrotransfers by Year

| | Admissions (Inborn) | Rate (%of total births) | Retrotransfers | Transfers Out | Inborn <32 weeks |
|---|---|---|---|---|---|
| 2014 | 310 | 15.6% | 19 | 21 | 5 |
| 2015 | 307 | 16.3% | 10 | 18 | 6 |
| 2016 | 311 | 17% | 7 | 16 | 4 |
| 2017 | 244 | 14.6% | 10 | 14 | 4 |
| 2018 | 256 | 15.9% | 8 | 20 | 4 |
| 2019 | 260 | 17.% | 11 | 23 | 5 |

# Section 2: Neonatal & Paediatrics
# *(b) Paediatric Report*

Ms Karen Leonard Clinical Nurse manager 3 & Dr Frances Neenan Consultant Paediatrician

## Introduction

This report includes details of clinical activity during the period January the 1st 2019 to December 31st, 2019 from the paediatric service at Portiuncula University Hospital. Data is included from St Therese's Paediatric ward, the Emergency Department, paediatric admissions to the Intensive Care Unit, the paediatric day ward, paediatric outpatient department and our most recent service development, The Paediatric Short Stay Observation Unit. The age profile of the patients is 0-16, both medical and surgical in line with national recommendations. Data supplied for this report was obtained from the Hospital Inpatient Enquiry system.

## The Paediatric Ward

St Therese is a 23-bed acute paediatric unit. 90% of all patients admitted to the ward in 2019 (1914) (Figure 1) were admitted from the Emergency Department. The average length of stay of patients on the paediatric ward was 1.81 days.

St Therese bed occupancy rate was lowest in July at 24%, the winter months had a higher occupancy rate with November having 50% bed occupancy. The timing of our Paediatric Short Stay Observation Unit (SSOU) opening (Sept 2019) was valuable in keeping these occupancy figures down from previous years in line with national recommendations.

Admissions to St Therese' included the specialities of general surgery, dental, oral & maxillofacial surgery, obstetrics/ gynaecology, respiratory and urology. The breakdown of activity is seen in Figure 2.

## Day Cases

Day care data includes scheduled care for both medical patients and surgical patients. Patients under the shared care of Paediatrics in PUH and the tertiary Paediatric centres (in keeping with the National Model of Care for Paediatric Healthcare Services in Ireland) are reflected in the number of patients seen as day cases.

**Figure 1: Admissions to St. Therese Ward**

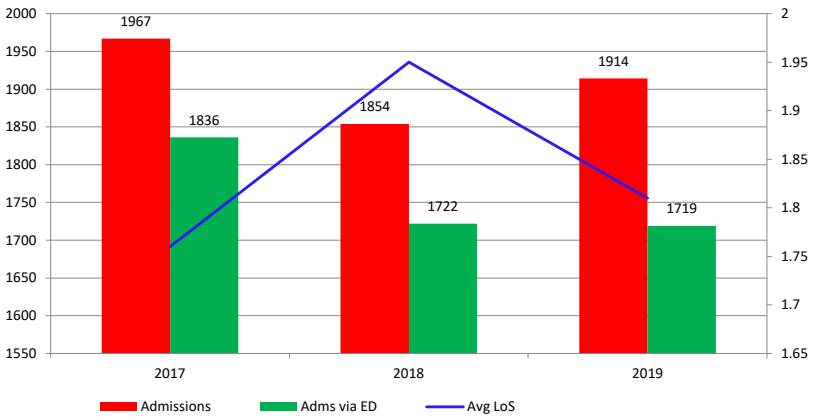



**Figure 2: Admissions to St. Therese Ward by Specialty**

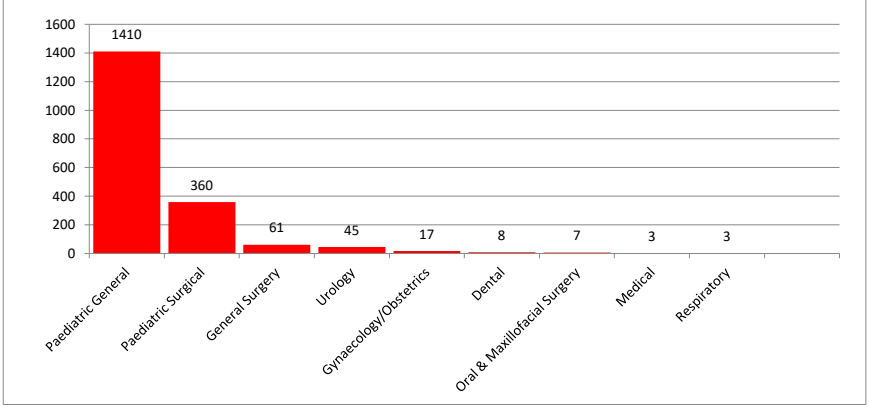
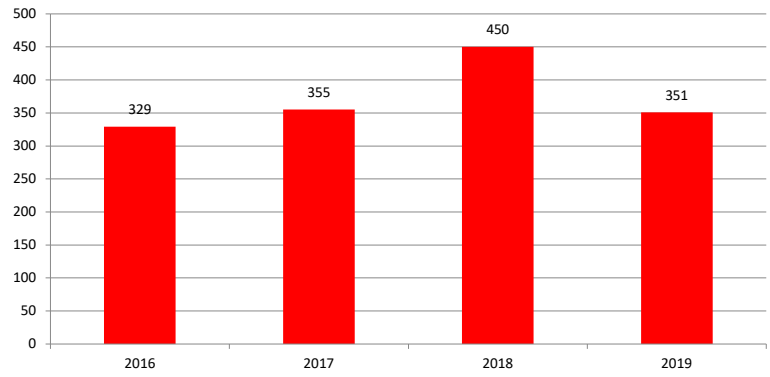


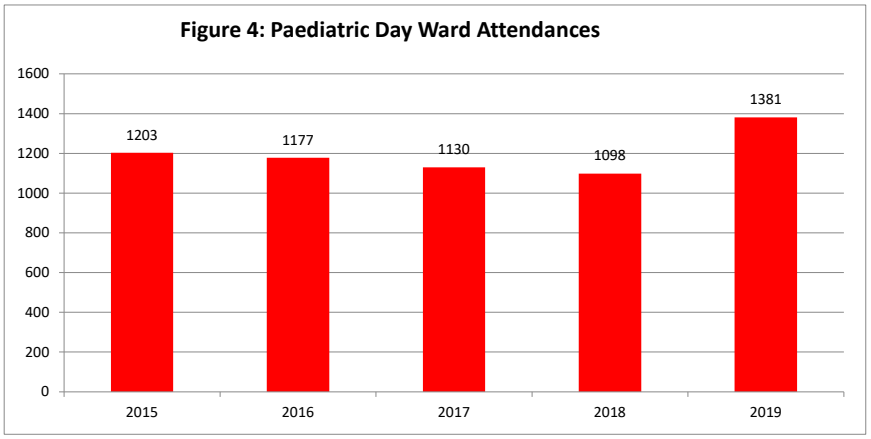

**Figure 3: Day Case Admissions to St. Therese Ward**




These patients are under the joint care of tertiary paediatric services such as Gastroenterology, Rheumatology, Neurology, Metabolic, Haematology, and Oncology.

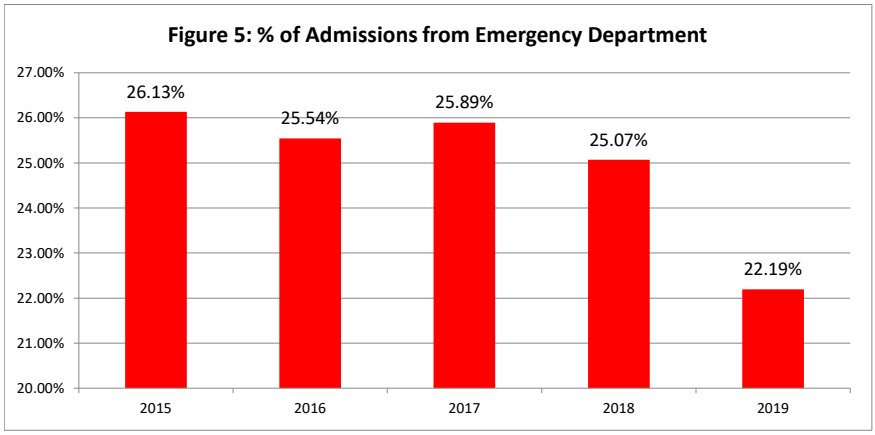
## The Paediatric Day Ward

This is a busy unit run by two paediatric nurses open Monday to Friday 0.76 WTE. Patients are booked in for phlebotomy, clinical review, radiological investigation and allergy testing. A total of 1381 patients were seen in the day ward this year, this shows a 25% increase compared to 2018 activity (Figure 4). This reflects a continued demand for space and time to review paediatric patients in our paediatric day ward due to constraints on OPD spaces.




## Paediatric ED Attendance Activity

During 2018 there were 7,200 attendances at the Emergency Department of children up to the age of 16 years, making up 27% of all attendances to the ED department in PUH. The 2019 admission rate from the Emergency Department was 22% (see figure 5), which is 3% lower than the previous year. This reduction in admission rates can be attributed in part by the opening of our Short Stay Observation Unit (SSOU) in September 2019 and also by continued implementation of a full shift pattern for our NCHDs including Paediatric Registrars with more senior Paediatric making decisions throughout a full 24 hour period.

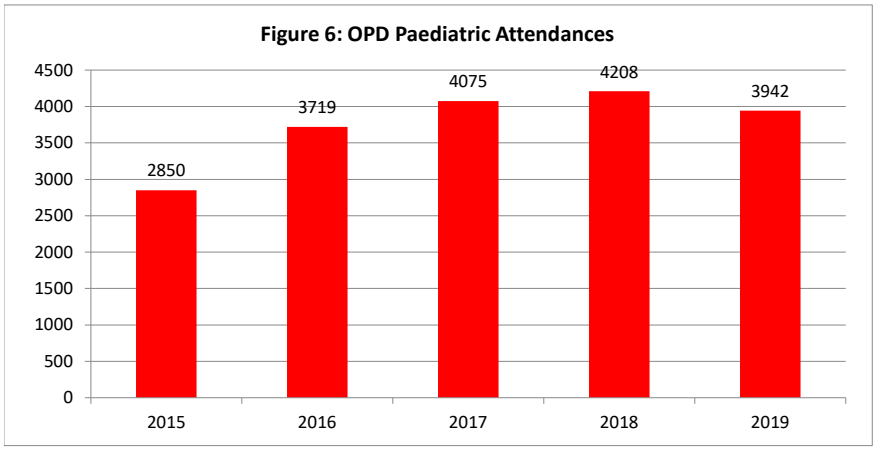



## ICU Admissions

Six children were admitted to ICU in 2019. Their admission was due to the following reasons Neurology -3, Endocrine-1, Haematological-1, Surgical-1.

Only one of these patients was transferred from ICU to a tertiary centre.

There is a noticeable reduction in children admitted to ICU for respiratory conditions. This reduction can be partially attributed to the use of High Flow Nasal Cannula (HFNC)/AIRVO and CPAP on the paediatric ward.



## Paediatric Outpatient Department

Portiuncula University Hospital provides a general paediatric outpatient service as well as specialist clinics in diabetes, respiratory, neurodevelopmental, dermatology and rapid access clinics. There are out reach clinics in Athlone and Roscommon also. The number of patients attending these clinics is below- see figure 6. Of interest also is the ratio of new to review patients seen at these clinics - the ratio for 2019 has remained stable at 1:3, which is in keeping with ratios from previous years. There are continuing challenges with providing an improved paediatric outpatient service this includes provision of phlebotomy service at the clinic and also in having adequate space for all clinics needed.

The DNA rate is 14%; this figure has improved with increased access to rapid access clinics as an initiative to reduce waiting times for Paediatric OPD.

## Paediatric Department Development

- The addition of a Childhood Diabetes Clinical Nurse Manager 2 (0.6 WTE) to our paediatric team has been extremely beneficial. There are 52 insulin dependent diabetic patients under our care including 10 patients on insulin pump treatment
- The Paediatric Department participated in the SAFE project (Situational Awareness for Everyone) a collaborative project developed by the Royal College of Paediatrics and Child Health UK. This led to a quality improvement initiative increasing situation awareness methods and delivering daily “safety huddles” on the ward.
- Bi monthly Paediatric Life Support (PLS) courses were started in September 2019. These one day resuscitation courses were multidisciplinary in attendance, consisting of staff from paediatric medical, nursing, ED, ICU, theatre and para-medical backgrounds. This was initiated to facilitate interdisciplinary working relationships and improve confidence and competence in managing the acute emergency care of paediatric patients.
- A Paediatric Short Stay Observation Unit (SSOU) consisting of a 3 bedded unit commenced September 2019. In the following 4 months it treated 68 patients. Approximately 40% of all patients treated in the SSOU were under 2 years of age. An internal audit over 3 months showed 25% of patients seen in SSOU were admitted to the Paediatric ward and 29% had investigations performed. Admission criteria to the SSUO included patients with mild respiratory difficulties, gastro-enteritis, accidental ingestions etc. This is a quality improvement initiative for paediatric patients presenting to the hospital through the acute pathway. Its aim is to facilitate a system that has good-quality paediatric care practice that is keeping patients who do not need to be in hospital out of it; is treating them swiftly once there; and discharging them safely to community support. This involves patients being seen and treated by paediatric staff in a timely fashion with senior paediatric decision making input to facilitate their pathway of care. It has been a very exciting and welcome development with positive feedback from both patients and staff.

## Conclusion

This report shows that we continue to have large numbers of patients presenting to our ED department. Our service developments have resulted in reduced inpatient admissions, reduced length of stay leading to a reduction in our bed occupancy rates. The SSOU has proven to be an effective, efficient and safe facility to manage infants, children and adolescents within an appropriate environment. The continued demand for outpatient, day ward and day case space reflects the increasing demand for an ambulatory care type model in the population we care for.

We remain committed to continuing to further improving ambulatory care services in PUH and thus improve our patients and families experience.

# Section 3: Allied Clinical Services
# *(a) Quality & Patient Safety Report*

Ms Lisa Walsh Quality and Patient Safety Manager

The Saolta Women's and Children's Directorate Department in Portiuncula University Hospital (PUH) continues to review and develop its quality and safety framework in line with Group developments and the transition to the Women's and Children's Managed Clinical and Academic Network (MCAN)

Regular multidisciplinary meetings continue to be held within departments and in cross-department and site settings throughout the week. These meetings focus on many aspects of care delivery, and include: staff education and training; policy and procedure review; audit; incident review and risk management.

Service user feedback (complaints and compliments); clinical incidents and hazards continue to be logged on the hospital group's quality information management system (Q-Pulse), and events logged are discussed at the weekly multidisciplinary incident review meetings (Maternity& Gynaecology & SCBU; and Paediatrics). In 2019 the HSE and State Claims Agency established a pilot project for the electronic point of occurrence data entry directly onto the NIMS system (ePOE). The Maternity floor at Portiuncula Hospital was selected as one of the pilot sites, and preparatory work commenced. It is anticipated that this pilot project will resume once the Public Health Emergency provisions due to the COVID-19 pandemic are stood down.

The integrated Maternity and neonatal WaC meetings continue to take place every second week. At this cross-site (UHG and PUH) multidisciplinary meeting emerging trends and any serious reported events are discussed and follow-up plans agreed. These may include: a further level of review of the event (PAR); consideration of escalation to the WaC Serious Incident Management Team meeting (SIMT); review of local policies and procedures; staff development. Furthermore, incidents are reporting on the State Claims Agency's National Incident Management System (NIMS), and those reported events that meet the HSE's criteria for a Serious Reportable Event (SRE) are flagged as such on the NIMS system.

**Reported incidents, complaints and positive feedback (origin of data: Q-Pulse)**

| | 2015 | 2016 | 2017 | 2018 | 2019 |
|---|---|---|---|---|---|
| General Incidents | 163 | 286 | 541 | 711 | 657 |
| Medication Incidents | 6 | 8 | 8 | 9 | 48 |
| Total Incidents* | 179 | 294 | 549 | 420 | 705 |
| | | | | | |
| Complaints** | 17 | 30 | 18 | 13 | 33 |
| Positive Feedback | 8 | 52 | 368 | 390 | 413 |

* Incidents include hazards and other non-clinical incidents.
** complaints informal (Q-Pulse) and formal(NIMS)

The National Standards for Safer Better Maternity Service were published in 2016 and self assessment against these standards continues to be progressed.

Staff information sessions are available on site throughout the year with regard to: record keeping, incident recognition and reporting; risk assessment and developing and populating a risk register; open disclosure staff awareness training and practical skills workshops; and informed consent.

