University Hospital Galway
Ospidéal na hOllscoile, Gaillimh
GALWAY UNIVERSITY HOSPITALS

Portiuncula University Hospital


Mayo University Hospital

Sligo University Hospital

Letterkenny University Hospital

Saolta
Grúpa Ollscoile Cúram Sláinte
University Health Care Group

Women's and Children's Directorate

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

Annual Clinical Report 2018

Contents

Foreword - Dr Ethel Ryan

I am delighted to introduce the Saolta Women's and Children's Directorate annual clinical report for 2018. It will be remembered as an emotional rollercoaster of a year, particularly in relation to healthcare for Irish women.

In April 2018 Ireland's cervical smear services came under huge scrutiny when it emerged around 221 women with cervical cancer were not informed that smear test results showing them to be clear, were inaccurate and that revised test results were kept from them. The review into the cervical cancer scandal in Ireland by UK health expert Dr Gabriel Scally found there were "serious gaps" in governance and expertise and failure across the whole system of a cervical screening programme. It is thought around 20 women have since died. The HSE continues to strengthen governance, quality assurance and management in the CervicalCheck programme and the wider National Screening Service. This is in line with the recommendations of Dr Scally in his final report.

In May 2018 Ireland voted decisively to change the Irish constitution to repeal the Eighth Amendment. This paved the way for new legislation to allow for the termination of pregnancies. The historic result was a landslide victory for the Yes vote by an overwhelming 2 to 1. Over 1.4 million voted 'Yes' to the proposal. This was signed into law by President Higgins in December 2018 with a commitment by the Minister of Health to make this new service available to women in January 2019. The Saolta Women's and Children's Directorate undertook significant work over the ensuing months to ensure this service would be available to women by January 2019. This new service has commenced and work continues to progress and strengthen it.

In October 2018, the W&C Directorate held its first Women's and Children's Serious Incident Management Team Meeting – a specialised version of the existing Serious Incident Management Team Meeting, to review clinical cases only pertinent to this directorate, allowing for learning in a non punitive manner, to improve clinical care and outcomes for women and infants.

2018 was also the year we saw the Paediatric & Neonatology National Clinical Care Programme approve 12 fully funded posts for UHG facilitating development of the Paediatric network for Saolta, keeping care as close to home as possible. These include consultant, nursing and HSCP posts to progress local services for all children.

Despite the ongoing challenges of staffing and financial restraints, the Women's & Children's Directorate continues to strive for clinical excellence for the women, infants and children we serve. The annual report allows us to review our service delivery in a very transparent way between the 5 hospitals and to improve it.

Finally, I would like to extend a very sincere thank you to all the contributors to the Saolta Women's and Children's annual report. Without this collaborative effort it would not be possible.

I would also like to say a huge thank you to Ms Gemma Manning, Saolta Quality & Safety Co-ordinator for the Women's and Children's Directorate who has managed to bring this report together from all five maternity, neonatal and paediatric sites. This report serves as a huge credit to all those who work within the Directorate; a testament to the great work undertaken.

Ethel Ryan
Group Clinical Director
Women's & Children's Directorate
Consultant Neonatologist / Paediatrician
Saolta University Healthcare Group

Statistical Summary 2018

Dr Una Conway and Ms Marie Hession

Number of Mothers/Births, last 10 years	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Number of Deliveries	3525	3537	3429	3377	3141	2987	2973	3002	2854	2858
Number of Mothers	3465	3467	3361	3301	3060	2914	2909	2946	2798	2805

In 2018, 2854 babies were delivered to 2805 women at Galway University Hospital. There was a slight increase from 2017. The mode of delivery for the majority of women was normal vaginal delivery at 47%. The rate of normal delivery continues to decrease yearly compared to recent years. The caesarean section rate was 34.7%, which is rising yearly. There is a greater than 10% rise in caesarean section rates over the last 10 years. 17.9% of women had an instrumental vaginal delivery.

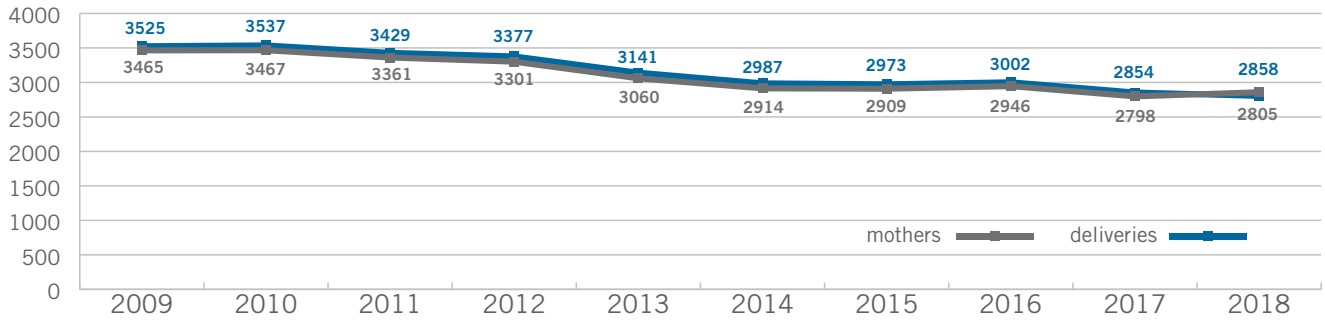
The number of mothers who had one previous caesarean section has risen slightly from 359 in 2017 to 405 in 2018. The percentage of women in this group who attempted vaginal delivery increased from 48.5% to 50.9%. The successful VBAC rate in this group was 51.5% with 48.5% requiring an emergency caesarean section for delivery. There is a slight increase on successful VBAC rate from last year.

There has been very little change over 10 years in birth weights and parity. The trend of older mothers continues with 16.4% of mothers being 40 years of age or older which rose from 11.7% last year. There was a rise to 1% of mothers being over 45 years from a rate of 0.7% in 2017. There continues to be a decline over 10 years in numbers of teenage pregnancies presenting for antenatal care. In 2018 in GUH, 0.4% of mothers were teenagers compared to 2.4% in 2008.

The overall perinatal mortality rate and the corrected perinatal mortality rate are the lowest ever in the last 10 years at 3.1 and 2.8 respectively. This rate was 42.8% in 2016 and 37.6% in 2015.

The total perinatal mortality rate is marginally lower at 0.5% compared to 0.7% in 2008

No. Mothers/Births over last 10 years



Obstetric Outcomes (Mothers)	Primip	%	Multip	%	Total	%
Induction of Labour	463	40.4%	388	23.4%	851	30.3%
Epidural Rate	735	64.1%	546	32.9%	1281	41.3%
Episiotomy	427	37.3%	125	7.5%	552	19.7%
Caesarean Section	431	37.6%	542	32.7%	973	34.7%
Spontanious Vaginal Delivery	331	28.9%	988	59.6%	1319	47.0%
Forcepts Delivery	112	9.8%	15	0.9%	127	4.5%
Ventouse Delivery	270	23.6%	107	6.4%	377	13.4%
Breech Delivery	2	0.2%	7	0.4%	9	0.3%
Total (Number)	**1146**		**1659**		**2805**	

Multiple Pregnancies	Primip (1096)	%	Multip (1702)	%	Total (2805)	%
Twins	19	1.7%	28	1.6%	47	1.7%
Triplets	3	0.3%	0	0.0%	3	0.1%

Onset for Multiple Pregnancies	Primip (22)	%	Multip (28)	%	Total (50)	%
Induced	3	13.6%	9	32.1%	12	24.0%
Spontaneous	7	31.8%	2	7.1%	9	18.0%
No Labour	12	54.5%	17	60.7%	29	58.0%
Elective C.S.	4	18.2%	10	35.7%	14	28.0%
Emergency C.S.	13	59.1%	8	28.6%	21	42.0%

Multiple Births	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Twins	58	69	66	74	73	69	64	55	52	47
Triplets	1	1	1	1	4	2	1	1	2	3
Total	59	70	67	75	77	71	65	56	54	50

Perinatal Deaths	Primigravida	Multigravida	Total
Stillbirths	3	5	8
Early Neonatal Deaths	0	1	1

Perinatal Mortality	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Overall PMR per 1000 births	9.4	7.6	5.4	6.4	7.4	6.0	7.1	6.0	4.6	3.1
Corrected PMR per 1000 births	6.5	6.5	3.5	3.3	4.1	5.0	4.4	3.7	3.5	2.8

	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Stillbirth Rate	0.6%	0.5%	0.3%	0.4%	0.6%	0.5%	0.5%	0.4%	0.4%	0.3%
Neonatal Death Rate	0.3%	0.3%	0.2%	0.2%	0.1%	0.1%	0.2%	0.2%	0.1%	0.1%
Total Rate	**0.9%**	**0.8%**	**0.5%**	**0.6%**	**0.7%**	**0.6%**	**0.7%**	**0.6%**	**0.5%**	**0.4%**

Parity		
0	1148	40.90%
1	956	34.10%
2	465	16.60%
3	156	5.60%
4	37	1.31%
5	24	0.86%
6	14	0.50%
7	2	0.07%
8	1	0.04%
9	1	0.04%
10	1	0.04%
	2805	

Parity	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
0	41.1%	43.2%	40.2%	37.9%	38.4%	39.7%	39.5%	39.3%	39.2%	40.9%
1,2,3	55.4%	53.6%	56.3%	58.5%	58.4%	57.3%	57.5%	57.7%	57.9%	56.3%
4+	3.6%	3.2%	3.6%	3.6%	3.1%	3.1%	3.0%	3.0%	3.0%	2.84%

Age	Primigravida	%	Multigravida	%	Total	%
15-19yrs	10	0.9%	0	0.0%	10	0.4%
20-24yrs	95	8.3%	42	2.5%	137	4.9%
25-29yrs	140	12.2%	147	8.9%	287	10.2%
30-34yrs	388	33.8%	387	23.3%	776	27.6%
35-39yrs	372	32.4%	737	44.5%	1109	39.5%
40-44yrs	135	11.8%	324	19.5%	459	16.4%
45>	7	0.6%	21	1.3%	28	1.0%
Total	**1147**	**100.0%**	**1658**	**100.00%**	**2805**	**100.0%**

