Maternity Patient Safety Statement

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

This is a monthly report, specific to the hospital named below setting out a range of information on the safety of maternity services.

Hospital Name	Cork University Maternity Hospital	Reporting Month	November 2018
Purpose & Context	This Statement is used to inform local hospital and hospital Group management in carrying out their role in safety and quality improvement. The objective in publishing the Statement each month is to provide public assurance that maternity services are delivered in an environment that promotes open disclosure. It is not intended that the monthly Statement be used as a comparator with other units or that statements would be aggregated at hospital Group or national level. It assists in an early warning mechanism for issues that require local action and/ or escalation. It forms part of the recommendations in the following reports: • HSE Midland Regional Hospital, Portlaoise Perinatal Deaths, Report to the Minister for Health from Dr. Tony Holohan, Chief Medical Officer, 24 February 2014; and • HIQA Report of the Investigation into the Safety, Quality and Standards of Services Provided by the HSE to patients in the Midland Regional Hospital, Portlaoise, 8 May 2015. It is important to note tertiary and referral maternity centres will care for a higher complexity of patients (mothers and babies), therefore clinical activity in these centres will be higher and therefore no comparisons should be drawn with units that do not look after complex cases.		

Headings	Ref	Information Areas	2018	
			November	Year to date
Hospital Activities	1	Total mothers delivered ≥ 500g (n)	676	6786
	2	Multiple pregnancies (n)	22	156
	3	Total births ≥ 500g (n)	698	6947
	4	Perinatal mortality rate – adjusted (per 1,000 total births)	0.14	1.29
	5	In utero transfer – admitted (n)	4	36
	6	In utero transfer – sent out (n)	0	0
Major Obstetric Events	7	Total combined rate (per 1,000 total mothers delivered) of major obstetric events for the following four obstetric metrics: • Eclampsia; • Uterine rupture; • Peripartum hysterectomy; and • Pulmonary embolism.	7.3	1.32

Headings	Ref	Information Areas	2018	
			November	Year to date
Delivery Metrics	8	Rate of instrumental delivery per total mothers delivered (%)	17.30%	17.74%
	9	Rate of nulliparas with instrumental delivery (%)	32.70%	33.01%
	10	Rate of multiparas with instrumental delivery (%)	7.31%	8.40%
	11	Rate of induction of labour per total mothers delivered (%)	34.76%	36.39%
	12	Rate of nulliparas with induction of labour (%)	39.47%	42.99%
	13	Rate of multiparas with induction of labour (%)	31.70%	32.61%
	14	Rate of Caesarean section per total mothers delivered (%)	34.02%	32.83%
	15	Rate of nulliparas with Caesarean section (%)	37.21%	34.11%
	16	Rate of multiparas with Caesarean section (%)	31.95%	32.01%
Maternity Services Total Clinical Incidents	17	Total number of clinical incidents for **Maternity Services** (reported monthly to NIMS) (n)	154	942

DEFINITIONS
(n) = Number
Nulliparas = Women who have never had a previous pregnancy resulting in a live birth or stillbirth (≥ 500g)
Multiparas = Women who have had at least one previous pregnancy resulting in a live birth or stillbirth (≥ 500g)
N/A = Not available

The Maternity Patient Safety Statement for University Hospital Waterford provides up to date information for management and clinicians who provide maternity services in relation to a range of patient safety issues for November 2018.

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

Hospital Group Clinical Director: Prof John R. Higgins, Group Clinical Director for Women & Children (Maternity Services)

Signature:

Hospital Group CEO: Mr. Gerry O'Dwyer

Signature:

Date: 9th January 2019