Local service user surveying is ongoing. The Maternity Department took part in the National Maternity Experience Survey in autmn /winter 2019. The report is anticipated in 2020. Locally surveying is ongoing. Comment cards are available in the Maternity and SCBU departments. Reports are generated on a monthly basis and circulated to all relevant heads of department. Positive feedback is received with regard to the staff friendliness and professionalism. Negative feedback occasionally relates to staff approach, and otherwise relates to the fabric of the building. All feedback is used to assist in the service's quality improvement plans.

Formal complaints are managed in accordance with the HSE national complaints policy, and since January 2018 all formal complaints have been logged on the HSE's Complaints Module hosted by the State Claims Agency on the National Incident Management System (NIMS).

The Staff recognise that safety awareness helps all members of the team to be proactive with regard to the challenges faced in providing safe, high quality care for mothers, babies and their young patients.

| Reported Clinical Incidents by speciality 2019 (origin of data: Q-Pulse) | |
|---|---|
| Obstetrics | 958 |
| Gynaecology | 25 |
| Paediatrics | 148 |

| Most frequently reported perinatal events 2019 (origin of data: Q-Pulse) | |
|---|---|
| Post partum haemorrhage | 90 |
| Unplanned admission to SCBU | 107 |
| Delivery interval EmLSCS >45 mins | |
| 3rd degree tears | 19 |
| Readmission | 40 |
| Birth injury | 2 |
| Preterm premature rupture of membranes | 8 |
| Manual removal of placenta | 14 |
| Maternal pyrexia | 11 |
| Multiple pregnancies | |
| Other | |
| shoulder dystocia | 4 |
| intra-uterine transfer | 11 |
| problems with epidurals | 3 |
| admission to adult ICU | 8 |

# Section 3: Allied Clinical Services
# *(b) Physiotherapy*

Ms Roisin O'Hanlon Physiotherapy Manager

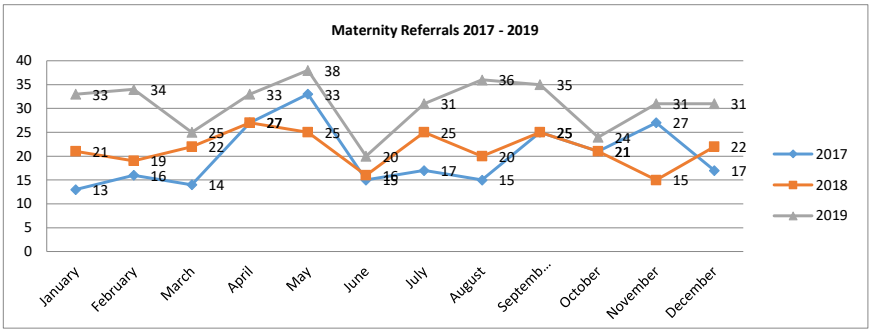
The Women's Health and Children's physiotherapy service is provided in both the in and outpatient setting, including ICU.

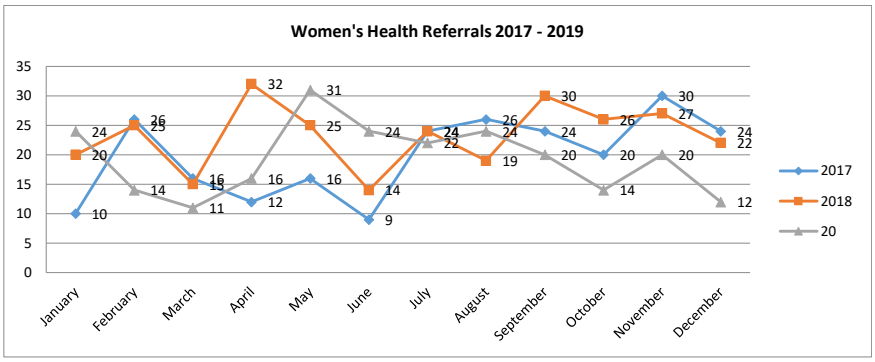
The out patient service is provided to consultant (in the main) and GP referrals from Roscommon and East Galway. We also accept referrals from outside our catchment area if the specialist service is not available there.

The service is provided by 0.8 WTE senior Physiotherapist. This allocation is from the general staffing levels and not a Physiotherapist appointed specifically for this service.

The demand on the service has increased over the past year, resulting in longer waiting lists. Referrals have remained consistently high and are increasing year on year.

As part of the role, we also provide input into teaching of NCHDs and midwives.




We offer the following services:

## Antenatal
- MSK physiotherapy for pelvic girdle pain, carpal tunnel syndrome, back pain and other musculoskeletal problems presenting in pregnancy
- Antenatal classes (monthly)

vContinence care – bladder and bowel

## Post natal
- Post natal information classes (three times weekly)
- Development and introduction of the physiotherapy post natal information booklet
- OASIS, both as an inpatient and outpatient follow up, as per national guidelines
- Scar management: Caesarean, episiotomy and perineal
- Post natal continence advice and treatment
- Prolapse advice and management
- Post natal MSK conditions

## Gynaecology
- Continence care for bladder and bowel
- Sexual Dysfunction, including dyspareunia and vaginismus
- Chronic Pelvic Pain
- Oncology – post radiation and surgical complications
- Painful Bladder Syndrome
- Post-operative care for all urogynaecological patients
- MSK conditions
- Prolapse assessment

As the catchment area for the maternity services is not defined, we provide both direct and indirect (e.g. advice) treatment to those referred. Some patients are referred on to their local services (where possible) to avoid them having to travel to Ballinasloe.

Paediatric physiotherapy is also provided to both in and out patients. In patient advice and treatment is delivered for conditions such as:
- Neonatal conditions: Erb's palsy, Congenital Talipes Equinovarus, Congenital Talipes Calcaneovarus, Neurological conditions (including congenital and acquired)
- Torticollis
- Respiratory
- Introduction of the physiotherapy post natal information booklet which includes information on prevention of plagiocephaly and advice on tummy time
- MSK and orthopaedics
- Oncology
- Complex chronic and life-limiting conditions, requiring planned discharges of patients who may potentially have frequent readmissions. Due to lack of other supporting disciplines our therapy input is provided in isolation, without the team support of OT, SLT or Psychology, for example. There is also limited access to equipment for rehabilitating this group of patients
- Paediatric Continence / Constipation

Neurodevelopmental care is provided to patients transferred from a tertiary centre and awaiting discharge home.

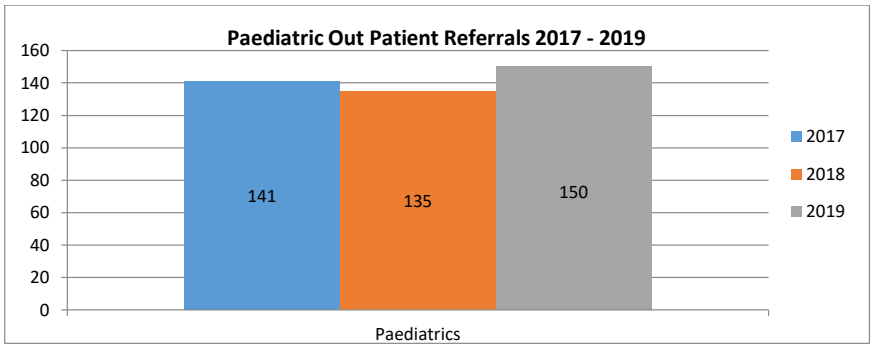
Outpatient physiotherapy is, in the main, related to MSK and Orthopaedic conditions. We also treat children with Respiratory conditions who are being followed through to adulthood and children with Rheumatological conditions who attend for infusios and have a physiotherapy review. We also see any referred children with Oncological conditions.

We accept referrals from consultants and GPs, and we work closely with the PCCC service to ensure that children needing specialist neurological treatment and MDT care are referred on to the most appropriate local service.

Paediatric physiotherapy is provided by 0.2 WTE senior Physiotherapist from general staffing levels. We do not have a specific appointment. This service would benefit from specialist paediatric training to meet national standards.

At this time, due to staffing levels we are unable to meet the recommendation of the national standard to assess all extremely premature babies and link them with relevant community services. We would also like to include staff for national programmes which would include diabetes, obesity and hypomobility among other things.

Another service plan aim would be clerical support to release clinical staff and ensure more accurate reporting to the MCAN.



# *Sligo University Hospital Introduction*

Dr Vimla Sharma Consultant Obstetrician and Gynaecologist & Associated Clinical Director for Women's and Children's

2019 was another busy year for Women's and Children's health departments at Sligo University Hospital. During 2019, 1347 mothers delivered 1368 infants. The corrected perinatal mortality rate was 1.54 per 1000. The caesarean section rate was 36.6% and the instrument delivery rate was 11.3%. A total of 297 Infants were admitted to NICU. 1276 gynaecological surgical procedure were performed. Outpatient's activities were comprised of a total of 4 onsite antenatal, 4 onsite Gynaecological clinics, parallel Advanced Midwife Practitioner (AMP) clinics, 1 onsite midwifery clinic and 4 outreach combined antenatal/Gynaecology clinics per week. 2019 saw development of outreach midwifery led antenatal clinic at Manorhamilton as per national guidelines for supportive care pathway.

*Ms Grainne McCann (General Manager), Ms Niamh McGarvey (Assistant Director of Midwifery), Dr Vimla Sharma (Associate Clinical Director), Ms Juliana Henry (Director of Midwifery) Women's & Children's Health department, SUH*

The women's health department welcomed the appointments of Dr Ravi Garrib (4th Consultant Obstetrician & Gynaecologist), Ms Niamh McGarvey (Assistant Director of Midwifery) and Ms Colette Kivelhan (CMM 3 Quality Improvement). Ms Catriona Moriarty CMM 2 for antenatal education retired in 2019 after a long and dedicated service. I would like to acknowledge her excellent contribution towards the hospital. Some of the achievements of 2019 were upgrading of electronic system to E3, introduction of Obstetric Emergency bleep, installation of baby alarm units in maternity ward and opening of long awaited "Solas Beag" the family bereavement room. We had our first inspection from HIQA (Health information and quality authority) for safer/better maternity services in Mar 2019. This was a very positive review and we will be implementing its recommendations in 2020. The research, audits and Education remained the integral part during 2019. The Women's health department at Sligo Medical Academy was busy with undergraduate medical students' and the department provided teaching and training of midwifery and nursing students as well. The increase in referral to colposcopy clinic continued in 2019 and this challenge was compounded by loss of a Consultant Colposcopist sessions with knock on effect on clinic waiting time. Some of the other challenges during 2019 were onerous rota of 1 in 4 at consultant level, Gynaecology theatre sessions, limited outpatient clinic space & unavailability of 2nd colposcopy room. While we are hoping to deal with these challenges in 2020, we are also aspiring to have 5th Consultant so we can develop ambulatory Gynaecology Clinic and High Risk Pregnancy Clinic.

It was a busy year for Children's health department as well. Dr R Tummaluru provided a good leadership during 2019 in his role of Speciality lead for Children's health department. There were 3131 children treated in Paediatrics ward between the inpatient and day unit attendance including 852 surgical admission. A total of 4468 attendance was noted at onsite outpatient clinics. A significant number also attended at community consultant's clinics. Some of the quality development achievements were Little Journey App, Motorised Car Initiative and Buddy beds. The Children's health department was likewise busy with Sligo Medical Academy students, nursing and midwifery students, research and audits. The significant challenges were outpatient waiting list and inadequate number of consultants. We are hoping to deal with it in 2020. In 2019 Dr Hilary Greaney retired from clinical practice and also from her role of Associate Clinical Director, Women's & Children's health Directorate in the hospital. I would like to acknowledge her very significant clinical, academic contribution to children's health and also administrative contribution in SUH. Dr Ghia Harrison was appointed as a 4th consultant Paediatrician in her place.

I would like to take this opportunity to sincerely thank each and every member of staff in Women's & Children's health department for their significant contribution to patient care and their support during the year. I would particularly like to thank our General Manager Ms Grainne McCann for her leadership and support during the year. I would like to specially thank the Director of Midwifery Ms Juliana Henry and her senior midwifery managerial team for their exceptional dedication, hard work and support during 2019. I would like to both acknowledge and to highlight the very considerable contribution to patient care made by our consultant obstetricians – Dr Heather Langan, Dr Nirmala Kondaveeti, Dr Ravi Garrib and Consultant Paediatricians – Dr Hilary Greaney, Dr Dara Gallagher, Dr R Tummaluru, Dr Ghia Harrison and Dr B Java (Locum Consultant).

## Maternity Unit

The Maternity Service in Sligo University Hospital is a multi sited service provided from the multi-storey building since 1992, over four floors. The site is an accredited site for General Practitioner (G.P) training and the Irish Committee in Higher Medical Training (I.C.H.M.T.). It is an Accredited site for Specialist Paediatrics Registrar (S.P.R) and a clinical placement site for Pre- Registration Midwifery and Nursing Students, Student Public Health nurses and Return to Midwifery Practice Students.

The inpatient combined antenatal/ postnatal ward on Level 4 works within a complement of 29 beds and in 2019 we opened a dedicated Bereavement Suite on the ward. Separate and on the same level, The Delivery Suite has three birthing rooms, two pre-labour beds and an admission room. It provides care for Admission, Ante-Natal Assessment, Induction of Labour (High Risk or overflow) and Care in Labour and Delivery. Operative deliveries are carried out in the main theatre suite on Level 8. The fetal assessment unit (FAU) and early pregnancy (EPAU) provides care Monday to Friday. The neonatal unit has 10 cots for babies >32 weeks' gestation. There are two community Midwifery Antenatal Clinics.

A number of specialities provide Outpatient clinics at Community Hospitals in our catchment area.

## Philosophy of Care

The speciality aspires to provide a quality, comprehensive service that offers choice, continuity of care and control through safe evidence based practice treating all women in their care with dignity and respect at all times. To ensure each mother, baby and indeed family receive the best quality care we work in collaboration within the speciality to strive to deliver evidence based quality care.

## Models of Care

The two models of care in SUH is 1: Medical led team care, with consultant led antenatal care based in the acute hospital outpatient facility three times a week. There are weekly outreach antenatal clinics in Manorhamilton, Carrick on Shannon, Ballymote (new 2019) and Ballyshannon. In December 2019 the Manorhamilton Obstetric Clinic was converted to a midwifery clinic.

.2: Midwifery clinics are provided by our Advanced Midwifery Practitioner in SUH and in Carrick on Shannon and Manorhamilton. These clinics facilitate women who are on the supportive or assisted pathway of care. There is also one weekly midwifery managed antenatal review clinic for women on the supportive pathway in SUH.