Age @ Delivery	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
15-19yrs	2.4%	2.2%	1.3%	1.5%	1.6%	1.1%	0.9%	0.7%	0.7%	0.4%
20-24yrs	9.3%	9.3%	8.2%	7.4%	6.9%	6.3%	6.9%	6.1%	5.4%	4.9%
25-29yrs	20.9%	20.9%	20.3%	18.4%	16.5%	15.4%	14.8%	14.1%	13.5%	10.2%
30-34yrs	34.6%	36.4%	36.5%	36.0%	35.9%	34.8%	33.6%	34.5%	30.7%	27.7%
35-39yrs	26.7%	25.3%	27.3%	29.5%	32.1%	32.0%	33.4%	34.1%	37.2%	39.5%
40-44yrs	5.9%	5.5%	6.0%	6.8%	6.5%	8.8%	9.8%	9.7%	11.7%	16.4%
45yrs>	0.3%	0.5%	0.3%	0.4%	0.6%	0.6%	0.7%	0.7%	0.8%	1.0%

County Of Origin	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Galway County	58.9%	56.9%	57.0%	56.3%	54.8%	53.8%	55.0%	56.5%	57.9%	56.1%
Galway City	32.8%	35.9%	35.9%	36.8%	38.9%	39.7%	37.7%	37.3%	36.0%	37.1%
Mayo	2.2%	2.3%	2.3%	3.4%	2.6%	2.3%	2.9%	2.1%	2.5%	2.5%
Roscommon	1.2%	1.3%	1.0%	2.0%	2.4%	1.0%	1.2%	0.9%	1.0%	1.1%
Clare	4.4%	3.2%	3.4%	1.0%	0.8%	2.7%	2.6%	2.5%	1.9%	2.5%
Others	0.5%	0.4%	0.5%	0.5%	0.5%	0.5%	0.5%	0.7%	0.7%	0.7%

Non National Births	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Number	834	929	816	854	732	736	723	731	683	718
%	23.7%	26.3%	23.8%	25.3%	23.3%	24.6%	24.3%	24.4%	24.4%	25.6%

Gestation @ Delivery	Primigravida	%	Multigravida	%	Total	%
<28 weeks	2	0.2%	3	0.2%	5	0.2%
28 - 31+6	10	0.9%	11	0.7%	21	0.7%
32 - 36+6	57	5.0%	84	5.1%	141	5.0%
37 - 39+6	451	39.3%	884	53.3%	1334	47.6%
40 - 41+6	617	53.8%	674	40.7%	1292	46.1%
42 weeks	10	0.9%	2	0.1%	12	0.4%
Total	**1147**	**100.0%**	**1658**	**100.0%**	**2805**	**100.0%**

Gestation @ Delivery	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
<28 weeks	0.6%	0.4%	0.4%	0.3%	0.6%	0.4%	0.4%	0.3%	0.3%	0.2%
28 - 31+6	0.9%	1.0%	0.8%	0.7%	0.9%	0.8%	0.9%	1.1%	0.7%	0.7%
32 - 36+6	5.1%	4.1%	4.9%	4.7%	4.6%	5.3%	5.3%	5.1%	5.8%	5.0%
37 - 39+6	41.8%	41.3%	42.8%	43.1%	47.0%	45.3%	45.2%	45.9%	49.0%	47.6%
40 - 41+6	50.3%	52.6%	50.4%	51.0%	46.5%	47.8%	47.9%	47.4%	44.0%	46.1%
42 weeks	1.2%	0.4%	0.7%	0.2%	0.4%	0.4%	0.3%	0.3%	0.4%	0.4%
Not Answered	0.1%	0.1%	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

Birth Weights	Primigravida	%	Multigravida	%	Total	%
<1,000gms	5	0.4%	3	0.2%	8	0.3%
1000-1499gms	7	0.6%	8	0.5%	15	0.5%
1500-1999gms	13	1.1%	9	0.5%	22	0.8%
2000-2499gms	36	3.1%	36	2.2%	72	2.6%
2500-2999gms	145	12.6%	133	8.0%	278	9.9%
3000-3499gms	402	35.0%	529	31.9%	931	33.2%
3500-3999gms	379	33.0%	626	37.8%	1005	35.8%
4000-4499gms	146	12.7%	271	16.3%	417	14.9%
4500-4999gms	13	1.1%	40	2.4%	53	1.9%
5000-5499gms	1	0.1%	3	0.2%	4	0.1%
Total	**1147**	**100.0%**	**1658**	**100.0%**	**2805**	**100.0%**

Birth Weights	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
<500gms	0.1%	0.1%	0.0%	0.0%	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%
500-999gms	0.5%	0.7%	0.6%	0.4%	0.6%	0.5%	0.5%	0.5%	0.4%	0.3%
1000-1999gms	2.0%	1.7%	1.7%	1.9%	2.8%	2.1%	2.5%	2.1%	2.5%	1.3%
2000-2999gms	13.9%	14.2%	14.2%	14.8%	15.0%	14.8%	13.7%	14.7%	14.3%	12.5%
3000-3999gms	68.5%	66.3%	68.3%	67.3%	66.4%	66.1%	67.8%	68.7%	67.0%	69.0%
4000-4499gms	13.9%	14.1%	14.1%	15.2%	13.1%	14.4%	13.1%	11.8%	13.6%	14.9%
4500-5000gms	2.4%	2.7%	2.5%	2.5%	1.9%	1.7%	2.2%	2.2%	2.2%	1.9%
5000-5499gms	0.3%	0.2%	0.4%	0.2%	0.1%	0.2%	0.2%	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	**3525**	**3537**	**3429**	**3377**	**3141**	**2987**	**2973**	**3002**	**2854**	**2858**

Induction of Labour	Primigravida	%	Multigravida	%	Total	%
2009	446	33.3%	475	23.3%	921	26.6%
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%

Perineal Trauma	Primigravida	%	Multigravida	%	Total	%
Intact	19	2.7%	254	22.7%	273	14.9%
Episiotomy	427	59.7%	125	11.2%	552	30.1%
2nd Degree Tear	170	23.8%	401	35.9%	571	31.2%
1st Degree Tear	31	4.3%	228	20.4%	259	14.1%
3rd Degree Tear	26	3.6%	15	1.3%	41	2.2%
Other Laceration	42	5.9%	95	8.5%	137	7.5%
Total	**715**	**100.0%**	**1118**	**100.0%**	**1833**	**100.0%**

Incidence of Episiotomy	Primigravida	%	Multigravida	%	Total	%
2009	520	52.0%	168	11.2%	688	27.6%
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%

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%

3rd Stage Problems	Primigravida	%	Multigravida	%	Total	%
Primary PPH	44	3.8%	38	2.3%	82	2.9%
Manual Removal of Placenta	14	1.2%	15	0.9%	29	1.0%
Hysterectomy	0	0.0%	6	0.4%	6	0.4%
Total	**58**	**5.0%**	**59**	**3.6%**	**117**	**4.3%**

Shoulder Dystocia	Primip		Multip		Total	
Shoulder Dystocia	13	1.13%	11	0.66%	24	0.85%

Fetal Blood Sampling (n - babies)	n = 1171	%	n = 1687	%	n = 2858	%
PH < 7.20	5	0.4%	3	0.2%	8	0.3%
PH 7.20 - 7.25	19	1.6%	2	0.1%	21	0.7%
PH > 7.25	151	12.9%	48	2.8%	199	7.0%

Cord Blood Sampling (n - babies)	n = 1171	%	n = 1687	%	n = 2858	%
PH < 7.20	56	4.7%	43	2.5%	99	3.5%
PH 7.20 - 7.25	93	7.9%	60	3.5%	153	5.4%
PH > 7.25	726	61.9%	644	38.2%	1370	47.9%

Caesarean Sections 2018	Primigravida	%	Multip	%	Total	%
Elective Caesarean Sections	86	7.5%	362	21.8%	448	16.0%
Emergency Caesarean Sections	345	30.1%	180	10.9%	525	18.7%
Total	**431**	**37.6%**	**542**	**32.7%**	**973**	**34.7%**

Robson Groups 2018			
Group 1 - Nullip Single Ceph Term Spont Lab	95	518	18.3%
Group 2 - Nullip Single Ceph Term Induced	243	506	48.0%
Group 2(a) - Nullip Single Ceph Term Induced	187		37.0%
Group 2(b) - Nullip Single Ceph Term pre-labour CS	56		11.1%
Group 3 - Multip Single Ceph Term Spont Lab	12	662	1.8%
Group 4 - Multip Single Ceph Term Induced	50	368	13.6%
Group 4(a) - Multip Single Ceph Term Induced	19		5.2%
Group 4(b) - Multip Single Ceph Term Pre-Labour CS	31		8.4%
Group 5 - Previous CS Single Ceph Term	351	452	77.7%
Group 5 (1)- With one previous C.S. Single Ceph Term	246		54.4%
Group 5 (2)- With two or more Previous C.S. Single Ceph Term	105		23.2%
Group 6 - All Nullip Breeches	57	59	96.6%
Group 7 - All Multip Breeches	61	63	96.8%
Group 8 - All Multiple Pregnancies	35	50	70.0%
Group 9 - All Abnormal Lies	17	17	100.0%
Group 10 - All Preterm Single Ceph	52	110	47.3%
Total	**973**	**2805**	**34.7%**

Vaginal Birth after Caesarean Section			
Total No. Of Mothers who had 1 previous Caesarean Section		405	50.9%
No of Mothers who opted for an elective caesarean section after 1 previous Caesarean Section		203	49.1%
No of Mothers who went into spontaneous/induced Labour after 1 previous Caesarean Section		202	100.0%
Outcome of this category	SVD	68	34.2%
	Ventouse	32	16.1%
	Forceps	4	2.0%
	Total VBAC	**104**	**51.5%**
	Emergency C.S.	98	48.5%

Fetal Medicine Unit

Dr Geraldine Gaffney and Ms Annette Burke

In 2018, there were 11960 ultrasound examinations. Of these, there were 9927 obstetric ultrasound examinations performed in the fetal medicine unit (FMU), and the remainder (17) 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 2016 scans performed there. Please see EPAU report for further detail.

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 wellbeing. In addition, there is a dedicated High Risk Clinic that accepts patients with either fetal or maternal problems during pregnancy. In 2018, 90.2% of patients booking had a first trimester scan and a detailed anomaly scan – a slight increase from 2017.

The unit is staffed with 3 midwife sonographers, two part time clinical specialist radiographers and there are 3 fetal medicine consultants. Two midwife sonographers, Ciara Mulconroy and Elaine Ryan, completed their MSc in Ultrasound successfully. We have 4 ultrasound machines in the maternity scan department.

In addition to weekly high risk fetal medicine clinics, there is a fortnightly 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 if they have pregestational diabetes or gestational diabetes on insulin or oral hypoglycaemic agents. Follow on ultrasound scans are preformed at 28 and 36 weeks if they have gestational diabetes on dietary treatment. In 2018, there were 341 diabetic patients of whom 21 had pregestational and 320 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. In 2017 we saw 72 sets of twins (57 DCDA and 15 MCDA) and 3 of triplets.

The ultrasound unit participates in ongoing research projects such as the EMERGE and PARROTT studies.

High Risk Fetal Medicine Clinic

In 2018 there were 1150 visits to the high risk clinic. This is an increase from 856 visits in 2017. The reason for referral was either for fetal or maternal complications in pregnancy. The majority of patients were booked to deliver at Galway University Hospital. However, we saw 8 referrals from other hospitals in the Saolta Hospital Group. 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.

Fetal Abnormalities

During 2018 there were 67 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 being a notable 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.

A list of the fetal abnormalities that were diagnosed is provided below.

Fetal Anomalies

The list and description of fetal abnormalities managed at the FMU during 2018 is outlined below:

List of abnormalities

Cranial / CNS/ Neuro

- Spina bifida
- Absent cavum septum pellucidum & corpus callosum
- Ventriculomegaly (3)
- Severe ventriculomegaly and enlarged CM/ Dandy Walker malformation. /open lip schizencephaly and hydrancephaly
- Cerebral / spinal abnormality with a deletion of 13q and duplication of 7q chromosomes
- Bilateral ventriculomegaly
- Spina bifida and hydrocephalus
- Aqueductal stenosis
- Schizencephaly

Cardiac

- Cystic hygroma &cardiac defect
- Trisomy 9 mosaicism and cardiac tricuspid regurgitation
- Complete AVSD, double outlet right ventricle and transposition, stomach is on the right
- AVSD T21 cystic hygroma
- VSD
- Right atrial isomerism, situs solitus. Mitral stenosis and hypo plastic left ventricle.
- Fetal SVT treated with Flecainide
- Single ventricle with total anomalous pulmonary venous drainage.
- Multiple cardiac rhabdomyomata in one twin.

Abdominal

- Dilated fetal bowel, cystic fibrosis
- Exomphalos with normal karyotype
- Gastroschisis

Renal
- MSKD
- Dilated renal pelvices
- Potters sequence
- Left hydronephrosis (2)
- Megacystis with polydramnios
- Multicystic kidney

Skeletal
- Talipes (2)
- Bilateral polydactyly (2)
- Short long bones
- Short long bones and AEDF
- Bilateral talipes
- Rhabdomyomata due to Sturge Weber in the co-twin
- Right hand missing, short right radius and ulna
- Short long bones and oligohydramnios
- Bilateral talipes (2)

Chromosomal
- T21 (2)
- T18 (3)
- T18 with an abdominal wall defect and a high probability NIPT for T18
- T13
- Increased NT, NIPT high probability T13
- High probability T13 on NIPT then miscarried
- Robertsonian translocation between chromosomes 13 and 14. (45, XY, der(13;14) (q10;q10)pat
- 47,XY,+9(13)/46,XY(21)
- Triploidy
- Isolated cystic hygroma
- Cystic hygromata (6)

Misc
- Amniotic band
- Sacrococcygeal Teratoma
- Cleft lip and palate
- Cystic Adenomatoid Malformation (CAM)
- Fetal pelvic cyst

Additionally there were a total of 24 amniocentesis performed but no CVS in 2018. These identified the following:
- Normal N=15
- Trisomy 21 N=1
- Trisomy 18 N=2
- Trisomy 13 N=2
- TriploidyN=1
- Translocation/DeletionN=2
- Parvovirus / CMVN=1

Achievements in 2018
- Appointment of Dr Mark Dempsey as a consultant in fetal medicine.
- Completion of the MSc in ultrasound by Ciara Mulconroy and Elaine Ryan.

Anaesthesia Report

Dr Joseph Costello

In 2018, 2523 procedures were performed in theatre of which 1812 were elective and 711 were emergencies. This number included all gynaecological and obstetric procedures for which anaesthesia care was provided.

256 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 2523).

There were 2858 deliveries to 2805 mothers in UHG in 2018.

Epidurals

- 1281 epidurals were performed (45.7% see Figure 1).
- 735 primigravidae (57.4%) received an epidural.
- 546 multigravidae (42.6%) received an epidural.
- 229 (31.2%) of those primigravidae who had an epidural had a ventouse delivery and 89 (12.1%) had a forceps delivery.
- 133 (24.4%) of multigravidae who received an epidural had a ventouse delivery while 35 (6.4%) had a forceps delivery.
- 464 Primigravidae were induced and 365 of this group (78.7%) received epidurals.
- 555 Primigravidae went into spontaneous labour and 361 of this group (65 %) received an epidural.
- 387 Multigravidae were induced and 242 of this group(62.5%) received epidurals.
- 812 multigravidae went into spontaneous labour and 305 of this group (37.6%) received an epidural.

Caesarean Deliveries

- 973 women (34.7%) delivered by caesarean delivery (see statistical summary).
- 75 caesarean deliveries were performed under general anaesthesia (7.7% of all caesarean deliveries)

Post-Dural Puncture Headaches

- There were 20 dural taps documented at epidural in 2018, giving a dural puncture rate of 1.6%.
- 23 (1.8%) of women needed an epidural blood patch, with 6 women requiring a second blood patch (Total of 29 blood patches performed).

Mode of Anaesthesia for Elective Caesarean Delivery

	Primip	Multip	Total	
Spinal	80	337	417	93.0%
Epidural	2	2	4	0.8%
Combined Spinal	2	12	14	3.1%
General Anaesthetic	2	11	13	2.9%
Total	**86**	**362**	**448**	**100%**

Mode of Anaesthesia for Emergency Caesarean Delivery

	Primip	Multip	Total	
Spinal	127	107	234	44.6%
Epidural	124	21	145	27.6%
Combined Spinal	62	22	84	16.0%
General Anaesthetic	33	29	62	11.8%
Total	**346**	**179**	**525**	**100%**

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

	Primip	Multip	Total	
Spinal	2	0	2	11.8%
Epidural	8	1	9	52.9%
Combined Spinal	3	1	4	23.5%
General Anaesthetic	2	0	2	11.8%
Total	**15**	**2**	**17**	**100%**

This figure included women who did not have a dural tap documented at epidural but were later treated with blood patch.

Intensive Care/High Dependency Unit (ICU/HDU) Admissions 2018

There was a total of 31 patients admitted to either ICU/HDU from the Obstetrics/Gynaecology service in 2018. 14 of these admissions were Obstetrical patients and 17 were Gynaecology patients.

There were 8 Obstetric admissions to the Intensive Care Unit of UHG in 2018:

- 4 case of sepsis
- 4 women suffering from major post-partum haemorrhage

There were 6 Obstetric admissions to the High Dependency Unit of UHG in 2018:

- 4 cases of sepsis.
- 2 women who developed PET that needed higher level of intensive monitoring/management.

Summary of patients needing Level 2 care on the labour ward in 2018

83 women required level 1 or 2 care on the labour ward in 2018 (2.8% of all deliveries). This was a decrease from 102 (3.6%) in 2017.

Post-Anaesthesia Care Unit (PACU)

80 women were admitted to PACU from the Women's and Children's Directorate in 2018. 79 of these cases were elective Gynaecologic admissions (post-surgery) and there was one Obstetrical Care admission.

High risk Obstetric Anaesthesia Clinic

268 women were assessed in the high risk obstetric anaesthesia clinic in 2018.

Figure 1. Overall trend in Epidural rates (numbers) since 2009

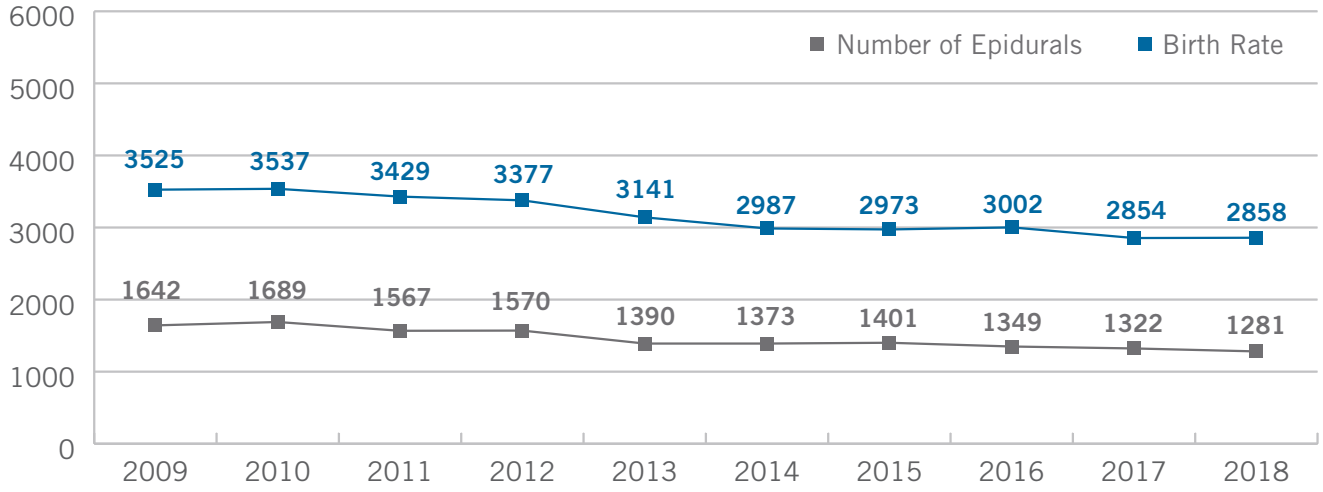


Figure 2. Percentage of Elective/Emergency caesarean deliveries under General Anaesthesia