## Sligo University Hospital and Women's & Children's Directorate Management Team

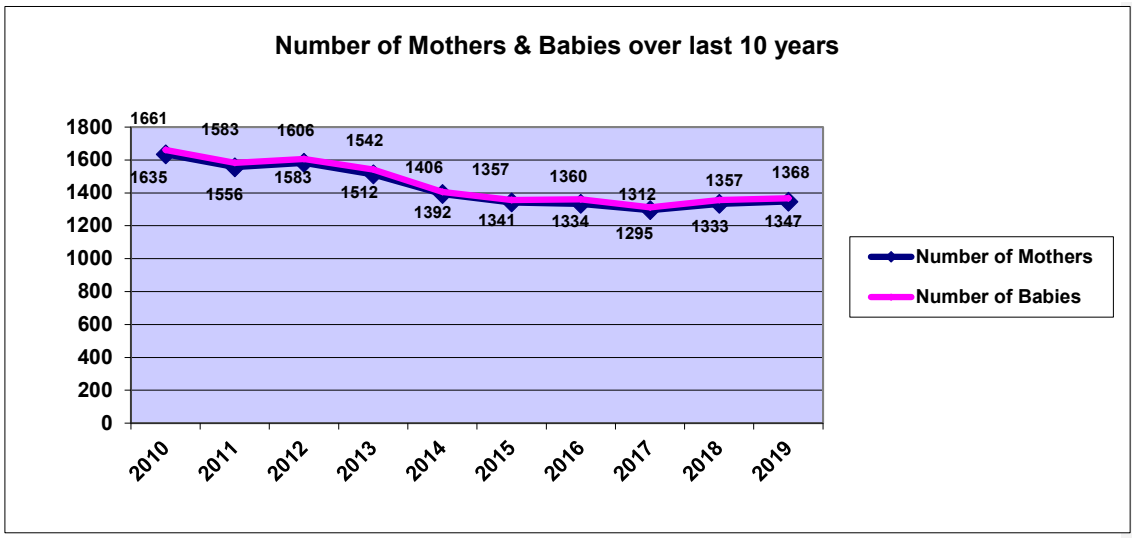
- General Manager: Ms Grainne Mc Cann
- Assistant General Manager: Mr Domhnall Mc Loughlin
- Associate Clinical Director for Women's and Children's: Dr Vimla Sharma
- Director of Midwifery: Ms Juliana Henry
- Director of Nursing: Ms Marion Ryder

# Section 1: Maternity
# *(a) Statistical Summary*

Ms Juliana Henry, Director of Midwifery, Ms Colette Kivlehan Clinical Midwife Manager 3 Quality Improvement,
Ms Louise O'Malley Clinical Midwife Manager 3

| | Primigravida | Multigravida | Total |
|---|---|---|---|
| Total Number of Mothers | 518 | 829 | **1347** |
| Total Number of Babies | 524 | 844 | **1368** |
| >24 weeks or >/= 500g | | | |

| | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 |
|---|---|---|---|---|---|---|---|---|---|---|
| Number of Mothers | 1635 | 1556 | 1583 | 1512 | 1392 | 1341 | 1334 | 1295 | 1333 | 1347 |
| Number of Babies | 1661 | 1583 | 1606 | 1542 | 1406 | 1357 | 1360 | 1312 | 1357 | 1368 |




| Obstetric Outcomes: | Primigravida | Multigravida | Total |
|---|---|---|---|
| Total Number of Mothers | 518 | 829 | **1347** |
| Total Number of Babies | 524 | 844 | **1368** |
| >24 weeks or >/= 500g | | | |

| Obstetric Outcomes (Mothers) | Primigravida | % | Multigravida | % | Total | % |
|---|---|---|---|---|---|---|
| Spontaneous Onset | 243 | 46.9% | 367 | 44.3% | 610 | 45.3% |
| Induction of Labour | 183 | 35.3% | 234 | 28.2% | 417 | 31.0% |
| Augmentation | | 0.0% | | 0.0% | | 0.0% |
| No Analgesia | | 0.0% | | 0.0% | | 0.0% |
| Epidural Rate | | 0.0% | | 0.0% | 531 | 39.4% |
| Episiotomy | | 0.0% | | 0.0% | 207 | 15.4% |
| Caesarean Section | 196 | 37.8% | 280 | 33.8% | 476 | 35.3% |
| Spontaneous Vaginal Delivery | 169 | 32.6% | 554 | 66.8% | 723 | 53.7% |
| Forceps Delivery | 43 | 8.3% | 3 | 0.4% | 46 | 3.4% |
| Ventouse Delivery | 63 | 12.2% | 24 | 2.9% | 87 | 6.5% |
| Breech Delivery | 0 | 0.0% | 2 | 0.2% | 2 | 0.1% |

| Obstetric Outcomes (Babies) | Primigravida | % | Multigravida | % | Total | % |
|---|---|---|---|---|---|---|
| Spontaneous Vaginal Delivery | | | | 0.0% | 0 | 0.0% |
| Forceps Delivery | 43 | | 3 | 0.4% | 46 | 3.4% |
| Ventouse Delivery | 63 | | 24 | 2.8% | 87 | 6.4% |
| Breech Delivery (Singleton) | 0 | | 0 | 0.0% | 0 | 0.0% |
| Breech Delivery (1st Twin) | 0 | | 0 | 0.0% | 0 | 0.0% |
| Breech Delivery (2nd Twin) | 0 | | 2 | 0.2% | 2 | 0.1% |
| Caesarean Section (Babies) | 196 | | 280 | 33.2% | 476 | 34.8% |
| **Total** | | | | **0.0%** | **0** | **0.0%** |

| Multiples: | Primigravida | Multigravida | Total |
|---|---|---|---|
| Total Number of Mothers | 518 | 829 | **1347** |
| Total Number of Babies | 524 | 844 | **1368** |
| >24 weeks or >/= 500g | | | |

| Multiple Pregnancies | Primigravida | % | Multigravida | % | Total |
|---|---|---|---|---|---|
| Twins | 6 | 1.2% | 15 | 1.8% | 21 |
| Triplets | 0 | 0.0% | 0 | 0.0% | 0 |

| Multiple Pregnancies by year | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 |
|---|---|---|---|---|---|---|---|---|---|---|
| Twins | 24 | 25 | 23 | 26 | 13 | 16 | 27 | 17 | 24 | 21 |
| Triplets | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 |
| **Total** | **24** | **25** | **23** | **26** | **14** | **16** | **27** | **17** | **24** | **21** |

| Perinatal Mortality: | Primigravida | Multigravida | Total |
|---|---|---|---|
| Total Number of Mothers | 518 | 829 | **1347** |
| Total Number of Babies | 524 | 844 | **1368** |
| >24 weeks or >/= 500g | | | |

| Perinatal Deaths | Primigravida | Multigravida | Total | % |
|---|---|---|---|---|
| Stillbirths | 1 | 2 | 3 | 0.22% |
| Early Neonatal Deaths | 1 | 1 | 2 | 0.15% |

| Perinatal Mortality Rate | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 |
|---|---|---|---|---|---|---|---|---|---|---|
| Stillbirth rate (per 1,000) | 5.4 | 3.2 | 3.7 | 1.3 | 3.6 | 3.7 | 6.6 | 3.8 | 3.0 | 2.2 |
| Neonatal Death rate (per 1,000) | 0.6 | 2.5 | 3.7 | 2.6 | 2.8 | 3.7 | 0.7 | 0.8 | 0.0 | 0.0 |
| Overall PMR per 1,000 births | 6.0 | 5.7 | 7.4 | 3.9 | 6.4 | 7.4 | 7.3 | 4.6 | 3.0 | 1.5 |

| Parity: | Primigravida | Multigravida | Total |
|---|---|---|---|
| Total Number of Mothers | 518 | 829 | **1347** |
| Total Number of Babies | 524 | 844 | **1368** |
| >24 weeks or >/= 500g | | | |

| Parity by year | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 |
|---|---|---|---|---|---|---|---|---|---|---|
| 0 | 29.5% | 31.0% | 28.7% | 29.3% | 26.6% | 29.1% | 29.3% | 36.0% | 29.3% | 35.5% |
| 1,2,3 | 61.0% | 59.0% | 60.1% | 59.2% | 61.0% | 59.6% | 59.1% | 51.7% | 48.2% | 55.1% |
| 4+ | 9.5% | 10.0% | 11.2% | 11.5% | 12.4% | 11.3% | 11.6% | 12.4% | 22.5% | 9.4% |

| Age @ Booking | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 |
|---|---|---|---|---|---|---|---|---|---|---|
| <15 years | 0.2% | 0.1% | 0.0% | 0.0% | 0.0% | 0.1% | 0.0% | 0.0% | 0.0% | 0.0% |
| 15-19 years | 2.7% | 3.3% | 2.4% | 1.9% | 2.8% | 1.9% | 2.1% | 2.4% | 1.7% | 2.0% |
| 20-24 years | 10.9% | 9.7% | 10.2% | 9.7% | 8.3% | 7.8% | 9.0% | 10.0% | 7.7% | 9.7% |
| 25-29 years | 23.9% | 23.5% | 22.7% | 21.8% | 19.2% | 21.9% | 18.5% | 18.9% | 19.1% | 17.2% |
| 30-34 years | 33.7% | 37.8% | 35.2% | 37.4% | 36.4% | 35.2% | 35.3% | 34.0% | 36.6% | 35.8% |
| 35-39 years | 23.7% | 21.9% | 24.4% | 23.9% | 27.7% | 26.5% | 29.0% | 28.7% | 29.0% | 28.5% |
| >40 years | 4.9% | 3.7% | 5.1% | 5.3% | 5.6% | 6.5% | 6.0% | 6.0% | 6.0% | 6.9% |
| **Total** | **100.0%** | **100.0%** | **100.0%** | **100.0%** | **100.0%** | **99.9%** | **99.9%** | **100.0%** | **100.1%** | **100.1%** |

| Origin: | Primigravida | Multigravida | Total |
|---|---|---|---|
| Total Number of Mothers | 518 | 829 | **1347** |
| Total Number of Babies | 524 | 844 | **1368** |
| >24 weeks or >/= 500g | | | |

| County of Origin | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 |
|---|---|---|---|---|---|---|---|---|---|---|
| Sligo | 55.3% | 56.5% | 56.7% | 55.4% | 55.2% | 55.2% | 55.0% | 54.40% | 55.80% | 53.00% |
| Donegal | 11.5% | 10.2% | 10.6% | 9.5% | 10.8% | 10.4% | 11.8% | 10.90% | 11.70% | 12.17% |
| Leitrim | 19.5% | 21.2% | 19.5% | 21.0% | 19.6% | 21.7% | 20.5% | 20.20% | 20.40% | 21.73% |
| Mayo | 1.9% | 2.4% | 1.8% | 2.7% | 1.9% | 2.1% | 1.9% | 2.50% | 1.30% | 0.80% |
| Roscommon | 10.6% | 8.4% | 10.5% | 10.6% | 11.6% | 10.0% | 9.6% | 11.10% | 9.70% | 9.56% |
| Cavan | 0.5% | 0.8% | 0.5% | 0.5% | 0.6% | 0.4% | 0.9% | 0.50% | 0.60% | 1.30% |
| Galway | 0.0% | 0.1% | 0.1% | 0.0% | 0.0% | 0.1% | 0.0% | 0.00% | 0.00% | 0.00% |
| Longford | 0.2% | 0.0% | 0.2% | 0.1% | 0.2% | 0.0% | 0.0% | 0.20% | 0.10% | 0.00% |
| Dublin | 0.0% | 0.1% | 0.0% | 0.1% | 0.1% | 0.0% | 0.1% | 0.00% | 0.00% | 0.00% |
| Others | 0.5% | 0.3% | 0.2% | 0.2% | 0.0% | 0.1% | 0.1% | 0.20% | 0.30% | 0.80% |
| **Total** | **100.0%** | **100.0%** | **100.1%** | **100.1%** | **100.0%** | **100.0%** | **99.9%** | **99.9%** | **99.9%** | **99.4%** |

| Non-national Births | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 |
|---|---|---|---|---|---|---|---|---|---|---|
| Number | 72 | 62 | 66 | 82 | 72 | 79 | 109 | 97 | 103 | 136 |
| % | 4.4% | 3.9% | 4.1% | 5.4% | 5.0% | 5.8% | 8.0% | 7.4% | 7.7% | 10.1% |

| Gestation at Delivery | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 |
|---|---|---|---|---|---|---|---|---|---|---|
| <24 weeks | 6 | 8 | 3 | 3 | 2 | 2 | 1 | 1 | 0 | 4 |
| 24-27 weeks | 5 | 2 | 3 | 1 | 5 | 6 | 2 | 1 | 2 | 1 |
| 28-31 weeks | 5 | 4 | 3 | 4 | 5 | 2 | 4 | 3 | 4 | 3 |
| 32-35 weeks | 39 | 25 | 31 | 37 | 36 | 53 | 64 | 65 | 75 | 36 |
| 36-39 weeks | 681 | 668 | 716 | 674 | 646 | 646 | 629 | 602 | 665 | 635 |
| 40-41 weeks | 869 | 832 | 810 | 796 | 685 | 611 | 606 | 603 | 556 | 673 |
| >42 weeks | 58 | 45 | 42 | 29 | 27 | 21 | 28 | 20 | 31 | 16 |
| **Total** | **1663** | **1584** | **1608** | **1544** | **1406** | **1341** | **1334** | **1295** | **1333** | **1368** |

| Birth Weights by year | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 |
|---|---|---|---|---|---|---|---|---|---|---|
| <2500g | 74 | 45 | 46 | 71 | 50 | 54 | 71 | 56 | 62 | 63 |
| 2500 - 2999g | 189 | 182 | 191 | 175 | 143 | 153 | 158 | 166 | 176 | 163 |
| 3000 - 3499g | 547 | 470 | 535 | 484 | 470 | 467 | 464 | 387 | 426 | 443 |
| 3500 - 3999g | 552 | 608 | 571 | 533 | 512 | 482 | 442 | 482 | 480 | 484 |
| 4000 - 4499g | 251 | 238 | 219 | 231 | 206 | 160 | 194 | 187 | 180 | 191 |
| >4500g | 50 | 41 | 46 | 50 | 25 | 41 | 31 | 34 | 33 | 24 |
| **Total Number of Babies** | **1,663** | **1,584** | **1,608** | **1,544** | **1,406** | **1,357** | **1,360** | **1,312** | **1,357** | **1,368** |

| Inductions: | Primigravida | Multigravida | Total |
|---|---|---|---|
| Total Number of Mothers | 518 | 829 | **1347** |
| Total Number of Babies | 524 | 844 | **1368** |
| >24 weeks or >/= 500g | | | |

| Induction of Labour | Primigravida | % | Multigravida | % | Total | % |
|---|---|---|---|---|---|---|
| 2010 | 168 | 28.7% | 222 | 21.1% | 390 | 23.9% |
| 2011 | 243 | 25.0% | 189 | 32.4% | 432 | 27.7% |
| 2012 | 168 | 29.4% | 260 | 25.7% | 428 | 27.0% |
| 2013 | 167 | 30.9% | 275 | 28.3% | 442 | 29.2% |
| 2014 | 165 | 35.6% | 260 | 28.1% | 425 | 30.5% |
| 2015 | 158 | 33.8% | 255 | 29.1% | 413 | 30.8% |
| 2016 | 160 | 32.9% | 255 | 30.1% | 415 | 31.1% |
| 2017 | 156 | 33.5% | 262 | 31.6% | 418 | 32.3% |
| 2018 | 167 | 34.9% | 183 | 21.4% | 350 | 26.2% |
| 2019 | 183 | 13.5% | 234 | 17.4% | 417 | 31.0% |

| Incidence of Episiotomy | Primigravida | % | Multigravida | % | Total | % |
|---|---|---|---|---|---|---|
| 2010 | 218 | 45.3% | 82 | 9.6% | 300 | 22.5% |
| 2011 | 180 | 40.5% | 82 | 10.1% | 262 | 20.9% |
| 2012 | 182 | 49.3% | 72 | 8.2% | 254 | 20.4% |
| 2013 | 158 | 41.0% | 74 | 9.2% | 232 | 19.4% |
| 2014 | 126 | 41.3% | 54 | 7.5% | 180 | 17.6% |
| 2015 | 141 | 44.2% | 53 | 8.2% | 194 | 20.1% |
| 2016 | 150 | 51.0% | 67 | 10.8% | 217 | 23.7% |
| 2017 | 128 | 44.3% | 46 | 7.6% | 174 | 19.4% |
| 2018 | 151 | 54.1% | 51 | 8.9% | 201 | 23.9% |
| 2019 | 158 | 30.5% | 49 | 5.91% | 207 | 15.4% |

| BBA – 3rd Stage - Dystocia: | Primigravida | Multigravida | Total |
|---|---|---|---|
| Total Number of Mothers | 518 | 829 | **1347** |
| Total Number of Babies | 524 | 844 | **1368** |
| >24 weeks or >/= 500g | | | |

| B.B.A. | Primigravida | % | Multigravida | % | Total | % |
|---|---|---|---|---|---|---|
| 2010 | 0 | 0.0% | 7 | 0.7% | 7 | 0.4% |
| 2011 | 1 | 0.1% | 2 | 0.1% | 3 | 0.2% |
| 2012 | 1 | 0.1% | 7 | 0.5% | 8 | 0.5% |
| 2013 | 1 | 0.2% | 6 | 0.6% | 7 | 0.5% |
| 2014 | 1 | 0.2% | 8 | 0.6% | 9 | 0.4% |
| 2015 | 0 | 0.0% | 6 | 0.7% | 6 | 0.4% |
| 2016 | 1 | 0.2% | 8 | 0.9% | 9 | 0.7% |
| 2017 | 0 | 0.0% | 10 | 1.2% | 10 | 0.7% |
| 2018 | 0 | 0.0% | 2 | 0.2% | 2 | 0.1% |
| 2019 | 0 | 0.0% | 2 | 0.2% | 2 | 0.1% |

| 3rd Stage Problems | Total | % |
|---|---|---|
| Primary PPH (1000ml) | 119 | 8.8% |
| Manual Removal of Placenta | 12 | 0.9% |

| Robson Groups: | Primigravida | Multigravida | Total |
|---|---|---|---|
| Total Number of Mothers | 518 | 829 | **1347** |
| Total Number of Babies | 524 | 844 | **1368** |
| >24 weeks or >/= 500g | | | |

| Mode of Anaesthesia for Elective and Emergency CS | Primigravida | Multigravida | Total | % |
|---|---|---|---|---|
| Spinal | | | 328 | 65.9% |
| Epidural | | | 98 | 26.1% |
| Combined Spinal | | | | 0.0% |
| General Anaesthetic | 50 | 8.0% | | |
| **Total** | **0** | **0** | **476** | **100.0%** |