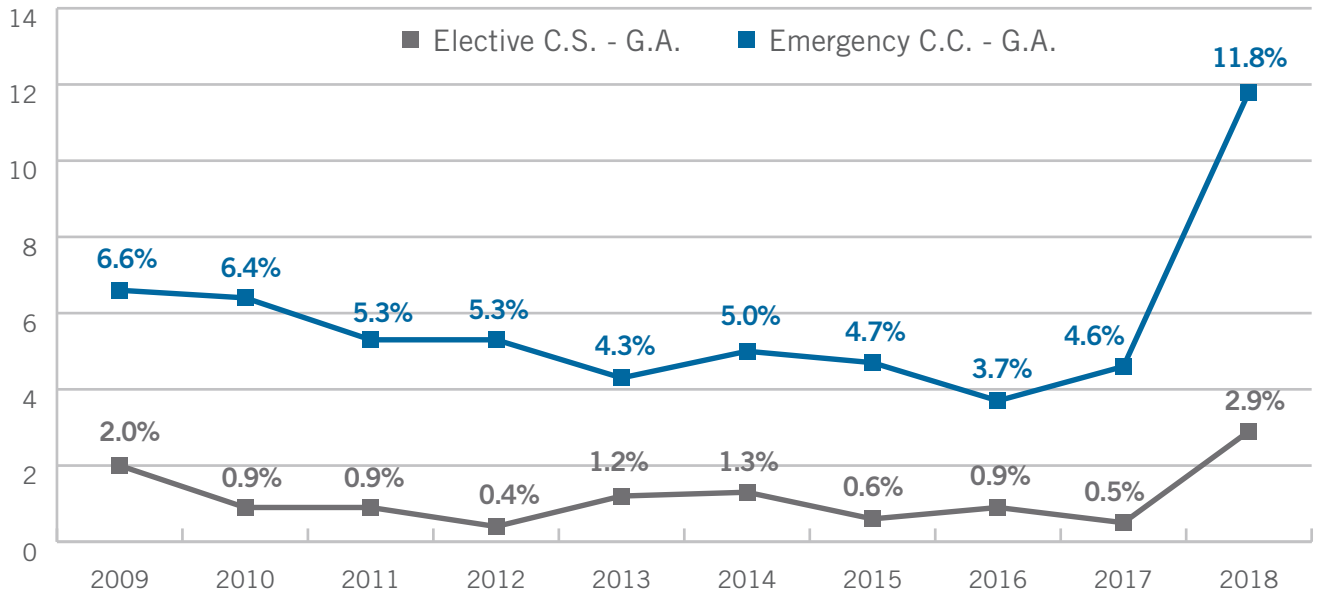
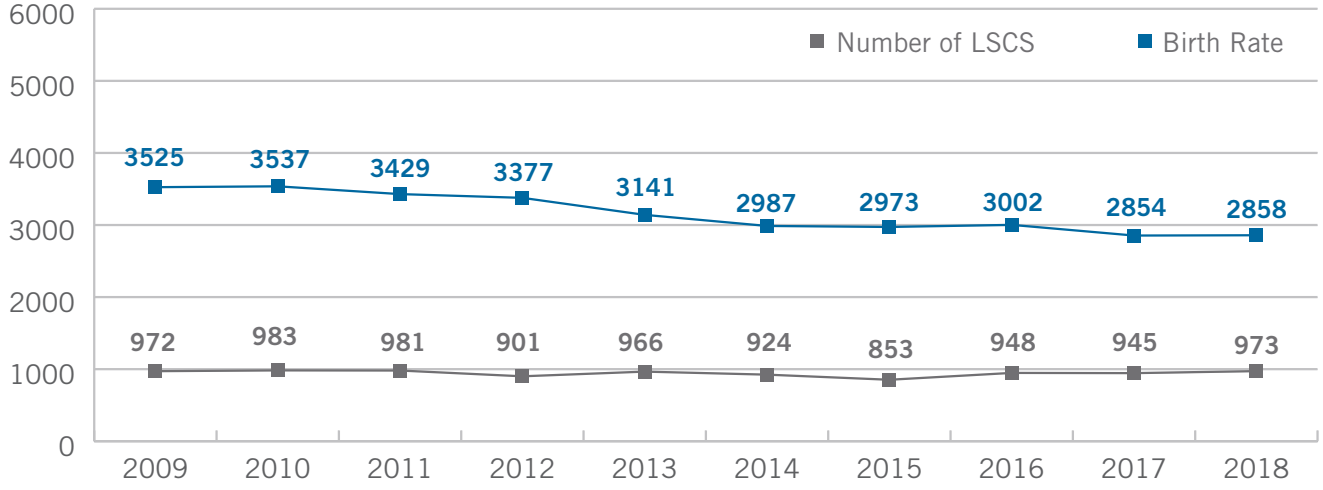


Figure 3. Number of Women who had a caesarean delivery



Neonatal Clinical Report

Dr. Donough O'Donovan, Dr. Ethel Ryan and Ms Marie Hession

During the year 2018 a total of 2858 infants were born at GUH, of which 409 (14.3%) were admitted to the neonatal unit (Figure 1). In keeping with national trends, the delivery rate has declined year on year since reaching a peak in 2008 (Figure 2). However, the total number of GUH deliveries in 2018 was slightly higher than in 2017, suggesting that we may have reached the end of year on year declining birth rates. Despite the fluctuating delivery rates, admissions to the neonatal unit have remained relatively consistent for the last five years (Figure 1).

Fifty eight percent (237 infants) of the neonatal unit admissions in 2018 were > 37 Wks gestation, whereas 172 infants (42%) were premature. GUH is a Level 2 (Regional) Neonatal Unit and provides neonatal intensive care to infants > 27 Wks gestation. Of the premature infants 8 were ELBW (BW < 1000g) and 24 infants weighted between 1000g and 1500g at birth (VLBW). Ten of the premature infants were < 28 Wks gestation, 29 were born between 28 and 31+6 Wks gestation and 133 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 2018 were almost identical to 2017.

One hundred and fifty-one infants (37%) were admitted from the Labour Ward, 155 (38%) from Gynae Theatre and 78 (19%) from the Post Natal ward (Table 3). Twenty-four infants (6%) were transferred into the neonatal unit from outside hospitals. The distribution of admission locations for 2018 was almost equal to what was reported in 2017.

Consistent with previous reports prematurity, respiratory distress and evaluation for sepsis remain the commonest conditions requiring admission to the neonatal unit, accounting for 69% of all admissions in 2018. Five infants were transferred to Dublin (Rotunda Hospital 1 and Coombe Hospital 4) for Therapeutic Brain Cooling in 2018.

There were 2 neonatal unit related deaths in 2018 (Details below). The 2018 overall neonatal unit related mortality rate (Number of deaths in neonatal unit per 1,000 live births) was 0.7 per 1000. A 2008 to 2018 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 2018.

Figure 1 - Neonatal Admissions

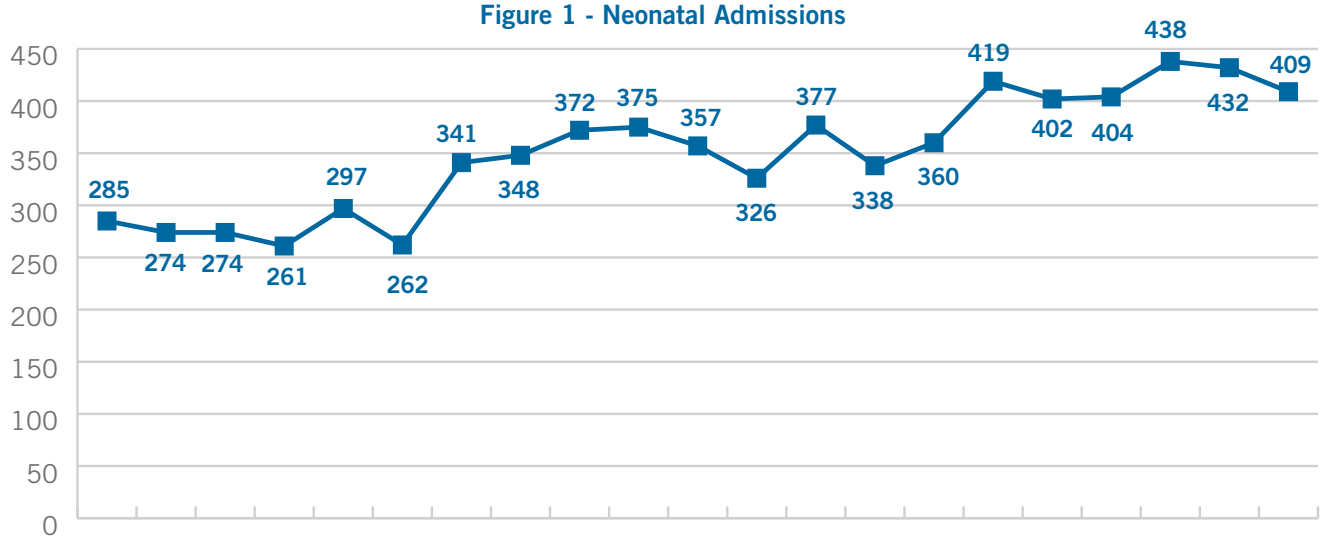
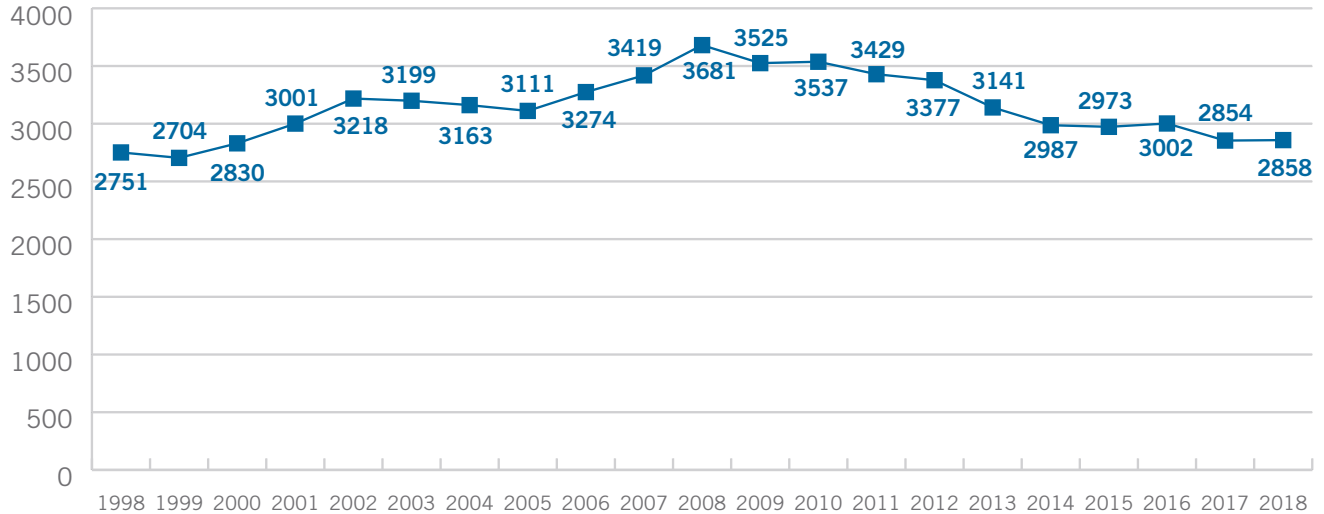


Figure 2 - Birthrate



1. BABY WEIGHTS ON ADMISSION 2018		
Weight	**No.**	**%**
500-599gms	1	0.2%
600-699gms	1	0.2%
700-799gms	0	0.0%
800-899gms	1	0.2%
900-999gms	5	1.2%
1000-1249gms	9	2.2%
1250-1499gms	15	3.7%
1500-1749gms	14	3.4%
1750-1999gms	15	3.7%
2000-2249gms	37	9.0%
2250-2499gms	48	11.7%
2500-2999gms	77	18.8%
>3000gms	186	45.5%
Total	**409**	**100.0%**

2. GESTATION AGE OF NEONATAL UNIT ADMISSIONS 2018		
<28wks	10	2.4%
28-31+6wks	29	7.1%
32-36+6wks	133	32.5%
>37wks	237	57.9%
Total	**409**	**100.0%**

3. SOURCE OF ADMISSION		
Source of Admission	**2018**	**%**
Delivery Suite	151	36.9%
Theatre	155	37.9%
St. Angela's Ward	78	19.1%
Transfer in/ Readmitted/Other	25	4.5%
Total	**409**	**100.0%**

4. SURVIVAL OF NEONATAL UNIT INFANTS 2018		
Weight	**Number**	**Deaths**
≤1000g	8	0
1001 - 1500g	24	0
1501 - 2500g	114	1
>2500g	263	1
Total	**409**	**2**

5. NEONATAL UNIT MORTALITY RATE 2018		
Total	2	0.7/1000
Excluding LCM	0	0/1000

6. GENERAL NEONATAL MORBIDITY	
IPPV	21
NCPAP	109
Respiratory Disorders: RDS/TTN	146
Meconium Aspiration	4
Pneumothorax	4
Evaluation for Sepsis	193
Small Bowel Obstruction / Perforation	2
Hypoglycemia	74
Perinatal Stress/Low Cord pH	15
Haematology: Jaundice/HDN/NAIT/Thrombocytopenia	26
Haematology: Factor VIII Deficiency	2
IVH	4
Birth Trauma and Fracture	4
Transferred for Therapeutic Cooling	5

7. CONGENITAL ABNORMALITIES	
Down Syndrome	3
Chromosome 9 Abnormality	1
Unnamed Dysmorphic Syndrome	1

8. CARDIAC / CHD / SIGNIFICANT ECHO FINDINGS	
ASD / VSD/ PDA /PPHN	17
AVSD	3
Ebstein's anomaly	1
Cardiac Rhabdomyoma	1

9. NOTABLE SIGNIFICANT MALFORMATIONS / OTHER	
Cleft Lip & Cleft Palate	1
Exomphalos	1
Tracheoesophageal fistula	1
Tuberous sclerosis	1
Myelomeningocele	1
Dandy Walker Syndrome	1
Schizencephaly	1
Ventriculomegaly	3
Congenital Cataracts	1
Congenital Megacystitis	1
Polycystic Kidney	1
Fractured Femur (Birth Trauma)	1
Abnormal MRI	1

10. NEONATAL BLOOD CULTURES/PCR	
GBS	1
E. Coli	1
Staphylococcus Aureus	2
Coagulase Negative Staphylococcus	7
Congenital CMV	1

11. NEONATAL TRANSPORT	
NTP	12
Ambulance + NICU Nurse	15
Total	**27**

12. FINAL DIAGNOSIS 2018 (OFTEN MORE THAN 1)		
Reason for Neonatal Admission 2018	**Year**	**%**
Prematurity / Low Birth Weight / RDS	172	42.1%
Low Cord PH	9	2.2%
Low Saturations	3	0.7%
Respiratory Distress / Grunting	59	14.4%
Sepsis at Risk	51	12.5%
Observation	23	5.6%
Social Reason	5	1.2%
Low Apgars	4	1.0%
Congenital Abnormality	5	1.2%
Jaundice	9	2.2%
Hypoglycaemia	11	2.7%
Sent for Cooling	5	1.0%
Other Fetal Reason	54	13.2%
Total	**409**	**100.0%**

13. MORTALITY TABLE 2008-2018			
Gestation	**Number**	**Survival to 28 days**	**Survival to discharge**
23wks	3	1 (33%)	1 (33%)
24 wks	21	9 (43%)	8 (38%)
25 wks	24	15 (63%)	14 (58%)
26 wks	25	22 (88%)	21 (84%)
27 wks	41	37 (90%)	37 (90%)
28 wks	52	47 (90%)	47(90%)
29 wks	73	72 (98.5%)	72 (98.5%)
30 wks	61	59 (97%)	59 (97%)
>30 wks	112	107 (96%)	107 (96%)
Total	**412**	**369 (90%)**	**366 (89%)**

14. SUMMARY NEONATAL UNIT DEATHS IN 2018			
Diagnosis	**GA**	**BW**	**Location of Death**
Mosaic Trisomy 9, Ebsteins anomaly, Cleft palate and Micrognathia.	36+5/40	1800 gms	Crumlin Hospital (DOL 4)
Dysmorphic Features, Ambiguous Genitalia, Obstructive Hydrocephalus, & Suspected Congenital Metabolic Myopathy.	37/40	2852 gms	GUH (DOL 18)

15. NEONATAL UNIT RELATED DEATHS IN 2018

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

1. **Pregnancy:** Gestation 37/40, BW 2852gms, Female, Twin 2, Elective LSCS, Twin 2 Polyhydramnios & small gastric bubble, Mother 41yo.
   Neonatal Course: Resuscitation with PPV. Apgars 0^{1} & 4^{5}. Neonatal Encephalopathy. Dysmorphic features. Transferred to Rotunda Hospital for Therapeutic Hypothermia. Abnormal EEG and MRI brain. Multiple abnormalities: Ambiguous genitalia, obstructive hydrocephalus, renal calculi. Failed multiple extubation attempts in Rotunda Hospital. Normal GUH microarray studies. Suspected congenital metabolic myopathy. Transferred back to GUH for palliative care. Withdrawal of care DOL 18. RIP.
   Diagnosis: Dysmorphic Features, Ambiguous Genitalia, Obstructive Hydrocephalus, Renal Calculi & Suspected Congenital Metabolic Myopathy.
   Postmortem: Declined.

2. **Pregnancy:** Gestation 36+5/40, BW 1800 gms, Male, Singleton, Emergency LSCS for antenatal diagnosis of Ebsteins anomaly, VSD and chromosome abnormality (Mosaic Trisomy 9), Antenatal Steroids, Mother 40yo, G4P2.
   Neonatal Course: PPV for 1 min, CPAP. Apgars 5^{1} & 8^{5}. Dysmorphic features. Multiple abnormalities: Cleft palate, Micrognathia, Ebsteins anomaly, VSD. Mosaic Trisomy 9. Transferred to Crumlin on DOL 2 for further evaluation. Condition deteriorated and decision for palliative care. RIP in Crumlin Hospital on DOL 4.
   Diagnosis: Mosaic Trisomy 9, Ebsteins anomaly, Cleft palate and Micrognathia.
   Postmortem: No.

Paediatric Report

Dr. Edina Moylett

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 2018. 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 Ambulatory Care Unit (opened October 2017) 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 directly to St Bernadette's, excluding recently discharged premature infants who may not be suitable for the paediatric unit owing to specific specialist neonatal requirements.

Data are broken down into the following principal categories, medical and surgical admissions with day cases and overnight admissions. Transfer data, where available, provided for UHG ICU admits and elective/ emergency tertiary hospital transfers.

Admission Information

The majority of data for this report were 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*. Ambulatory care data received from Ms Annmarie Furlong, CNM2, ambulatory care/ OPD; patient transfer data from Ms Ann Matthews, CNM3, paediatrics. Comparative data, where available, are provided for preceding years. 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.