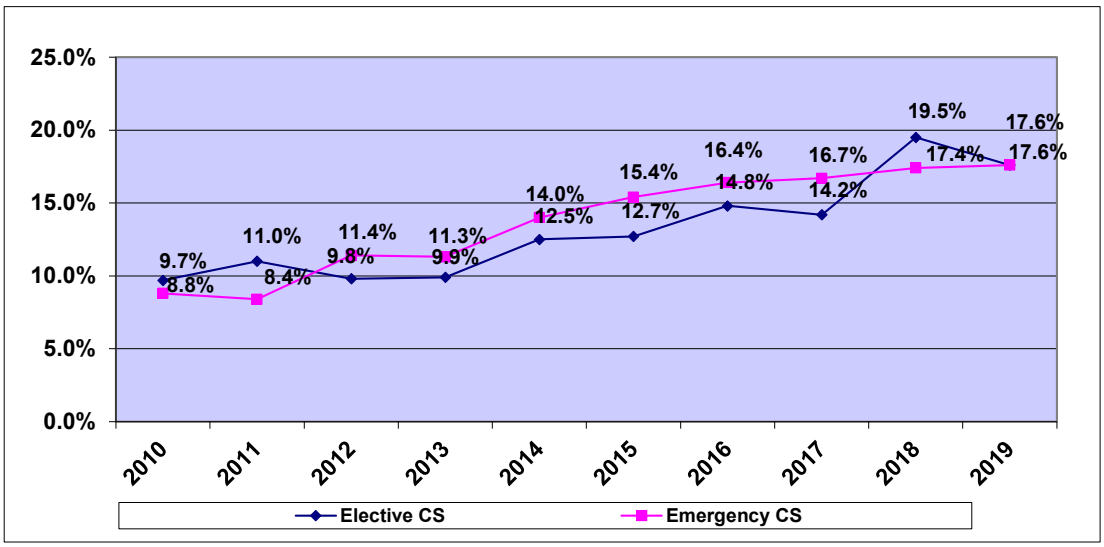
21 of 42 GAs were conversions from regional anaesthesia to facilitate Caesarean Section surgery

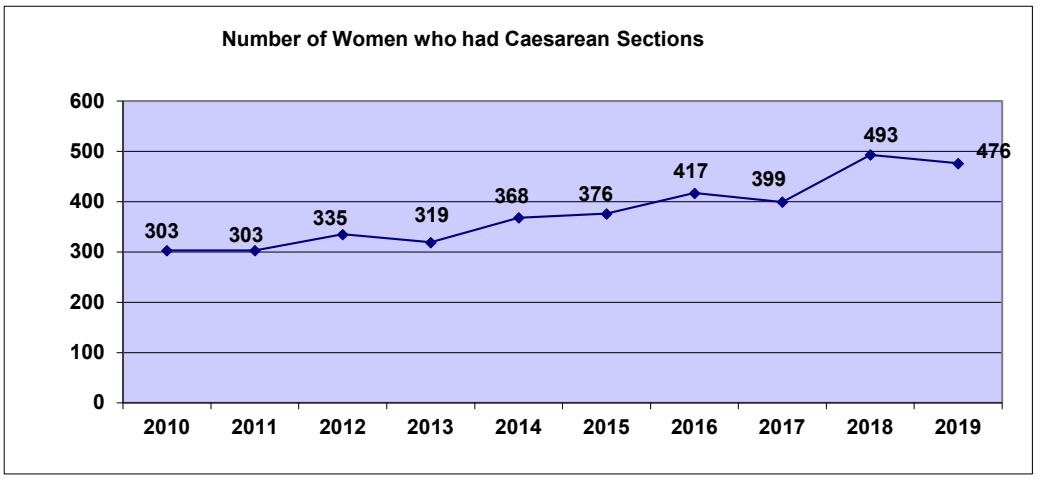
| Mode of Anaesthesia for Emergency CS | Primigravida | Multigravida | Total | % |
|---|---|---|---|---|
| Spinal | | | 0 | 0.0% |
| Epidural | | | 0 | 0.0% |
| Combined Spinal | | | | 0.0% |
| General Anaesthetic | | | | |
| **Total** | **0** | **0** | **0** | **0.0%** |

| Mode of Anaesthesia for CS following unsuccessful attempt at instrumental delivery | Primigravida | Multigravida | Total | % |
|---|---|---|---|---|
| Spinal | | | 0 | 0.0% |
| Epidural | | | 0 | 0.0% |
| Combined Spinal | | | | 0.0% |
| General Anaesthetic | | | | |
| **Total** | **0** | **0** | **0** | **0.0%** |

| Anaesthetics Graphs: | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 |
|---|---|---|---|---|---|---|---|---|---|---|
| Number of Women who had Epidurals in Labour | 509 | 560 | 589 | 577 | 475 | 482 | 501 | 490 | 480 | 531 |
| Percentage of Women who had Epidurals in Labour | 31.1% | 36.0% | 37.2% | 38.1% | 34.1% | 35.9% | 37.6% | 37.8% | 36.0% | 39.4% |

| | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 |
|---|---|---|---|---|---|---|---|---|---|---|
| Elective CS | 9.7% | 11.0% | 9.8% | 9.9% | 12.5% | 12.7% | 14.8% | 14.2% | 19.5% | 17.6% |
| Emergency CS | 8.8% | 8.4% | 11.4% | 11.3% | 14.0% | 15.4% | 16.4% | 16.7% | 17.4% | 17.6% |




| | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 |
|---|---|---|---|---|---|---|---|---|---|---|
| Number of Women who had Caesarean Sections | 303 | 303 | 335 | 319 | 368 | 376 | 417 | 399 | 493 | 476 |

| Breastfeeding: | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 |
|---|---|---|---|---|---|---|---|---|---|---|
| Breastfeeding Initiation Rates | 974 | 923 | 897 | 913 | 815 | 798 | 796 | 820 | 818 | 776 |
| Breastfeeding on Discharge | 796 | 794 | 734 | 771 | 700 | 694 | 725 | 715 | 699 | 459 |

# Section 1: Maternity
# *(b) Director of Midwifery Report*

Ms Juliana Henry

There were 1368 deliveries in 2019 and each year the changes in our maternity population become more and more evident. We are caring for many women who are older and have higher level care needs. As we continue to implement the National Maternity Strategy we are focusing our midwifery care across all pathways. In 2019 we continued to provide midwifery support at all Obstetric Clinics and provide a weekly Supportive Care Clinic in Sligo University Hospital. We opened a second community Midwifery Antenatal Clinic in Manorhamilton Co Leitrim. The popularity of our Advanced Midwife Practitioner clinics who provides care for women on both the supportive and assisted models of care continues to grow year on year.

During 2019 we upgraded our delivery suite and installed Piped Entonox and secured funding from the National Women and Infants health programme to redevelop an area in the delivery suite to a 'home from Home' Room for low risk mothers. Plans are currently in draft and work is due to commence in 2020. Funding from the Nursing and Midwifery Planning and Development Unit also made it possible to install baby alarm units in the maternity ward and source perineal suturing maniquins to commence training for midwives. Health promotion supported the funding of a dedicated breastfeeding room in the main foyer of the hospital and is a welcome and much needed addition to supporting staff who are breastfeeding and visitors to the hospital. The Maternity Unit implemented a Neonatal Early warning system and is a welcome quality initiative in the care of newborn babies. In March 2019 Maternity Services SUH had its first inspection from HIQA the Health Information Quality Authority for safer better Maternity Services. This was a very positive review and we look forward to implementing all of the recommendations from this review in 2020.

Bereavement care is extremely important part of our service and the 24th September 2019 saw the opening of the long awaited 'Solas Beag' family bereavement room in the Maternity Department. The room is dedicated to all the parents and family members who have experienced pregnancy or perinatal loss. "Making the 'Solas Beag' a reality required a huge fundraising effort which started with a donation from a family in memory of Zoe and Anna. With the help of the Friends of Sligo University Hospital; our staff; voluntary groups including the Innisfree Wheelers, Grange AC and Coolaney Gospel Choir; organisations including the Radisson Hotel and County Sligo Golf Club; and huge support from past patients and the wider community, we were able to raise €28,700 to date. This included a single donation of €7,300 from Regina Higgins who ran the women's mini-marathon of her baby son Jake who would have been 10 years old this year. The 'Solas Beag' family bereavement room was officially opened by Kian Egan and Regina Higgins. I would like to thank all of the Multidisciplinary staff who helped and supported with our funding raising efforts. I would also like to thank the 'Solas Beag' Working group in particular Ms Maria White CMS Bereavement Support and Colette Kivlehan CMM3 quality Improvement for their roles in leading this project.

In October 2019 we upgraded our Electric Information System moving from MIR to E3. The midwifery team were centrally involved in this change initiative ably led by Colette Kivlehan CMM3 Quality Improvement. This was a challenging process and its success was only made possible by the many staff who worked as super users and the Midwifery and Nursing team who supported the project and embraced the change. In December 2019, We also introduced an Obstetric Emergency Bleep which was a Multidispliinary Project between Midwifery, Obstetric, Anaesthetic, Paediatric and Clerical. We were delighted to finally implement this project after many years of planning!

We were delighted to welcome Ms Niamh Mc Garvey to the Assistant director of Midwifery Role which had been vacant since 2016. Ms Colette Kivlehan was appointed to the role of Clinical Midwife Manager 3 in Quality Improvement. After a long and dedicated service Ms Catriona Moriarty CMM2 for Antenatal Education retired from her role.

Education of Midwifery and Nursing students is a vital part of our role as a teaching hospital. I wish to thank Ms Karlene Kearns, clinical Placement Co- Ordinator and all of the Midwifery preceptors for the great support provided to all students.

Many of our Midwifery and Nursing Staff undertook various academic courses over 2019. We are very grateful to the CNME and NPDU who funded over 25,000 Euro to support staff in undertaking Continuing Education. The following is a list of the academic courses taken in 2019.

## Education and Training

- Ms Colette Kivlehan CMM in Quality Improvement undertook Patient Safety and Ethical Practice Modules in St Angela's College Sligo.
- Leona Mulvey Staff Midwife undertook Patient Safety and Ethical Practice Modules in St Angela's College Sligo.
- Ms Jennifer Curley, undertaking Nurse Colposcopy Training
- Ms Leanne Smith Staff Midwife undertook Patient Safety Module in St Angelas.
- Ms Lorna Mc Dermott Staff Midwife commenced her Masters in Ultrasound
- Ms Mairead Beirne completed her Masters in Perinatal Mental Health at University of Limerick.
- Ms Michelle Moriarty Completed her a MSc Quality & Safety in Healthcare
- Joanne Morahan Staff Nurse Quality and Healthcare Module and Patient Safety Module.
- Catherine Greaney Staff Nurse Masters in Nursing and therapeutic Communication in St Angelas.
- Barbara Carney Staff Midwife High Dependency in Maternity Care Module NUIG
- Sharon Reynolds Staff Midwife High Dependency in Maternity Care NUIG.

Finally, I wish to thank all of the Multidisciplinary staff in Women's and Infants health who have supported and embraced all the changes we implemented in 2019 and especially for their hard work in ensuring women and babies receive safe and quality care.

# Section 1: Maternity
# *(c) Registered Advanced Midwife Practioner Service*

Ms Roisin Lennon Advanced Midwife Practitioner

In 2019 a total of 271 women were cared for by the AMP with approximately 1400 antenatal reviews. This amounted to 20% of all women attending Sligo and Carrick on Shannon for their antenatal care. In 2018 there were 226 with approximately 1315 antenatal reviews. In 2017 there were 155 women cared for by the AMP with approximately 835 antenatal reviews.

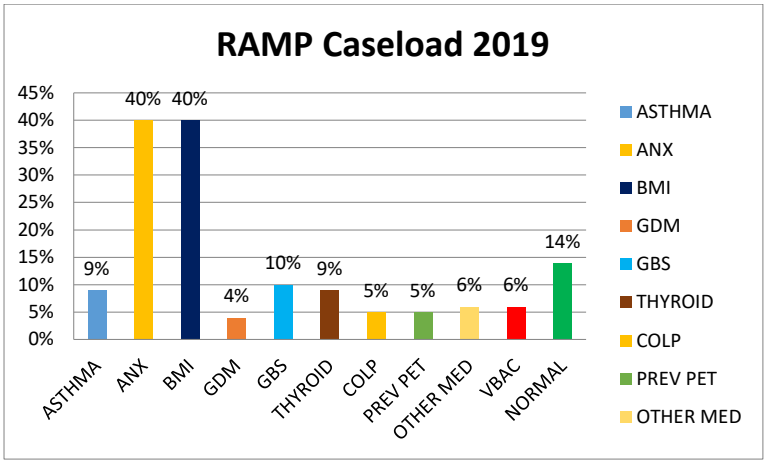
## Caseload:

80% of the women met the criteria for advanced practice care with 20% being supported care but attending the RAMP assisted care pathway. 15 % of these were seen in the Carrick on Shannon clinic where this clinic is a combination of supported and assisted care but care is given by the RAMP. Of the remaining 5% of women attending the RAMP, they had attended previously or came to suit work/family commitments. Around 40% of those receiving care either had a history of depression or anxiety or reported their previous birth as being traumatic, despite appearing on paper to be normal when the notes were reviewed with them. Approximately 40% of women had a raised BMI, 4% had gestational diabetes mellitus (GDM) (diet controlled) and 7% wished to have a vaginal birth after a previous caesarean section. The rest of the women had stable medical conditions, a history of group B strep with around 10% being referred at term by the midwives for ongoing plan of care.

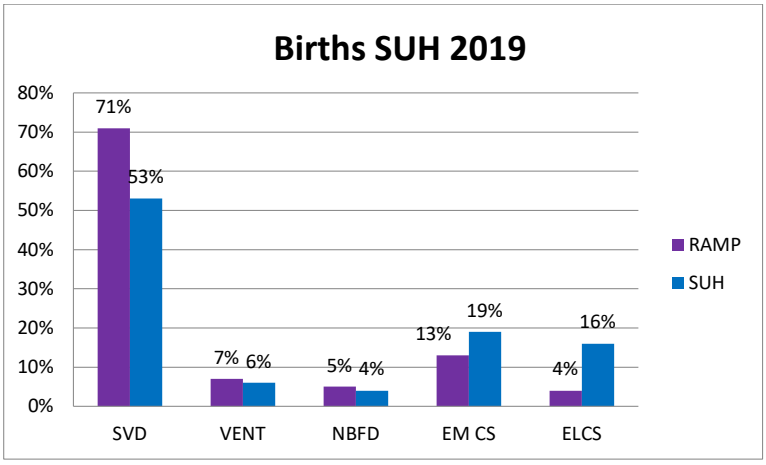
## Shared Care with consultant:

The AMP provided shared care with the consultant obstetrician for 3% of women. One lady had polyhydramnios at 38 weeks, 2 had slightly abnormal liver function tests but no cholestasis, 2 had small for gestational age babies, 2 had elevated urea or uric acid but no protein urea or hypertension and the other 2 had rising blood pressures but normal bloods at term. Care was planned in collaboration with the consultant for these women.

**Graph 1:**

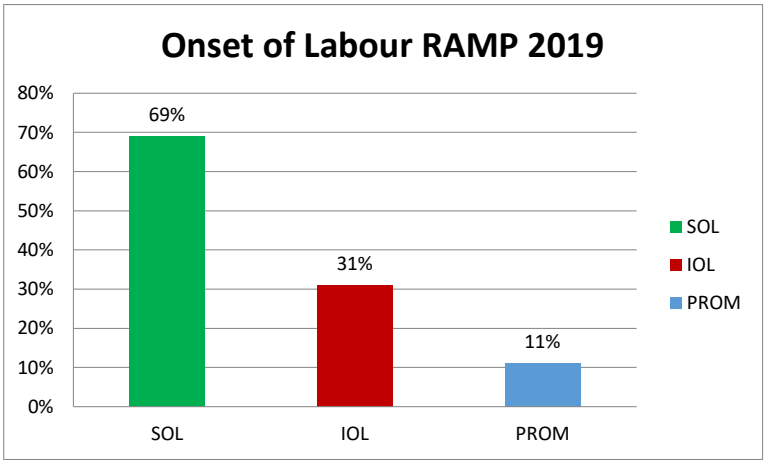



**Graph 2:**




**Onset of labour and IOL:**

**Graph 2:**



## Transfer to consultant

Another 2% of women were referred back to the consultant team for various reasons including breech at 39 weeks, pre eclampsia, cholestasis and GDM on medication.

24% of inductions of labour resulted in a CS. Of these, 25% were PROM and never in established labour with 25% having a CS at full dilatation for OP and the rest for either non reassuring CTG or no progress in the first stage of labour. The induction rate in SUH was 32% with a 52% failed induction rate.