Admissions Bernadette's Ward

Figure 1 outlines all admissions to UHG during 2018; note 3,960 children admitted to St Bernadette's ward, c. 11/ day; 2,040 medical and 1,920 surgical cases. Of the 2,040 medical cases, only 129 day case procedures, 6% general paediatric activity. Average age for day cases, 5.4 years; average length of stay for overnight admissions, 3.6 days with average age 5.2 years. The total admission figure for 2017 was 4,084 patients, continued downward trend from prior average of 4,500.

The majority of acute paediatric medical admissions are direct from the ED, during 2018, approximately 18% of children ≤16 years seen in the ED were admitted (2,714/14,872).

Figure 2 outlines the surgical activity on St Bernadette's ward for 2018. Of the 1,920 surgical cases, there were 550 day cases accounting for almost one-third (29%) of the surgical paediatric activity.

Other wards in UHG

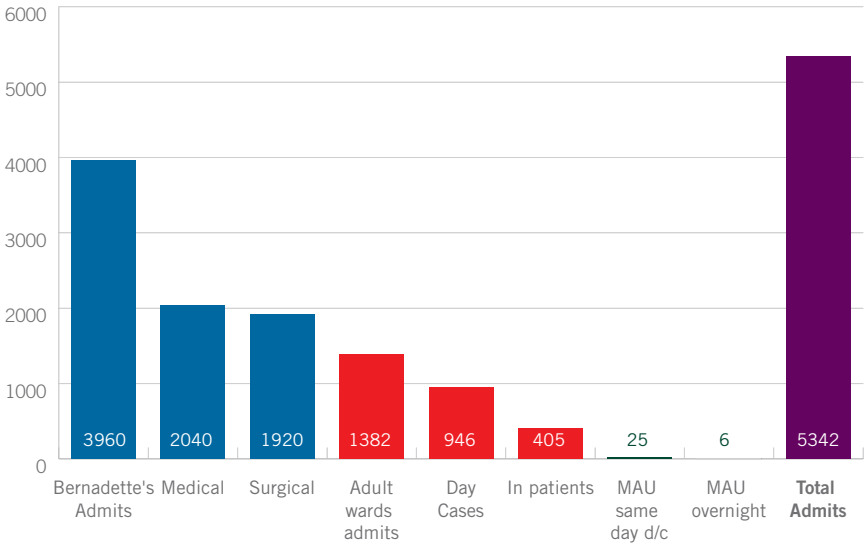
During 2018, 1,382 children up to 16 years old were admitted to 'adult' UHG wards, c.4/day, and similar figure of 1,302 during 2017. Of the 1,382 on adult wards, 946 admitted as day cases, 405 overnight admissions, and average duration of stay 19 days. There were 31 children up to 16 years in the Medical Assessment Unit, 25 same day MAU discharges. Approximately 250 children admitted with 'surgical' diagnoses to adult wards during 2018, 523 'surgical' day cases.

Should the admission age for St Bernadette's paediatric unit increase to 16 across all disciplines, there would be c.5,400 children in total per year, c.15/ day, an increase from the current 11/day.

Paediatric ED Activity

During 2018, there were 14,782 (15,902 during 2017) attendances to the UHG ED up to 16 years of age, c.41 patients reviewed per day. Approximately 18% (2,714/14,872)of patients presenting to the paediatric ED admitted to UHG. This admission rate is in line with national average.

Figure 1.
All paediatric admissions, Day and Overnight to UHG during 2018



Paediatric Ambulatory Care Activity

The paediatric ambulatory care unit (located on St Bernadette's ward) received the first patients on October 1, 2017. Clinical activity includes, IV infusions, phlebotomy, cannulation, clinical review, allergy procedures, neurology testing, endocrine testing and sweat tests. Only those patients presenting to the admissions department are currently recorded on the PAS hospital IT system. In total, 1,500 children were seen in ambulatory care during 2018; 547 formal admissions, clinical reviews, 430; oncology patients for blood work, 218; dermatology reviews, 80; plastic surgery reviews, 144; sweat tests, 50; other 30. A significant amount of this activity would typically have taken place on St Bernadette's, the ED or hospital phlebotomy.

ICU admissions and Direct Transfers from St Bernadette's

There were 60 (52, 2017) children ≤ 14 years of age admitted to the UHG ICU during 2018, one child was >14 but <16. The majority of patients admitted from the ED to ICU, 11 children transferred from St Bernadette's to ICU. The average age 5.1 years, majority in the 5-14 year age group, 6 infants under 4 weeks old; see Figure 3 for age breakdown. The average duration of stay was 1.08 days (range, 0.2 to 6.8 days), very similar to 2017 (1.16 days). The Table outlines admission diagnoses and discharge destination. Respiratory causes remain the principle reason for ICU admission. The majority of children discharged to St Bernadette's ward; only 20% (12 children) transferred to tertiary services, 4 with the retrieval team.

Transfers from St Bernadette's to Tertiary Hospital

During 2018, 54 children were transferred to a tertiary hospital, 24/54 accompanied by nursing staff. Of those unaccompanied by nursing staff (30), 14 travelled by ambulance. Only 3 of 54 children transferred to Beaumont for neurosurgery input, 36 children transferred to Children's Hospital Ireland at Crumlin.

Figure 2. Paediatric Surgical Admissions, Bernadette's, 1,920, 2018

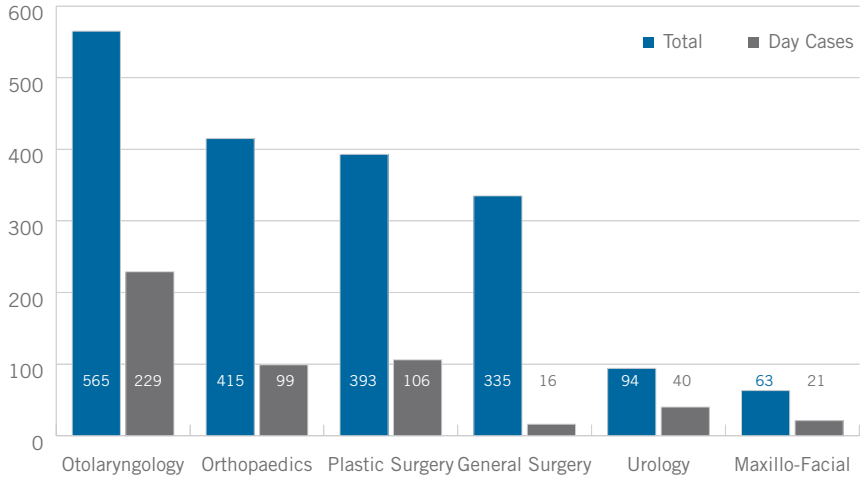
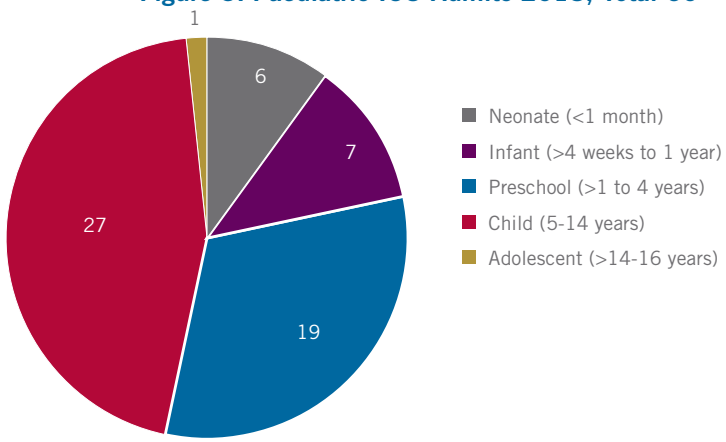


Figure 3. Paediatric ICU Admits 2018, Total 60



ICU / ICU Admission Diagnosis	N
Respiratory	32
Bronchiolitis	*10*
Asthma	*9*
Seizure/Status epilepticus	6
Infection related	6
DKA	6
Other	3
Trauma related	4
Post-surgery	3
Total	**60**
Paediatric Discharge Destination	**N (%)**
Tertiary hospital	12 (20)
St Bernadette's Ward (paediatrics)	48 (80)

Paediatric Out-Patient Report

Dr. Mary Herzig

Introduction

This report presents the available data on medical paediatric out-patient clinical activity for year-end December 31, 2018. Out-patient procedures performed by nursing staff (e.g. sweat testing, phlebotomy, intravenous infusions, and Mantoux testing), are now electronically captured and are reported in this document. These duties have been transferred to a paediatric day ward which opened in 2018.

The UHG OPD facility was built in the 1950's and remains at maximum capacity. Clinical sessions for new staff are accommodated by reducing the number of existing clinics. This allows for an increase in the breadth of services available to children, but will not address the waiting lists. A new build is ultimately required to cater for the increasing referrals and complexity of patients referred to UHG.

The paediatric out-patient department runs 9-10 medical clinics per week accommodating 9 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 new nurse led clinics for diabetes, physiotherapy hip clinic, allergy and cystic fibrosis. The following figures represent the cumulative number of patients seen across all 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. Nurse and physio led clinics are listed separately.

2018 DATA

Number of Medical Consultant Patients

The total number of out-patients appointments offered to patients is similar to previous years at n=6622. There were 1658 new (25%) and 4964 return (75%) appointments. There is no 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

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.

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%**

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 indicated a trend of increased referrals which may now be reaching a plateau.

Consultants have prioritized new referrals over review patients in 2017 and 2018 to reduce the number of patients waiting and their wait time.

NUMBER OF PATIENTS ON PAEDIATRIC WAIT LIST TOTALS	
2013	432
2014	723 (+67%)
2015	1086 (+50%)
2016	1227 (+13%)
2017	1008 (-18%)
2018	1008 (even)

The wait time is addressed by running extra new patient only clinics in available slots where staff and facilities are available.

Out-Patient Waiting List 2009-2018

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**

Number of Long Waiters Year End:

(months)	12-15	15-18	18-21	21-24	24-36
2016	124	60	11	0	0
2017	140	78	39	21	14
2018	67	28	15	13	9

Increasing and continuing effort needs to be made to increase the number of out-patient sessions with appropriate capital and staff resources due to the expanding paediatric department. Priorities for 2019 include planning for capital expansion of existing OPD facilities to cater for new specialities and the increasing demand for appointments and increasing office and work space for medical and administrative staff

Day Ward And Nurse Led Clinics

With the opening of the day ward and the start of nurse led clinics, we now have data on number of children using these services. The existing space in the paediatric ward was reconfigured to allow this at the cost of office and administrative space. This space will need to be found for existing staff in order to optimize their roles.

2018 OPD DATA	Number Children
General OPD Nurse	9
Day Ward	978
Physio Hip	187
CF	3
Diabetes	39
Allergy	19
Total	**1235**

Paediatric Academic Department

Professor Nicholas Allen

Introduction

The Academic Department of Paediatrics is part of NUI Galway Medical School, main office located in the Clinical Science Institute, adjacent to Galway University Hospital.
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, friendly 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 introduction of Mini-CEXs. Students are encouraged to 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, 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 educated 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 2018, took place in the Ardilaun Hotel and featured invited speakers Prof. Declan Cody, Dr. Niamh McGrath, Dr. Rosemary Geoghegan, as well 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 (Letterkenny)
Dr J Gleeson (Sligo)
Dr Shyam Pathak (Castlebar)
Dr Lucy Hurley (Portiuncula)

Clinical Lecturers: Galway University Hospital Galway

Dr D O'Donovan
Dr O Flanagan
Dr M Herzig
Dr E Ryan
Dr A Lyons
Dr Niamh McGrath

Mayo University Hospital, Honorary Clinical Lecturers

Dr (Honorary Prof) M O'Neill
Dr J Letshwiti
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 H Greaney
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 2018 was Professor Jürgen Schwarze, Edward Clark Chair of Child Life and Health, Consultant Paediatrician and Immunologist, University of Edinburgh

Final Undergraduate Paediatric Results
A total of 189 students completed the 4MB3 course in 2018:

Result	%	(number of students)
First Class (H1)	9.54%	(19)
Second Class (H2)	41.70%	(83)
Pass	33.66%	(67)
Fails	10.05%	(20)

National Henry Hutchinson's intervarsity awards
- Stephen O'Brien: 1st place in Paediatrics (NUIG)
- Kate Rigney: 3rd place in Paediatric (NUIG)

Postgraduate

MD Student: 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).

RESEARCH/AUDIT

International Peer Review Publications:

- Gorman KM, Cary H, Gaffney L, Forman E, Waldron D, Al-Delami F, Lynch BJ, King MD, Allen NM. Status dystonicus due to missense variant in ARX: Diagnosis and management. Eur J Paediatr Neurol. 2018; pii: S1090-3798(17)31999-2.
- Allen NM, Ewer A, Nakou V, Konstantoulaki E, Wraige E, Gowda V, Jungbluth H. Unusual Presentations of Dystrophinopathies in Childhood. Pediatrics. 2018 Apr;141(Suppl 5):S510-S514.
- Forman EB, King MD, Allen NM. Interferonopathies in laboratory-negative suspected congenital infection. Lancet Infect Dis. 2018 Jan;18(1):27.
- Forman EB, Gorman KM, Conroy J, Arthur N, Grant C, Ennis S, Allen NM, Lynch SA, King MD. Cost of exome sequencing in epileptic encephalopathy: is it 'worth it'? Arch Dis Child. 2018 Mar;103(3):304.
- Lumsden DE, Allen NM. Rethinking status dystonicus: A welcome start to a challenging problem. Mov Disord. 2018 Jan 23. doi: 10.1002/mds.27291.
- Allen NM, Dafsari H, Wraige E, Jungbluth H. Neck-Tongue Syndrome: An Under-Recognised Childhood Onset Cephalalgia. J Child Neurol 2018; 33(5):347-350.
- Umana E, Rana A, Maduemem K, Moylett E. Introduction of an Oral Fluid Challenge Protocol in the Management of Children with Acute Gastroenteritis: A Regional Hospital Experience. Ir Med J. 2018 Jun 7;111(6):775.
- Semple A, O'Currain E, O'Donovan D, Hanahoe B, Keady D, Ní Riain U, Moylett E. Successful termination of sustained transmission of resident MRSA following extensive NICU refurbishment: an intervention study. J Hosp Infect. 2018 Nov;100(3):329-336.
- 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. Epub 2018 Apr 5. Ir J Med Sci. 2019 Feb;188(1):219-222.
- Smith V, Begley C, Newell J, Higgins S, Murphy DJ, White MJ, Morrison JJ, Canny S, O'Donovan D, Devane D. Admission cardiotocography versus intermittent auscultation of the fetal heart in low-risk pregnancy during evaluation for possible labour admission – a multicentre randomised trial: the ADCAR trial. BJOG 2018[Epub ahead of Print].

Other Abstracts/Research Presentations

- O'Rahelly, Jungbluth H, Allen NM, Jungbluth H. Expanding Spectrum of Fetal Acetylcholine Receptor Inactivation Syndrome and novel treatment approach with oral Salbutamol. Irish Paediatric Association 2018[Poster].
- Hayden J, Lynch BL, Dann L, Allen NM. Is Narcolepsy Incidence increasing or symptoms just better recognised? Irish Paediatric Association Dec 2018[Poster].
- Parental Attitudes To Influenza Infection: Willingness For Annual Paediatric Vaccination Yuxin Woon1, E Moylett. IPA 2018 December Galway [Oral].
- Edwards Murphy D; M McMorrow; J Morgan; S Kyne; E Moylett. BP recording amongst hospitalised paediatric patients: are we in line with the most recent AAP recommendations? IPA 2018 December Galway [Poster].
- Simon Piggott1, Ethel Ryan1, Una Ni Riain2 and Edina Moylett1 .Two Cases Of Late Onset Gbs Despite Post Natal Benzyl Penicillin. IPA December 2018 Galway [Poster].
- Kyne S, Jones D, Edwards Murphy D, McMorrow M, Morgan J and Moylett E. Documentation of paediatric blood pressure: a necessary task? IPA December 2018 Galway [Poster].

Audit Presentations/Abstracts

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

Invited Presentations

- Engaging Clinicians & Clinicians Research Agendas. Prof. Nicholas Allen. Science Foundation Ireland (SFI) FutureNeuro Research Centre, Clinical Neurosciences Study Day, 26th Oct 2018, Albert Hall, Royal College of Surgeons of Ireland, Dublin, Ireland.

Gynaecological Surgery Report 2018

Professor John J Morrison and Ms Shaijy Avarachan

The surgical procedures performed during 2018 are outlined below. They are shown alongside the figures for the 3 previous years. The statistics also include the gynaecology procedures in the major theatre in the general hospital.

	2015	2016	2017	2018
LSCS	853	948	942	960
Laparoscopy	109	147	87	52
ERPC	184	140	173	199
Ectopic pregnancy	17	11	19	24
Hysteroscopy	602	585	649	627
Tubal ligation	25	16	6	14
Laparotomy	27	37	10	28
Wertheim's /Radical hysterectomy	2	9	2	5
Omentectomy	0	12	4	2
Abdominal hysterectomy +/- BSO	41	62	37	38
Myomectomy	5	19	15	9
TAH,BSO&PLND			20	38
TAH, BSO & omentectomy & Appendicetomy +/- PLND			19	29
Vaginal hysterectomy	7	4	6	0
Vaginal hysterectomy & PFR	8	11	13	6
Pelvic floor repair	34	32	35	34
TCRE	9	10	25	30
Endometrial ablation	30	27	41	48
Cystoscopy	26	21	21	27
TVT	26	25	20	5
Sacrocolpopexy	0	4	1	0
Macroplastique collagen	0	4	2	5
Removal of TVT mesh	0	0	3	3
Vulvectomy	1	5	2	5
LLETZ	10	5	3	9
Bartholins	10	9	22	22
Vulval Biopsy	17	15	38	41
Laparoscopic Hysterectomy+/-BSO	30	35	29	30
Laparoscopic Hysterectomy /BSO/ PLND			1	9
Lap Radical Hysterectomy /BSO/ PLND			1	1

	2015	2016	2017	2018
Laparoscopic sacrocolpoplexy			2	0
Lap Hysterectomy & sacrocolpoplexy			4	1
Lap unilateral salpingo-oophorectomy			7	16
Laparoscopic cystectomy			8	15
3rd Degree tear repair	39	36	37	32
Lap dye hysteroscopy	97	117	120	89
Mirena insertion	148	96	165	135
Examination under anaesthetic	20	24	23	21
Cervical cerclage/suture	7	20	11	15
Removal of cervical suture			1	0
Manual removal of placenta	23	15	23	15
Instrumental /vacuum extraction delivery	39	35	92	69
Fenton's procedure	0	4	5	1
Caesarean hysterectomy	1	2	2	6
Ovarian debulking	12	20	34	24
Laparoscopic BSO		34	24	22
Excision of skin tag			6	0
Removal of drain			1	0
PPH Bakri balloon insertion			1	0
Removal of Mirena coil			10	11
Cervical smear under GA			1	9
Colpoclesis			6	4
Labiaplasty			2	0
Excision of labial cyst			1	4
Major	1376	1470	1349	1261
Minor	992	1047	1284	1323
Total	**2368**	**2517**	**2633**	**2584**
Elective cases	1589	1803	1804	1840
Emergency cases	779	714	829	744
Total	**2368**	**2517**	**2633**	**2584**

Urogynaecology Report

Dr Susmita Sarma

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 and Rachel Clarke, physiotherapists for their invaluable help.

Urodynamics:

In 2018, 87 appointments were sent and 66 urodynamic investigations were performed. Cystistat is used to treat painful bladder syndrome and is administered during the urodynamic clinic session.The assistance of Mary Connolly HCA who retired this year was greatly appreciated in the urodynamic clinic. Geraldine Adair commenced 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: 66

DIAGNOSIS:	
Stress Urinary Incontinence:	26 (38.8%)
Mixed Urinary Incontinence:	7 (10.6%)
Normal	13 (19.6%)
Detrusor overactivity	11 (16.6%)
Voiding problems:	3 (0.04%)

SURGERY:	
Tension free vaginal tapes	4
Periurethral Macroplastique	5
Cystoscopy	15
Sacrospinous fixation	2
Colpocleisis	2

Surgery using mesh for stress incontinence was suspended by the CMO in July 2019.