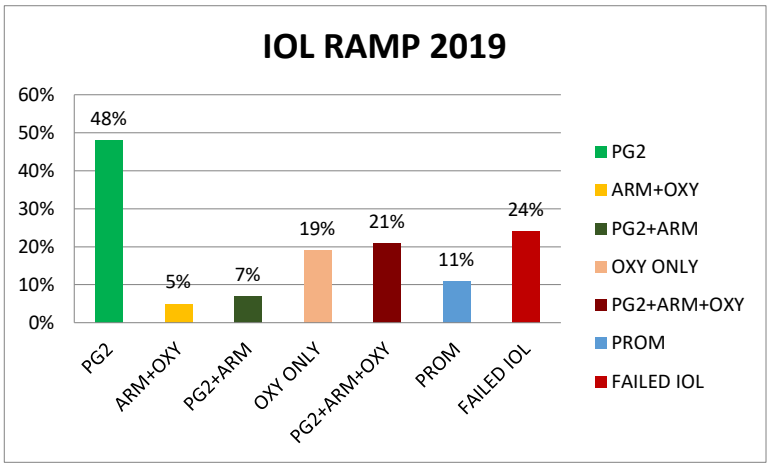
## KPI 1 & 3:

KPI 1 and KPI 3 evaluating the women's experience of midwife led care (supported pathway) and RAMP led care (supported/assisted pathway) has proven challenging. An online Surveyhero questionnaire was developed in July 2019. It took a few months to arrive at the final version which got sign off in December. The plan is to post the details of the survey, along with a consent form to all women who attended RAMP and MMC care and to evaluate the results then. Several cards, letters and emails of thanks and gratitude have been received by the RAMP from her caseload and these have been kept.

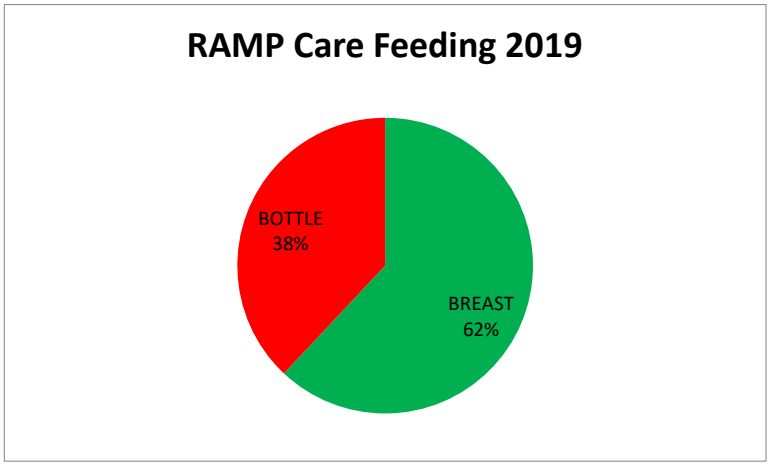
## KPI 2 VBAC:

15 ladies with one previous CS attended for AMP care in 2019. 2 requested a repeat elective CS. Neither wished a VBAC. 2 had repeat elective CS for unstable lie. 1 had a repeat elective CS for breech. The other 10 ladies had successful VBACs. 8 were SVD, 1 had a Ventouse and 1 had a forceps birth.

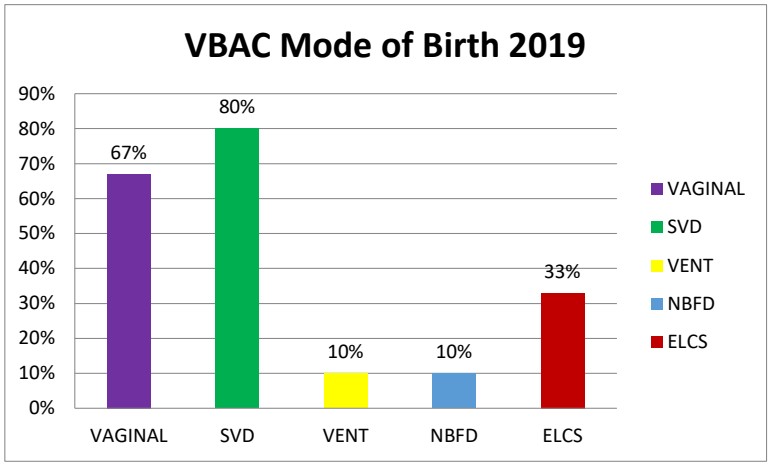
**Graph 3:**




**Graph 4:**




**Graph 5:**



# Section 1: Maternity
# *(d) Obstetrics & Gynaecology Anaesthesia Report*

Ms Colette Kivlehan Clinical Midwife Manager 3 Quality Improvement, Dr Emer OMahony Consultant Anaesthetist

In 2019, there were a total of 1276 gynaecology procedures performed. This included 476 caesarean sections, of which 238 were elective and 238 emergency. A total of 50 general anaesthetics were administered for Caesarean Sections, 23 of which were conversions from regional anaesthesia to facilitate surgery. Labour ward activity included 1130 deliveries. There were 426 (31.6%) inductions of labour and 531 (47%) epidurals performed during 2019. There were 148 instrumental deliveries, of which 83.7% had an epidural.

## ICU & HDU admissions 2019

There were 22 maternity admissions to Intensive Care (including High Dependency Care) .

These are classified as:
- 11 PPH
- 7 Pre Eclampsia
- 2 sepsis
- 1 anaesthetic recovery
- 1 anaphylaxis

Admissions, once clinically well, were discharged to Maternity Ward.

## Developments in 2019

- On call rota now consists of 2 NCHD's 2 consultants.
- PROMPT training is ongoing but proving challenging during 2019.
- Acute pain team Monday to Friday.
- Anaesthestic antenatal talk.
- Obstetric emergency bleep introduced in Dec 2019.

## Pre-assessment Anaesthesia Clinic

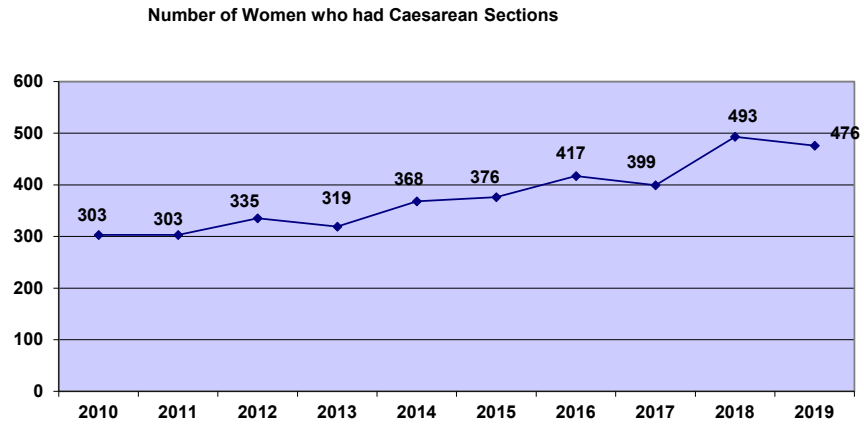
125 women were assessed in the high-risk Anaesthetic Clinic in 2019.

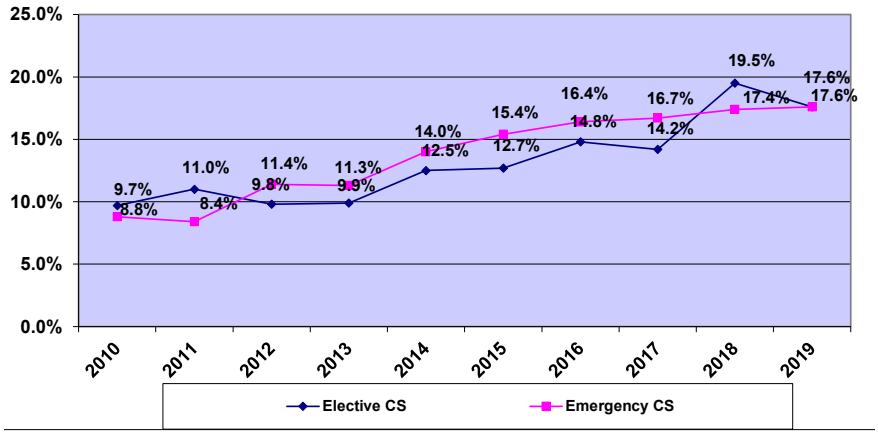
## Post-Dural Puncture Headaches

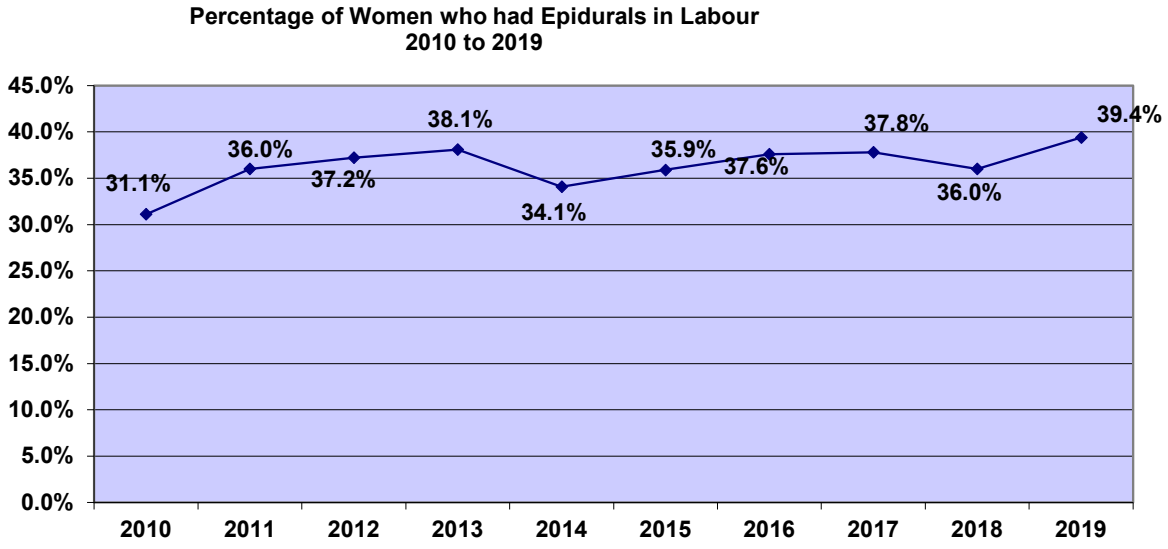
3 patients required blood patches for PDPH.

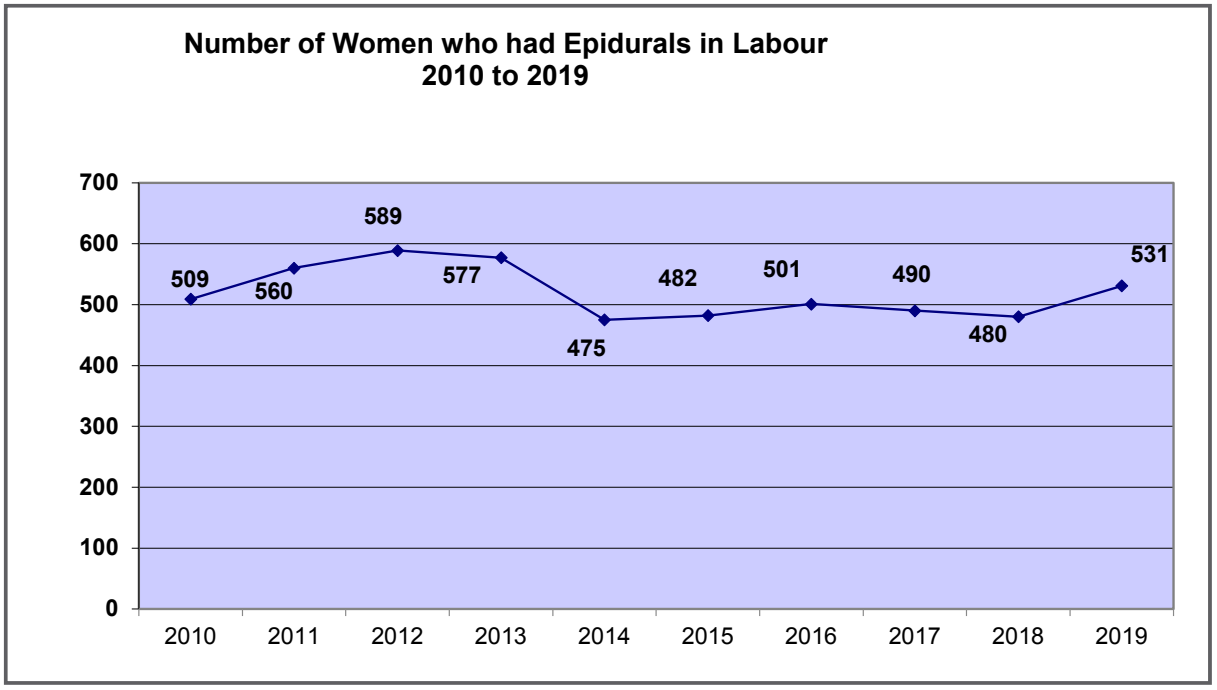
| | Caesarean Sections | Percentage |
|---|---|---|
| Total | 476 | 100 |
| Elective | 238 | 50 |
| Emergency | 238 | 50 |
| Spinal | 328 | 69% |
| Epidural Top-Up | 98 | 20% |
| General Anaesthesia | 50 | 10% |

*14 of 50 GA were conversions from Regional anaesthesia to facilitate Caesarian Section surgery.




Percentage of Women who had Epidurals in Labour
2010 to 2019
45.0%
40.0%
35.0%
30.0%
25.0%
20.0%
15.0%
10.0%
5.0%
0.0%
31.1%
36.0%
37.2%
38.1%
34.1%
35.9%
37.6%
37.8%
36.0%
39.4%
2010
2011
2012
2013
2014
2015
2016
2017
2018
2019


Number of Women who had Epidurals in Labour
2010 to 2019
700
600
500
400
300
200
100
0
509
560
589
577
475
482
501
490
480
531
2010
2011
2012
2013
2014
2015
2016
2017
2018
2019

# Section 1: Maternity
## *(e) Antenatal Clinics*

Ms Ita Morahan CMM2 & Ms Colette Kivlehan CMM3

Sligo University Hospital antenatal service covers a large geographical area within the Saolta group. Counties included are Sligo, Leitrim, south Donegal, west Cavan, north Roscommon and east Mayo. We provide safe, women centred and easily accessible care at Sligo, Ballyshannon, Manorhamilton and Carrick on Shannon clinics.

Antenatal clinics run Monday to Thursday incorporating consultant led, midwife led and midwife only booking clinics. We have a team of ten midwives and one health care assistant.

Currently our consultants triage GP antenatal referral letters. Booking appointments are scheduled between 12-14 weeks with most dating scans completed in our Fetal Assessment unit prior to booking with midwife and consultant. The booking visit comprises of individualised risk assessment and health education with a midwife followed by obstetric consultant clinical review. Further antenatal care is provided under the Supported, Assisted or Specialised antenatal care models (DOH 2016) based on overall findings and discussion with the midwife and consultant at the first visit.

We deliver midwifery led care to low risk women under the Supported model in Sligo, Carrick on Shannon and since December 2019 in Manorhamilton clinic also. The midwife clinic in Sligo University Hospital on Monday afternoons is led by senior midwives. Our Advanced Midwife Practitioner (AMP) Roisin Lennon conducts clinics Monday to Thursday for Supported and Assisted care at these locations. The latter under criteria agreed upon at specialty level. Specialised obstetric antenatal care for high risk women is provided at all four clinic locations with the support of Sligo Fetal Assessment unit when required.

In April 2019 Sligo University Hospital added a new service to its maternity service. An antenatal and gynaecological outpatients clinic was opened in Ballymote, Co. Sligo. This area was chosen as it covers a large geographical area in South Sligo and into Counties Roscommon and Mayo. This clinic has become very popular and has proven to be a beneficial addition to the service.

2019 also brought change and improvement in the antenatal and gynaecological outpatient service in Ballyshannon, Co Donegal. We relocated the clinic in Ballyshannon to a newly built primary care centre with modern facilities to enhance the clinic experience for the women.

Collaborative care between our consultant obstetricians and specialties such as neurology, haematology and rheumatology ensure seamless, comprehensive and high-quality antenatal care. Screening for gestational diabetes is conducted in accordance with HSE guidelines. Pregnancies complicated with Diabetes receive multidisciplinary care by Obstetricians, Midwifery, Clinical Midwife Specialists (Sonographer), Endocrinologists, dieticians and the Diabetic Clinical Nurse Specialists.

Separate midwife-only booking clinics commenced in Autumn 2018 due to increased demand at our out-lying venues, notably Carrick on Shannon. Women from these clinics are booked by a midwife in Sligo and followed up by the consultant at the next out-lying clinic. This has ensured timely access for women to the service and efficient use of resources at all sites.

Our Bereavement Support midwife (BSM) Maria White began her role in January 2018. Adhering to the National Standards for Bereavement Care following Pregnancy Loss and Perinatal Death Maria provides and co-ordinates formal and standardised bereavement care to women in all areas of pregnancy loss that may have attended or are attending antenatal clinics. This includes miscarriages, fatal fetal abnormalities/life limiting conditions and stillbirths. Maria works with the multi-disciplinary team as an identifiable resource to bereaved parents, siblings and families around the time of loss, following discharge home and support in subsequent pregnancies. Supporting parents with their hospital appointments is a large part of the BSM role. Maria advocates on behalf of parents as they navigate through hospital visits ensuring scheduling is sensitive to their needs.

With Maria's expertise and support Sligo University Hospital have held Maternity Bereavement Study days. These are an opportunity for staff to learn about best practice and bereavement services available within the hospital and community setting.

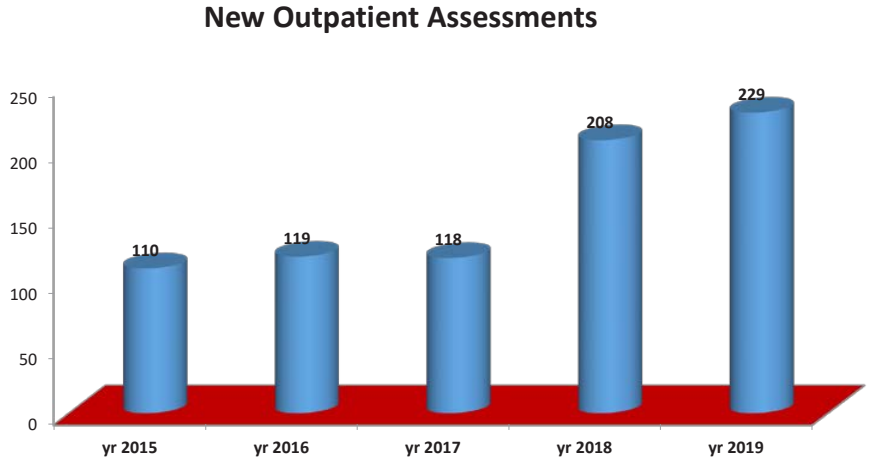
We consistently promote midwifery led care to all normal risk women. Providing high standard of holistic care to women attending all of our antenatal clinics is our priority. We look forward to future developments in the service such as the appointments of a Mental Health Liaison midwife and a diabetic Midwife Specialist.

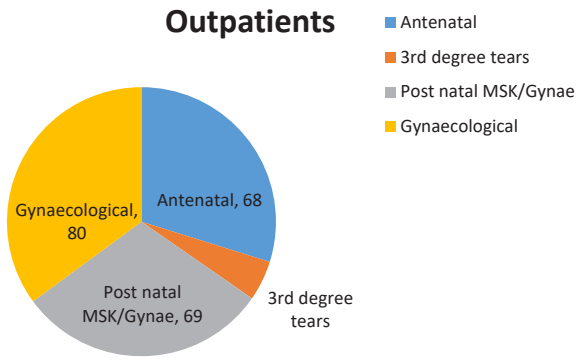
# Section 1: Maternity
# *(f) Physiotherapy Women's Health & Continence Service*

Ms Joanne Kilfeather Senior Physiotherapist

The Physiotherapy Women's Health and Continence Service encompasses both Inpatient and Outpatient Physiotherapy care. The Inpatient service to the maternity ward endeavours to offer Physiotherapy advice and treatment to all post natal mothers.

In 2019, 1,032 mothers were given postnatal Physiotherapy advice on the Maternity ward. This information related specifically to safe functional movements, respiratory care and basic exercise advice and precautions after a caesarean delivery. Advice regarding posture, pelvic floor exercises and baby positioning is explained to mothers, regardless of the modes of delivery. A total of 141 mothers received additional, subsequent follow up on the maternity ward in the days after their delivery. Outpatient Physiotherapy follow-up is always made for mothers post 3rd/4th degree tears at both two weeks and six weeks post partum. Postnatal outpatient follow-up is offered to all women in the initial weeks post delivery. The outpatient service receives primarily hospital generated referrals for both Obstetric and Gynaecological patients.




The number of antenatal outpatient referrals accounts for 45% of the outpatient attendances; this is an increase of 11% on 2018. In late 2018 we started an early Physiotherapy antenatal class which focused specifically on exercise in pregnancy and musculoskeletal issues, this possibly has impacted on the number of women seeking referral for musculoskeletal issues in pregnancy, as the birth rate did not increases significantly on the previous year.

## Antenatal Education

Physiotherapy provides two of the five daytime classes. This service is run in conjunction with our midwifery colleagues.

| Total No. Day Classes | Total Attendance for Expectant Mothers |
|---|---|
| 41 | 336 |

## Initiatives

The Antenatal evening classes have been replaced with a video tour of the maternity services in Sligo University Hospital. This video is available on-line to all expectant mothers and their birthing partners.

This initiative was driven by a few factors that necessitated change;

- Infection control and privacy for birthing mothers had become a concern on the labour ward when the "tour of the labour ward" was occurring every month in the hospital. The video has now reduced unnecessary footfall to the labour ward.
- Need for equality in accessibility of this service to mothers and their partners who may live too far from the hospital to orientate themselves with the environment.

# Section 1: Maternity
# *(g) Maternal & Fetal Assessment Unit / Early Pregnancy Assessment Unit / Fetal Ultrasound*

Ms Niamh McGarvey Assistant Director of Midwifery for Women's and Children's

## Maternal and Fetal Assessment Unit

In 2019 there were 709 elective patients and 1213 emergency patients reviewed in FAU, totalling 1922 women. The number of women cared for in the fetal assessment continues to increase year on year. The unit provides a service to antenatal women who require evaluation of both fetal and maternal wellbeing in an emergency or elective setting. Referrals to the unit are by Consultant Obstetrician/ NCHD's, GP's, Advanced Midwife Practitioner or midwives. In addition to ultrasound services we provide additional services such as CTG monitoring, Glucose tolerance testing, pre operative assessment, monitoring of hypertensive disorders of pregnancy and administration of antenatal corticosteroids and RAADP

## Early Pregnancy Assessment Unit (EPAU)

In 2019 there we 816 women reviewed in the EPAU at SUH. The EPAU manages emergency referrals, inpatient referrals as well as women with scheduled non urgent appointments. The EPAU in SUH is staffed by 2 Clinical Midwife Specialists and 2 midwife Sonographers. The EPAU has a designated Senior Obstetric Registrar and is supported by a Clerical officer. A Bereavement Clinical Midwife Specialist is available to council woman following an adverse pregnancy outcome. Women can access the EPAU service by Obstetric referral, or by GP. Women with a history of ectopic pregnancy, early pregnancy loss, or gestational trophoblastic disease are also seen in the EPAU.

In This unit staff provide care, support and advice to women who develop complications in the first 13 completed weeks of pregnancy, and support women and their partner following the diagnosis of an early pregnancy loss in a caring and supportive manner.

## Fetal Ultrasound

The ultrasound service in SUH includes the provision of a dating scan between 11-13+6 weeks gestation, an anomaly scan at approximately 20 weeks gestation, and other scans as deemed necessary such as: assessment of fetal growth, placental location, fetal wellbeing, amniotic fluid volume, Umbilical artery Doppler, Large for gestational age, estimated fetal weight.

High risk women e.g. Twin Pregnancies, are scanned on a 2-4 weekly basis depending on chorionicity of twins. Women with gestational diabetes, small for gestational age, Intra uterine growth restriction, pre-eclampsia, antibodies etc. are scanned on a 2-4 weekly basis of more frequently if deemed necessary by the Clinical Midwife Specialist or Consultant Obstetrician.

A total of 6,654 ultrasound scans were performed in 2019.

This figure includes:
- 816 EPAU scans
- 1103 Dating scans
- 1116 Anomaly scans
- 354 Cervical length scans
- 3263 Other for indications as outlined above.

During 2019 there were 50 pregnancies diagnosed with 1 or more fetal abnormalities. These abnormalities were confirmed or suspected at either the dating or anomaly scan and were referred on to a tertiary referral centre for review, on-going care and management, or discharged back for care in SUH.

A list of the fetal abnormalities diagnosed in 2019 is outlined below:

**CNS malformations:**
Microcephaly, >NT, Ventriculomegaly, Cystic hygroma, Bilateral CPC's, Anencephaly, Spina Bifida, Pericardial effusion, Heart block

**CVS malformations:**
Right hypoplastic heart, Echogenic foci

**Renal tract malformations:**
Unilateral renal agenesis, SUA, Renal pyelectasis, Multicystic kidneys

**Musculo-skeletal malformations:**
Micrognathia, Meningocele

**GI malformations:**
Abdominal ascites

**Chromosomal Abnormalities:**
Known T21, T13

Other: Bronchial atresia, Bilateral pleural effusion, Bilateral cleft lip and palate, Hydrothorax. Amniotic band, Placentography, Abnormal Umbilical Artery Dopplers

In 2019 there were 23 women referred for fetal echocardiogram due to family history of congenital heart disease, type 1 Diabetes or other clinical indication.

# Section 2: Neonatology & Paediatrics
# *(a) Neonatal Intensive Care Unit*

Ms Carmel Durkin Clinical Nurse Manager 2 Special Care Baby Unit

## Introduction

The unit is lead by 5 paediatricians and staffed by a CNM 2 and SCUB nurses, supported by a multidisciplinary team which includes healthcare assistants, a clerical officer, dietician, radiology, paediatric physiotherapist, paediatric trained cardiac technician, social work department, paediatric liaison nurse, CMS in bereavement support, chaplains and a neonatal staff nurse who is also a lactation consultant.

Periodically satellite clinics for paediatric cardiology and cleft lip / palate are held in Sligo University Hospital. Ophthalmology, ENT, orthopaedic, and dermatology referrals and reviews are available locally as required.

## Neonatal Unit Activity 2019

In 2019 there were 297 admissions to NICU which included 8 social admissions and 14 day cases. Admissions for 2019 were slightly lower than previous years. All admissions were from delivery ward, theatre, maternity ward or tertiary hospitals. In total there were 27 transfers to and from tertiary units, also lower numbers than previous years. The NNTP team retrieved 9 infants for transfer to tertiary neonatal units and paediatric hospitals for ongoing management. The NNTP team also facilitated 2 transfers back from tertiary neonatal units, 16 of these transfers were undertaken by our own staff, 9 were retro transfers for ongoing neonatal care, 7 infants were emergency transfers but did not require NNTP team.

The average daily occupancy rate for 2019 based on allocated bed spaces was 41.73%.Looking at infant dependency as per BAPM (British Association of Perinatal Medicine) the average daily occupancy rate for intensive care was 0.41%, high dependency was 5.62% and special care was 98.42%.Preterm infants i.e.<37/40 gestation accounted for 34.6% of all admissions and 65.4% were term infants (excluding day cases). No infants required therapeutic hypothermia throughout the year. There were no neonatal deaths in 2019.

## Quality Initiatives in 2019

- Clinical placement of student midwives in NICU
- Introduction of neonatal skin assessment score in NICU
- Audit and poster presentation of infant skin assessment, presented at Clinical Audit Study Day at Sligo University Hospital.
- Audit of use of parenteral nutrition in NICU
- Audit of NICU management of newborn hypoglycaemia
- Audit of emergency neonatal and paediatric transfers from Sligo University Hospital to tertiary centres over a two-year period. (Presented at the Europaediatrics World Congress )
- Case report: Management of a neonate with brachial artery thrombosis
- (Presented at the Europaediatrics World Congress)
- Smart pumping information for mothers expressing
- Standardisation of daily/weekly NICU equipment checks
- Video laryngoscope purchased and staff training in using same
- Purchase of LED phototherapy unit
- Introduction of neonatal resuscitation record sheet to maternity services
- Euroking, neonatal admissions and discharges computerised records
- Appointment of CNM 3 Quality and Safety for Maternity Services
- Lean Whitebelt certification for CNM 2 and 3 staff nurses, implementation of lean sigma principles in NICU

## Professional Development

- 4 nursing staff attended Neonatal study day facilitated by University Hospital Galway
- 1 nurse attended Legal and Professional Issues study day
- 3 nurses attended Bereavement study day
- CNM 2 attended Business case master class, Human factors and patient safety, Critical conversations study days.
- 1 nurse commenced studies in Msc. In Nursing RCSI
- 1 nurse commenced studies in Postgraduate Diploma in Health Sciences at St Angela's College, Sligo.
- Nursing staff certified in NRP and STABLE course.

## Conclusion

Continuing professional development is encouraged to ensure safe, quality evidenced based practice. Challenges to the service include unit design, lack of storage facilities, lack of parent facilities, privacy for staff and parents, and recruitment of neonatal nurses. I would like to take this opportunity to thank all the staff for their continued dedication and commitment to the service. Thanks also to the wider multidisciplinary team, CNM3's, ADOM and DOM for their advice, support and leadership.

# Section 2: Neonatology & Paediatrics
# *(b) Paediatric Insulin Pump Service Report*

Ms Claire Maye / Ms Sinead Molloy

## Introduction

This report reflects the activity of the paediatric diabetes service in Sligo University hospital for the period January to December 2019. The data includes information for the regional centre of excellence for paediatric insulin pump therapy for the North West of Ireland including children referred from Letterkenny University Hospital.

## Overview

There were approximately 110 patients who attended the paediatric diabetes centre in SUH in 2019. This number includes a total of 20 patients referred from Letterkenny University hospital for insulin pump suitability assessment, of which 8 patients went on to commence pump therapy in 2019. Table 1 displays a breakdown of the age profile of the patients using insulin pump therapies. The service completed 25 insulin pump patient education programmes with 12 new pump starts and 13 pump upgrades.8 patients commenced continuous glucose monitoring. In 2019 53% of patients attending the diabetes service were using insulin pump therapy

**Table 1.**

| Children with T1D attending SUH | Total Number | Total Number on a pump | Total number of children with Type 1 Diabetes shared care with tertiary centre |
|---|---|---|---|
| 0-5 yrs | 5 | 3 | 2 Dublin |
| 6-12yrs | 33 | 18 | 3 Letterkenny |
| 13-15yrs | 33 | 14 | 4 Letterkenny |
| 16-18yrs | 21 | 13 | 1 Letterkenny |
| Total | 92 | 48 | 10 |

## Metabolic control

There has been a continued improvement in insulin pump users' metabolic control year on year for all patients attending the diabetes service with a mean HbA1C of 60mmol/mol (7.6%) in 2019. Overall mean HbA1c of our insulin pump cohort has been maintained in 2019 this year to 56mmol/mol (7.3%) internationally recommended target of 7%. In 2019 in Sligo University hospital the mean HbA1c of patients using multi dose injections for their diabetes care is 64mmol/mol (8%).

## Continued care

As per the model of care 2015 all children with Type 1 diabetes are offered outpatient review with the multidisciplinary team every 3 months, 88% of patients attended these clinics with 70% of patients receiving review with the diabetes nurse specialist or diabetes dietician in the diabetes centre between clinic visits. This includes the running of structured diabetes education programmes with children and their families, CHOICE programme.

Diabetes Technology has greatly enhanced service provided. Children on insulin pump have their data reviewed virtually and this is followed on with phone call to parents making adjustments to insulin doses between clinic visits.

# Section 2: Neonatology & Paediatrics
# *(c) Paediatric Report*

Ms Bernie Biesty Clinical Nurse Manager

## Introduction

This report includes clinical activity for the period January 1st to December 31st 2019 for Paediatric Services in Sligo University Hospital. Data is included for Paediatric Ward and Day Unit, paediatric admissions from the Emergency Department (ED), paediatric admissions to Intensive Care Unit (ICU) and admissions to the paediatric ward by specialty. Data supplied for this report was obtained by the Hospital Information Management System.

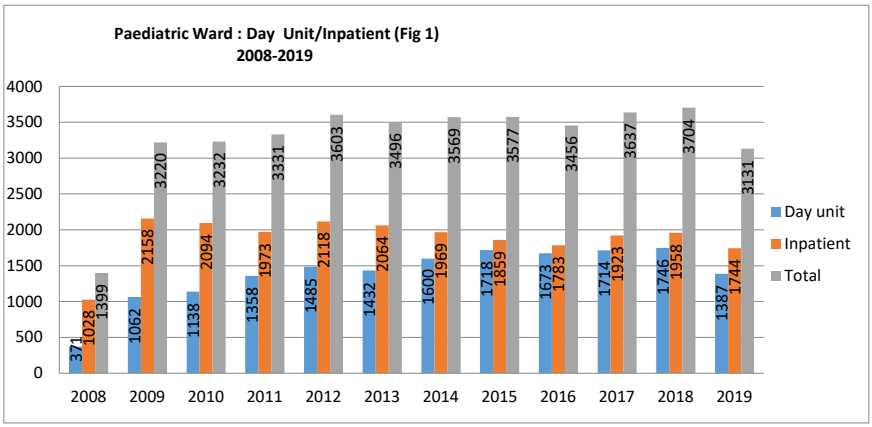
## Overview of Paediatric Ward Activity 2019

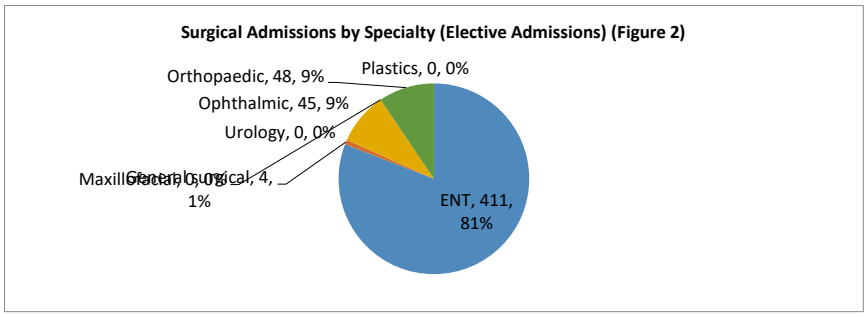
There were 3,131 children treated in the Paediatric Ward between the inpatient and day unit attendances (Figure 1) .There were 1,744 admissions to the Paediatric Ward (1,958 in 2018). There was 85.78% bed occupancy, a decrease of 15.48% from last year, with over 100% occupancy 4 months of the year. The average length of stay was 2.96 days compared to 3.19days in 2018. There were a total of 32 transfers out to other hospitals and 4 transfers in from other hospitals.

## Paediatric Day Unit

There were a total of 1,387 infants and children treated in the Paediatric Day Unit in 2019, as a ward attender or day case. These included a variety of reasons including the shared care management of children with complex and chronic illness requiring close monitoring and treatments locally. Other reasons for attendance included clinical reviews, phlebotomy, radiological procedures including MRI under GA, biological agent infusions and blood and blood product administration. A working group has been established to examine current practices and explore the options available to capture more accurate data for in patients, day unit and ward attenders.

There were 852 surgical admissions, 508 of those elective. The elective surgical admissions by specialty are displayed in Figure 2.




## Paediatric Emergency Department Activity

There were 7,238 paediatric attendances in the ED with 1,342 children admitted via ED (18.5%).

## ICU Admissions

There were 6 children admitted to ICU SUH during 2019, similar to 2018. Diagnoses include DKA (4), Cardiac Arrest (1) and Aspiration Pneumonia (1).Of these 6 ICU admissions, 2 were transferred to PICU. The remaining 4 patients who were not transferred spent between 22-51 hours in ICU for monitoring purposes before transferring back to the paediatric ward for further management.

## Paediatric OPD

Paediatric outpatient clinics are provided in SUH and outreach clinics in Carrick on Shannon and Donegal Town. Community clinics are held in the following locations:

- Primary Care Centre, Sligo
- Donegal Community Hospital
- Manorhamilton Community Hospital
- Dromod Primary Care Centre
- Crua Gorm Early Intervention School age service, Donegal Town
- Primary Care Centre, Manorhamilton
- Nazareth House, Sligo
- The Beeches, Carrick on Shannon
- Tubbercurry Health Centre
- Holy Family
- St Cecilia's School

Data available on the Hospital Information System is not inclusive of all clinics and therefore not accurate. 2019 figures show 4,468 attendances at outpatient clinics, with 1,530 new patients and 2,938 reviews. However this figure does not include a significant number of community Consultant Paediatric clinics. For example 10 new and 110 review patients were seen in the Donegal Town Community clinic in 2019 and this activity is not recorded. None of the Joint Assessment clinics are included (over 100 new patients per year) and none of the MDT review patient clinics are included (over 200 patients per year). The new patient Autism assessment clinics are also not included (20 patients per year).

## PEWS 2019

The use of the Paediatric Early Warning Score System continues to be an integral part of clinical practice on the unit. Nursing and medical staff alike are competent in its' use, specifically for earlier detection and intervention of the critically ill child. All staff were recertified in 2019 with a course update. Of note, what was originally the medical escalation suspension section, has now following guidance from the national early warning committee, been changed to a medical suspension agreement, whereby the medical and nursing team discuss the most appropriate intervention for the child, thereby improving communication between the team members. PEWS Audits are continued monthly, which continue to show greater than 90% compliance with use of PEWS and appropriate escalation. Figure 3 shows overall compliance for 2019.

## Paediatric Sepsis

SUH participated in a 3 month Paediatric Sepsis Pilot from October-December 2019. Staff Nurses Declan Maye and Siobhan O Donnell who are Sepsis Champions based on the Paediatric Ward and Dr Tummaluru, Consultant Paediatrician led this initiative and provided medical and nursing staff with education, training and support to improve recognition and standardising the response to Paediatric Sepsis. We are awaiting feedback on this pilot. The sepsis champions also participated in SUH World Sepsis Day with a stand displaying information about paediatric sepsis.

## Audit and Research

SUH Paediatric Department was extremely well represented at the Europaediatrics World Congress in Dublin in June 2019. The following research was presented

**GP100 Toddlers, teens and everything in between. should all children be admitted to the same ward?**
Jun 2019
Rachel Mullaly, Elena Nechita, Mags Clancy, Sinead Keaveney, Dara Gallagher

**P228 An audit of emergency neonatal and paediatric transfers from sligo university (SUH) to tertiary centres over a two-year period**
Jun 2019
Samy Allawendy, Emmanuel Osakwe, Dara Gallagher, Wouter Jonkers

**P575 Case report: twins with Niemann Pick syndrome**
Jun 2019
Samy AA Allawendy, Cormac Duff, Dara Gallagher, Ann Sheehan

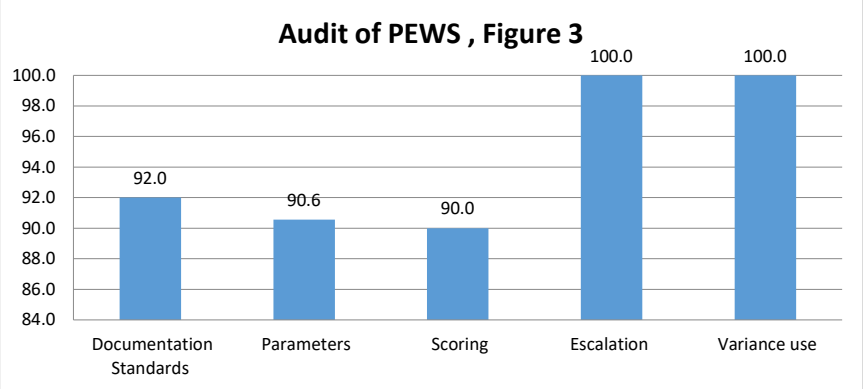
**GP218 Growth patterns in a paediatric outpatient clinic and its association with child eating behaviours and parental feeding style**
Jun 2019
Aisling Lee, Louise Rattigan, Dara Gallagher, Laura Keaver

**P144 These hips don't lie: a completed audit of hip surveillance among children with cerebral palsy**
Jun 2019
Catherine Breen, Ghia Harrison, Dara Gallagher, Hilary Greaney

**P520 Growth patterns in a paediatric outpatient clinic at sligo university hospital and its association with child food preference and parental perception of child weight status**
Jun 2019
Christine Houlihan, Louise Rattigan, Dara Gallagher, Laura Keaver

## Nursing Metrics

| Sligo University Hospital : HSE Children's Services (2018) - Paediatric Ward - | Mar 2019 | Apr 2019 | May 2019 | Jun 2019 | Jul 2019 | Aug 2019 | Sep 2019 | Oct 2019 | Nov 2019 | Dec 2019 | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Child and Adolescent Mental Health | 100% | 100% | | | | | | | 100% | | 100% |
| Discharge Planning | 92% | 100% | 89% | 100% | 100% | 89% | 91% | 67% | 50% | 50% | 81% |
| Healthcare Associated Infection Prevention | 100% | 100% | 100% | 100% | 100% | 79% | 80% | 89% | 87% | 100% | 93% |
| Medication Management | 100% | 100% | 95% | 100% | 97% | 95% | 94% | 86% | 98% | 93% | 96% |
| Nursing Care Planning | 98% | 100% | 100% | 100% | 92% | 83% | 88% | 74% | 86% | 78% | 89% |
| Nutrition | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 57% | 100% | 100% | 96% |
| Pain Assessment and Management | 73% | 100% | 100% | 100% | 100% | 100% | 75% | 50% | | 100% | 83% |
| Vital Signs Monitoring / PEWS | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 91% | 100% | 100% | 99% |
| **Total** | 98% | 100% | 97% | 100% | 97% | 90% | 91% | 79% | 91% | 88% | 93% |



**GP68 More than a fever: a case series of atypical kawasaki disease**
Jun 2019
Cormac Duff, Dara Gallagher, Rohininath Tummaluru, Anthony Ryan

**P67 Case report: Management of a neonate with brachial artery thrombosis**
Jun 2019
Samy Allawendy, Dara Gallagher, Cormac Duff, Emmanuel Osakwe, Saima Aslam

**P603 Uropathogen profile in the paediatric population – a comparative study between two geographically distinct regions in Ireland**
Jun 2019
Samy AA Allawendy, Mahmoud Farhan, Alessandra Biagini, Alan Finan

**P410 How NICE are we? A quality improvement project to improve compliance to mental health screening during clinical consultation of children with cerebral palsy according to the nice guidelines**
Jun 2019
Catherine Breen, Ghia Harrison, Hilary Greaney

**P569 Dejerine-Sottas syndrome and cranio-facial dysmorphisms: a case report**
Jun 2019
Alessandra Biagini, Elena Nechita, Willie Reardon, Ghia Harrison

**P156 Adherence to vitamin D prophylaxis in infant under 1 years of age. a re-audit of vitamin D supplementation, compliance and education in sligo university hospital**
Jun 2019
Alessandra Biagini, Ghia Harrison, Rolf Knapp, Rohininath Tummaluru

## Professional Development

- Ms Sarah Parke (staff nurse), Ms Caroline Beirne (staff nurse), Ms Bernie Biesty (CNM2) and Ms Emer Parke (staff nurse) all successfully completed APLS, facilitated by SUH.
- Ms Nicola Waters (staff nurse) successfully completed Higher Diploma in Education, NUIG and registered as Nurse Tutor.
- Ms Lorraine Williams (staff nurse) , successfully completed Post Graduate Diploma, Advanced Leadership, (Year 1)( Level 9)RCSI
- Ms Annette Bruce (Paediatric CF CNS),successfully completed Masters of Science Respiratory Nursing, RCSI
- Ms Clare o Sullivan (staff nurse), successfully completed Stand Alone Modules in Advanced Research, Ethics, St Angela's College, Sligo (NUIG).

## New Developments & Quality Achievements in Paediatrics 2019

- Little Journey App
- Motorised Car Initiative
- Buddy Beds

## "Little Journey" App

A virtual reality app to help children prepare for surgery and reduce their anxiety ahead of going into hospital was launched by SUH in December 2019. The "Little Journey" app is geared towards children aged 3-13 years and it gives them a 360 degree view of all area they will visit at the hospital. It also has information about anaesthiology, which is tailored to their age. In 2018, approx 1,300 general anaesthetics were administered to children at SUH and using this app, information is provided to children using child-friendly animation and can begin to prepare children and their parents for surgery and ease their distress. The app gives children the chance to meet animated healthcare characters who will explain what they do and what happens the day of surgery. They can also see some of the equipment which will be used to care for them and find out what to expect on the day of their procedure including a virtual tour of the Paediatric Day Ward, the anaesthiology room and the recovery room at SUH. The 'Little Journey" app is free to download. The app is used in 16 countries and Sligo is the first hospital in Ireland to introduce it for patients. Dr Anne Dolan, Consultant Anaesthesiologist at SUH led this initiative in SUH.

## Motorised Car Initiative

Studies have demonstrated that the transport of a child to theatre in a children's ride-on toy car has a beneficial effect on pre-operative levels of anxiety when compared with transport on a standard hospital wheelchair/trolley.Having read these studies a committee was set up to look at this as an option to improve the patient experience.

The hospital management and Director of Nursing were fully supportive of the project. NMPDU agreed to come on board and support the project also an initial letter to the different car companies yielded positive results and 11 motorised toy cars were donated to the project. Concerns re storage, cleaning, maintenance, time delays going to theatre, charging etc. were all highlighted. Therefore it was decided to have a trial which proved to be very successful. Clear guidelines were provided on inclusion and exclusion. The project was piloted for children undergoing elective ENT procedures. Parents and staff were asked to fill in an evaluation on their experience. It was identified as a very positive patient experience. It reduced anxiety for the children and their parents. It is hope in the future to roll this initiative out.

## Buddy Beds

In 2019 a Quality Improvement Initiative introduced in the Paediatric Ward, was the purchasing of Buddy Beds for parents. The Buddy Beds are chairs that convert to comfortable beds allowing for a restful night's stay for a parent. Repeatedly, through feedback from parents, the lack of appropriate sleeping arrangements available to parents who would have to stay with their child overnight in hospital was raised. To date, 21 Buddy Beds have been purchased through kind donations and a fundraising campaign. These beds are vitally important and the benefits are far reaching with parents and family members having somewhere appropriate to rest and have some semblance of a night's sleep while at the same time being near their child to comfort them. The Paediatric Ward received tremendous support from local organisations, schools, crèches, clubs, government departments, social clubs and fundraising organisations such as SHOUT and Friends of Sligo University Hospital. Feedback from parents has been very positive. We would like to express our sincere gratitude to all who donated and helped fundraise money to purchase these beds; they have made a significant contribution to improving the patient and parent experience. The Paediatric Department would like to acknowledge Ms Orla McDonagh , Acting CNM2, Paediatric Ward who led this Quality Improvement Initiative.

# Section 3: Gynaecology
## *(a) Gynaecology Report*

Dr Ravi Garrib Obstetric Consultant and Gynaecologist

Outpatient care at Sligo University Hospital is provided through gynaecology outpatient clinics, each led by a consultant. Outpatient facilities are shared by various specialities in the hospital leading to challenges in growing the service. Three of the consultant led teams have access to a weekly gynaecology clinic while the fourth team has access to only 3 gynaecology clinics per month. This is due to infrastructural constraints in the shared outpatient department. Our goal going forward would be to find space for this clinic thus increasing our monthly clinics at SUH to 16 per month which in turn will result is a decrease of the waiting time for new gynaecology consultations. During 2019 there were 453 new gynaecology patients seen along with 2144 reviews resulting in a total of 2897 patient visits to GOPD.

In addition to clinics at SUH, there are a further 12 combined antenatal and gynaecology clinics per month that are held at the following peripheral locations; Ballyshannon, Carrick-on-Shannon and most recently in Ballymote. These consultant led clinics were responsible for 1223 additional gynaecology consultations during the course of 2019. In total there were 4120 patients seen at our Gynaecology clinics during 2019, an increase of 223 over the 2018 period.

Women who present to the hospital with acute gynaecological complaints are assessed in the emergency gynaecology assessment room which is in the surgical / gynaecology ward. This area offers an environment more conducive to the privacy and support required for women presenting with an acute gynaecological illness. There are infrastructural Challenges with this service for example the gynaecology assessment room is small and cramped, and has no ventilation or natural light. There were 1397 gynaecology assessments during 2019 which is broadly in keeping with numbers seen over the past 3 years.

We continue to provide a dedicated early pregnancy assessment service which runs from 7 to 9:30 am, 5 days per week. In addition, women who present acutely with early pregnancy complications are scanned on an ad-hoc basis throughout the day depending on clinical need. The service is appointment driven and is accessed by referral from General Practitioners, the gynaecology ward and the gynaecology acute assessment service. The service would benefit from the addition of a room where patients may be counselled and further management discussed following a diagnosis of a poor pregnancy outcome. Further growth of the service however is currently limited by infrastructural constraints.

We have continued to provide a Mirena IUS insertion clinic on a monthly basis for patients who are not suitable for insertion in general practice. This has run well over the course of 2019 and continues to help decrease the waiting list for day case procedures. An additional weekly rapid access gynaecology clinic was run over 2 months at the end of the year to help manage patients inappropriately referred to colposcopy. This initial trial was successful in managing the extended waiting list for colposcopy services and may be of further use in the future.

The provision of inpatient gynaecological services continues to be a challenge as the service is incorporated with general surgery in a combined ward of 28 beds. These beds are meant to be shared by gynaecology and surgical patients but are often taken up by boarding medical patients. This creates challenges including; access to these beds, the risks inherent in placing medical patients in the same ward as post-operative patients as well as in the skill and staffing mix required to manage this disparate group of patients. In particular it is a challenge ensuring there are sufficient gynaecology trained nurses and midwives working on the ward. Where possible, an emergency gynaecology bed is held at all times for emergency gynaecology admissions such as women ectopic pregnancies or bleeding following a miscarriage. This facilitates timely admission and access to theatre when required.

In conclusion further development of the gynaecology service is dependent on access to space to increase the number of clinics. There is on-going engagement with other relevant role players to facilitate this.

# Section 3: Gynaecology
# *(b) Gynaecology Surgery*

Dr Heather Langan Consultant Obstetrician & Gynaecologist

The speciality this year has continued to provide a Women's health service to women of all ages with continued focus on conditions specific to the female population. Care is carried out in a multidisciplinary setting which incorporates both general surgery and gynaecology patients.

The gynaecology service continues to provide 12 outpatient clinics in Sligo on a monthly basis together with 12 combined gynaecology/antenatal clinics in our peripheral locations of Manorhamilton, Carrick on Shannon and Ballyshannon again on monthly basis. We endeavour to ensure all of these clinics give a consultant provided service to maximise our patient

experience and ensure clinics are at their most efficient. In an effort to streamline personnel provision in Sligo University campus we have discontinued our Manorhamilton peripheral clinic in December 2019. It is planned for further peripheral clinic streamlining into Sligo in 2020.

The Provision of an inpatient gynaecology service continues to be challenging as the service is incorporated within the general surgical in patient ward with 10 notional gynaecology beds out of the 28 beds on the ward. This continues to provide us with major challenges in terms of staffing levels, skill mix and access to these notional beds being restricted due to the continual influx of medical boarding patients on the ward.

The lack of protected inpatient space for patients with range of women's health conditions prevents us from providing suitable accommodation for these patients. This year in particular list cancellations for January through to March 2019 secondary to winter bed pressures have been significant and have reduced overall operation numbers.

We now have a single designated emergency gynaecology bed that is held at all times to allow our very emergent gynaecology patients, for example, suspected ruptured ectopic pregnancies or incomplete miscarriage patients with significant bleeding , rapid access to the ward with subsequent timely access to theatre when required. This has improved the patient journey in this very vulnerable and high risk group of individuals.

The out of hours Emergency Gynae Assessment Room is also situated within the Surgical/Gynae Department. This has been an extremely challenging year for this service which has seen a significant increase in emergency presentations. On average we provide emergency gynaecology assessment for both pregnant and non pregnant patients for 150 patients monthly.

We continue to provide an early pregnancy assessment service, with the addition of a designated senior registrar being onsite for all our EPAU sessions.

It has been a challenging year for Colposcopy services in the continued aftermath of the Cervical service review. Having lost a consultant colposcopist we have reduced our clinical sessions from 16 to 12 per month which has had a significant knock on effect for clinic waiting times.

We provide one Mirena IUS insertion clinic on a regular basis to allow patients from our outpatient service, whom we consider to be inappropriate for insertion in a General Practice setting, the opportunity to have their procedure without the need for day services hence overall reducing our day services waiting times a little.

Continued discussions remain in progress with regard to the establishment of an ambulatory gynaecology service, but both infrastructural limitations and staff shortages have sadly delayed this process.

We are now in a position to offer termination of pregnancy services for fatal fetal abnormalities and life limiting conditions locally.

# Section 3: Gynaecology
# *(c) Gynaecology Surgery Report*

Dr Heather Langan Consultant Obstetrician & Gynaecologist

| Gynaecological Surgery Report 2019 | |
|---|---|
| Balloon Ablation Uterine | 1 |
| Biopsy Cervix | 3 |
| Biopsy of endometrium | 10 |
| Biopsy vagina | 4 |
| Blood patch for PDPH | 1 |
| Cervix Cautery/Diathermy | 1 |
| Colposcopy | 11 |
| Cystectomy | 0 |
| Cystoscopy | 2 |
| D&C | 340 |
| Diagnostic Laparoscopy | 13 |
| ERPC | 33 |
| EUA Gynae | 36 |
| EUA Vaginal | 8 |
| ERCP | 1 |
| Excision of Bartholins Cyst | 5 |
| Excision of skin tags | 4 |
| Excision of lesion NOC | 2 |
| Excision of wart | 1 |
| Fentons Procedure | 3 |
| Hymenotomy | 1 |
| Hysterectomy +/- BSO | 0 |
| Hysterectomy subtotal | 0 |
| Hysterectomy TAH | 8 |
| Hysterectomy TAH + BSO | 20 |
| Hysterectomy Vaginal | 3 |
| Hysterectomy Vaginal + Pelvic Floor Repair | 5 |
| Hysterectomy vaginal +/- pelvic floor repair | 1 |
| Hysteroscopy | 349 |
| I &D Bartholins Abscess | 3 |
| I&D, Abscess | 0 |
| Insertion of Mirena Coil | 109 |
| Insertion of Ring Pessary | 1 |
| IUCD Removal & Re-insertion | 1 |
| Labial Resection | 1 |
| Labial Excision | 2 |
| Labial Reduction | 1 |
| Laparoscopy | 13 |
| Laparoscopy & Dye | 9 |
| Laparoscopy Tubal Ligation | 3 |
| Laparotomy Exploratory | 1 |
| Laparoscopy+/- Laparatomy | 1 |
| Laparotomy ?Salpingectomy | 0 |
| Laparotomy | 8 |
| LLETZ | 33 |
| LSCS | 0 |
| Marsup of Bartholins Gland | 0 |
| Omentectomy | 0 |
| Ovarian Cystectomy | 10 |
| Oophorectomy | 2 |
| Open endometrial ablation | 0 |
| Pelvic Floor Repair +/- Hysterectomy | 0 |
| Perineal body re-fashioning | 2 |
| Proctoscopy | 1 |
| Polypectomy Cervical | 9 |
| Polypectomy Uterine | 7 |
| Removal of foreign body NOC | 2 |
| Removal of Mirena | 31 |
| Removal of Nova T coil | 1 |
| Removal of cervical polyps | 3 |
| Removal labial cyst | 2 |
| Removal of Vaginal Pessary | 0 |
| Repair Ant | 2 |
| Repair Ant & Post | 2 |
| Repair of Episiotomy | 1 |
| Repair of 3rd degree tear | 1 |
| Repair Pelvic Floor Prolapse | 3 |
| Repair Posterior | 1 |
| Repair vaginal posterior | 1 |
| Repair Vaginal Anterior | 3 |
| Salpingectomy Bilateral | 0 |
| Shirodkar Suture | 3 |
| Smear | 30 |
| Sterilisation Laparoscopic | 1 |
| Suturing of Wound | 1 |
| Tubal ligation | 6 |
| Vulval Biospy | 0 |
| Polypectomy Cervical | 0 |
| Polypectomy Uterine via Hysteroscopy | 0 |
| I&D Abcess | 0 |
| Aspiration of Ovarian Cyst | 0 |
| Biopsy Cervix | 0 |
| Vulval Biopsy | 23 |
| Insertion of IUCD | 0 |
| Labial Resection | 0 |
| Excision Vaginal Cyst | 0 |
| Ectopic Pregnancy Sapingectomy | 0 |
| Salpingectomy | 1 |
| Salpingectomy, Laparoscopic | 2 |
| Salpingo-oophorectomy | 5 |

Note- elective sections are recorded as 65, this is due to majority of elective sections being carried out on the emergency list. Actual number of elective sections is 238.

# Section 3: Gynaecology
# *(d) Colposcopy Service*

Dr Vimla Sharma Consultant Obstetrician and Gynaecologists, Ms Jennifer Curley trainee Colposcopists

## Team Members

- Dr Vimla Sharma Consultant Obstetrician Gynaecologist and Lead Colposcopist
- Dr Heather Langan Consultant Obstetrician & Gynaecologist
- Dr Nirmala Kondaveeti Consultant Obstetrician & Gynaecologist
- Ms Sinead Griffin Clinical Nurse Manager
- Ms Jennifer Curley RGN
- Ms Triona Mc Intyre RGN
- Ms Mary Delaney RGN
- Ms Patricia Murphy Administrative Officer
- Ms Davina Cox Administrative Officer

The colposcopy clinics at Sligo University Hospital continue to provide quality assured colposcopy services as set out in organisational and clinical guidance of cervical check quality standards. On average there are three Consultant led colposcopy clinics per week and four nurse led smear clinic per month. Timely diagnosis and treatment are the key priorities of the service.

2019 was another very busy year for the colposcopy service. The biggest challenge was same as of last year -to deal with increasing referrals to unit. A total of 621 new patients (20% more than 2017) attended the service and 1172 women (up by 23%) attended for follow up/review visit. There were 127 LLETZ treatments were performed under local anaesthetic and 3 were performed under general anaesthetic. The appointment cancellation rate & DNA rates were more or less the same over last few years. The challenges faced by Cervical Check and colposcopy units nationally in 2018 continued in 2019 as well.

A total of two cases were diagnosed with cervical cancer. Both were squamous cell carcinoma and were promptly referred to Gynae- Oncology services for further management.

Ms Jennifer Curley was registered as trainee Colposcopist with BSCCP after completing required colposcopy course and was getting required training. She did start her cases/logbook and aiming to do her exit OSCE early 2020. Two research projects were underway in 2019, to be completed in 2020 – "ASC-H, high grade or low grade? A four year review at SUH." and Management of Focal CIN 2 in young population.

## Partnership Services

The service continued to work in partnership with Irisoft UK (which provide a patient management and audit software system known as compuscope) and Medlab Pathology, Dublin (provides cytology and HPV testing services. Multidisciplinary team meetings were held at one to two monthly interval during first half of 2019 and these were on hold in later part of the year in light of lab changeover at cervical check.

## Reporting

Monthly, quarterly and annual reports of activity were generated and submitted to cervical check.

## Summary

In summary 2019 was as busy and challenging year as of 2018 for the colposcopy service at Sligo University Hospital. All consultants, nursing and administrative staff worked hard to provide quality care to all women who attended the service.

**LLETZ histology results January – December 2019**

| Histology | Numbers | Percentage |
|---|---|---|
| CIN1 | 24 | 18.46 |
| CIN 2 | 64 | 49.23 |
| CIN3 | 33 | 25.38 |
| CIN 3 + HCGIN | 1 | 0.76 |
| CIN3 + SMILE | 1 | 0.76 |
| HCGIN/AIS | 3 | 2.30 |
| SCC Invasive | 2 | 1.53 |
| Normal | 2 | 1.53 |
| Total | 130 | 100 |

# Section 4: Allied Clinical Services
# *(a) Neonatal & Paediatric Physiotherapy Services*

Dr Vimla Sharma & Ms Jennifer Curley

## Neonatal and Paediatric Physiotherapy Outpatient Service

Outpatient paediatric physiotherapy is a consultant referral based service for the following conditions; developmental dysplasia of the hip, torticollis and plagiocephaly, congenital and positional talipes, obstetric brachial plexus palsy, rheumatology, congenital syndromes, neurodevelopmental delay, asthma management/inhaler technique, musculoskeletal conditions; and a premature baby enhanced surveillance programme. We provide shared care with tertiary hospitals for patients with Cystic Fibrosis, rheumatology and oncology. We also provide outpatient/ domiciliary physiotherapy service to patients with cystic fibrosis along with 6 monthly MDT clinic reviews.

The neonatal OPD services were curtailed this for the first 4 months of 2019 due to the loss of Sheila Kiely to internal promotion as Physiotherapy Manager who was then replaced by Rachel Wirtz, Clinical Specialist Paediatric and Neonatal Physiotherapist in May 2019. In line with the HSE Model of Care for Neonatal services in Ireland, an enhanced developmental surveillance programme is offered to all parents of babies born at or before 30 weeks gestation and this service was maintained during the period of reduced staffing but in-patient visits to the NICU were reduced compared to last year.

## Paediatric Physiotherapy Inpatient Service

- An inpatient physiotherapy service is available for all patients referred on the paediatric ward in the areas of respiratory, neurology, orthopaedic, neurodevelopmental delay and musculoskeletal issues. The on-call physiotherapy service is available 24/7 to this high demand area and correlates to the third highest user of on-call in Sligo University Hospital (see figure 1).

## Physiotherapy Service for Developmental Dysplasia of the Hip

- Internationally the standard early treatment of neonates with developmental dysplasia of the hip is considered to be the application of a Pavlik hip abduction harness and in Sligo University Hospital this treatment is provided exclusively by the paediatric physiotherapy department. Patients from counties Sligo, Leitrim, Roscommon, South Donegal and North Mayo avail of the DDH service in Sligo University Hospital. Since the introduction of the new national DDH screening programme in 2017, the numbers of babies requiring Pavlik harness treatment has increased significantly (see fig 2). The provision of a Pavlik harness treatment service requires substantial physiotherapy input, with a total of 421 physiotherapy treatment slots provided in 2019. The babies journey in this physiotherapy led service is from the initial application of the harness and parent education, weekly harness reviews and drop in clinics for harness re-application on repeat ultrasound scanning days, to weaning stage.
- The role out of the baby hip team in October 2019 involves weekly multidisciplinary meeting with Radiology Consultant, Sonographers, Orthopaedic Consultant, Paediatric Physiotherapy Team, Paediatric representative, Orthopaedic administrator and CMN2. This involves a virtual clinic review of current babies in harness and planning and coordination of the babies care while they are in pavlik harness and smooth transition to Orthopaedics once their harness journey is completed.
- It also enables regular communication across this multidisciplinary team and generates discussion for any Orthopaedic referral to tertiary hospitals should any baby need further management of their hip dysplasia.
- To date this service has placed an increase in the demand of physiotherapy resources and has impacted on the waiting times for all other paediatric outpatient referrals. The long term sustainability of the DDH service in Sligo University Hospital will be directly related with securing additional resources.

## Staffing

The paediatric physiotherapy team consists of 2 WTEs; 1.0 WTE Clinical Specialist in outpatients, 0.5 WTE Clinical Specialist Cystic Fibrosis, 0.5 WTE Senior physiotherapist in inpatient paediatrics. In 2019 the outpatient physiotherapy service was operating at a 50% capacity until May due to the promotion of a WTE clinical specialist in paediatrics and neonates into a management role. The Neonatal intensive care service was maintained throughout this period but at a reduced capacity. This staffing shortage in the paediatric physiotherapy service was due to delays in recruitment and processing of posts. This staffing shortage is reflected in the number of outpatient physiotherapy treatments for 2019 (see table 1). Resources could not be redirected from inpatients to the outpatient service due to the on-going increase in demands of the inpatient service (see fig 1).

| 2019 | Number of New Patients | Number of Physiotherapy Treatments |
|---|---|---|
| Inpatient Paediatrics | 233 | 442 |
| Outpatient Paediatrics | 166 | 648 |
| Neonatal Intensive Care | 21 | 62 |
| Outpatient Paediatric Cystic Fibrosis | 2 | 51 |
| Developmental Dysplasia Of The Hip | 39 | 421 |

**Figure 1-Number of Inpatient Paediatric Referrals**

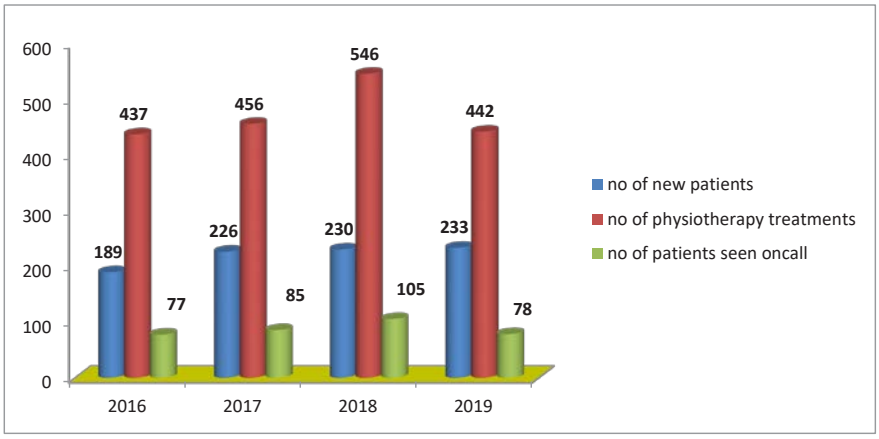
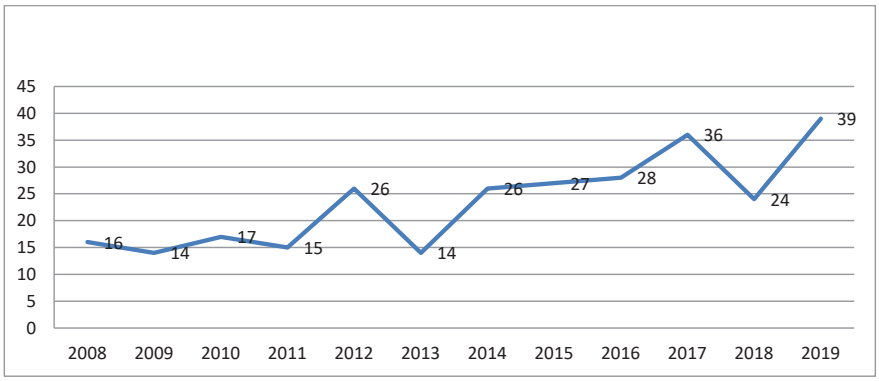



**Figure 2- Number of Babies referred for Pavlik Harness Treatment 2008 to 2019**



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