Colposcopy Clinic Report

Dr Michael O'Leary and Ms Maura Molloy

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 SM, Marguerite Bourke SM.
Healthcare assistant: Karen McGinley

Activity

There were 4114 women attended Galway Colposcopy clinic in 2018, of these 1429 were first visits and 2685 were review appointments. A total of 1375 referrals to Colposcopy were received, 185 high grade smears, 377 low grade smears and 813 had clinical indication for referral. These referral numbers reflect a drop in abnormal smears (from1010 in 2009 to 562 in 2018) but a rise in clinical indications. Contrasted with figures from 2009 when we saw 1151 first visits and 138 of these were for clinical indications, the clinical indication referral rate went from 12% of total referrals in 2009 to 59% of total referrals in 2018. Non attendance was 4% amongst first visits and 8% for follow up appointments, 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 at the request of Neurology department for a small number of women prior to Lemtrada therapy for multiple sclerosis.

Cytology and high risk HPV testing were provided by Medlab Pathology. 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.

There were 322 LLETZ treatments performed, 302 of LLETZ treatments performed had CIN 1 or > (table 1). Cervicalcheck standards were met (>80% of excisions should have CIN on histology). Cold coagulation, an ablative treatment was performed on 26 women for persistent CIN1.

Cancer

There were 26 cases of cervical cancer seen at the colposcopy clinic in 2018. The ages of women presenting with cervical cancer ranged from 24 to 62 years. Histology of cervix carcinomas included, 16 squamous cell, 6 adenocarcinoma, 4 adenosquamous, 1 neuroendocrine and one B cell non Hodgkins. Four of the cervix cancers were at stage 1a. Women seen with other types of cancer included 1vaginal cancer (recurrence of papillary serous carcinoma) and 1 squamous cell vulval cancer.

Cervicalcheck audit

The colposcopy team had a very challenging year in 2018. Background is that Cervicalcheck undertook audit of previous smears of women who were diagnosed with cervicalcancer.

Some previous screening smears were found on review to have been abnormal and court proceedings ensued leading to media coverage. Cervicalcheck set up a helpline and 201 women who had previously attended Galway Colposcopy called the helpline. The colposcopy nursing/midwifery team returned all 201 calls to discuss issues and reassure women, calls varied in length from 10 minutes to 30 minutes. Women also called the clinic directly, 286 calls in 4 weeks following the first court proceedings and again nursing midwifery staff returned these calls. Cervicalcheck identified 31 women from Galway colposcopy who were affected by the Cervicalcheck audit of previous smears and these women were all contacted and most were reviewed by the Consultants and Advanced Midwife Practitioners for long discussions. There was an increase in women attending primary care for free screening tests and this led to long delays in reporting as the laboratories did not have capacity to process the volume of smears submitted. This delay of up to 5 months for results impacted Colposcopy patients and staff.

Histology Result 2018	Diag. Biopsy (punch)	Excision	Total Biopies
Cervical Cancer	15	13	28
Adenocarcinoma in situ / CGIN	8	8	16
CIN3	92	136	228
CIN2	137	93	230
CIN1	467	48	515
CIN Uncertain Grade	1	0	1
VAIN3	3	0	3
VAIN2	6	2	8
VAIN1	11	0	11
VIN3	2	0	2
VIN2	2	0	2
VIN1	3	0	3
HPV / cervicitis only	472	14	486
No CIN / No HPV (normal)	295	8	303
Inadequate	17	0	17
Result not known	1	0	0
Total	1532	322	1854

Outreach clinic

Midwifery staff from Galway Colposcopy clinic continued a smear clinic at Portiuncula Hospital Ballinasloe on two Friday afternoons per month, 235 women attended the outreach clinic in 2018. 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.

Summary

Our colposcopy team both clinical and clerical worked exceptionally hard in 2018 to manage a large increase in referrals, mainly clinical indications and to return phone calls to very anxious women. The surge in referrals with normal smear but suspicious cervix is reflective of a national trend that places a big workload on Colposcopy clinics.

Despite the increase in referrals the number of women with high grade precancer seen in our Colposcopy clinic is reducing and we continue to work to reduce the incidence of cervical cancer in the West of Ireland and midlands.

Obstetrics & Gynaecology Academic Report

Professor John J Morrison

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 (Ballinasloe)

Clinical Teachers in Obstetrics and Gynaecology, affiliated hospitals

- Dr 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 2018 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 SHO's.

Formal one-day education meetings are held every year. The first of these is held in March, and involves a postgraduate educational weekend for all of the teachers in Obstetrics and Gynaecology. The speakers for the 2018 meetings are listed in the external speakers section below. 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, Nicholson SM, Morrison JJ. Vaginal birth after caesarean section: Current status and where to from here? *Eur J Obstet Gynecol Reprod Biol* 2018 May; 224:52-57. doi: 10.1016/j.ejogrb.2018.02.011. Epub 2018 Mar 7

Viljoen K, Segurado R, O'Brien J, Murrin C, Mehegan J, Kelleher CC; DMed on behalf of the Lifeways Cross Generation Cohort Study Steering Group, Morrison JJ. Pregnancy diet and offspring asthma risk over a 10-year period: the Lifeways Cross Generation Cohort Study, Ireland *BMJ Open* 2018 Feb 20;8(2):e017013. doi: 10.1136/bmjopen-2017-017013

Mone F, O'Mahony JF, Tyrrell E, Mulcahy C, McParland P, Breathnach F, Morrison JJ, Higgins J, Daly S, Cotter A, Hunter A, Dicker P, Tully E, Malone FD, Normand C, McAuliffe FM. Preeclampsia prevention using routine versus screening test-indicated aspirin in low-risk women *Hypertension* 2018 Dec; 72(6):1391-1396. doi: 10.1161/HYPERTENSIONAHA.118.11718

Ryan G, Nicholson SM, Crankshaw DJ, Morrison JJ. Human uterine contractility at term in relation to previous cesarean section *American Journal of Obstetrics & Gynecology* 2018; Vol. 218, Issue 1, S349–S350

Mulcahy C, Mone F, McParland P, Breathnach F, Cody F, Morrison JJ, Higgins J, Daly S, Dornan S, Cotter A, Dicker P, Tully E, Malone FD, McAuliffe FM. The impact of aspirin on ultrasound markers of uteroplacental flow in low-risk pregnancy: secondary analysis of a multicenter RCT. *Am J Perinatol* 2018; doi: 10.1055/s-0038-1675208. Epub 2018 Nov 5

N Dundon, S Nicholson, GA Ryan, D Crankshaw, JJ Morrison. Inhibitory effect of insulin on uterine contractility in vitro and increased risk of caesarean section. *American Journal of Obstetrics & Gynecology* 2018; Volume 218, Issue 1, S20

Smith V, Begley C, Newell J, Higgins S, Murphy DJ, White MJ, Morrison JJ, Canny S, O'Donovan D, Devane D.

Authors' reply re: Admission cardiotocography versus intermittent auscultation of the fetal heart in low-risk pregnancy during evaluation for possible labour admission-a multicentre randomised trial: the ADCAR trial. *BJOG* doi: 10.1111/1471-0528.15491. Epub 2018 Nov 5

Ryan G, Nicholson SM, Crankshaw DJ, Morrison JJ. Human uterine contractility at term in relation to parity. *American Journal of Obstetrics & Gynecology* 2018; Vol. 218, Issue 1, S236

Mone F, Mulcahy C, McParland P, Breathnach F, Downey P, McCormack D, Culliton M, Stanton A, Cody F, Morrison JJ, Daly S, Higgins J, Cotter A, Hunter A, Tully EC, Dicker P, Alfirevic Z, Malone FD, McAuliffe FM. Trial of feasibility and acceptability of routine low-dose aspirin versus Early Screening Test indicated aspirin for pre-eclampsia prevention (TEST study): a multicentre randomised controlled trial. *BMJ Open* 2018 Jul 28;8(7):e022056. doi: 10.1136/bmjopen-2018-022056

Oral presentations

Society of Maternal-Fetal Medicine Dallas, February 2018

Inhibitory effect of insulin on uterine contractility in vitro and increased risk of caesarean section. Dundon N, Nicholson S, Ryan GA, Crankshaw DJ, Morrison JJ

Junior Obstetrics & Gynaecology Society (JOGS) Annual Scientific Meeting, RCPI November 2018

1. Effects of parity on human myometrial response to oxytocin and ergometrine in vitro. Ryan GA, Crankshaw DJ, Morrison JJ
2. Spontaneous myometrial contractility in the third trimester of pregnancy in women with a previous caesarean section in relation to past mode of delivery. Ryan GA, Crankshaw DJ, Morrison JJ (Winner of Third Prize for Best Oral Presentations)

Diabetic Pregnancy Study Group Rome September 2018

1. Bogdanet D, Khattak A, Mustafa M, Carmody L, Kirwan B, O'Shea P, Gaffney G, Dunne F. What is the impact of weight gain less than that recommended by IOM on pregnancy outcome for women with GDM and BMI>/= 30?
2. Mustafa M, Khattak A, Bogdanet D, McKenna L, Carmody LA, Kirwan B, Gaffney G, O'Shea P, Dunne F. Gestational diabetes (GDM < 24 weeks) is associated with worse pregnancy outcome despite early treatment, when compared with GDM diagnosed at 24-28 weeks gestation.

Poster presentations

Society of Maternal-Fetal Medicine Dallas, February 2018

1. Human Contractility at Term in Relation to Parity. Ryan GA, Nicholson SM, Crankshaw DJ, Morrison JJ. Department of Obstetrics and Gynaecology, University College Hospital Galway
2. Human Contractility at Term in Relation to Previous Caesarean Section. Ryan GA, Nicholson SM, Crankshaw DJ, Morrison JJ. Department of Obstetrics and Gynaecology, University College Hospital Galway

Junior Obstetrics & Gynaecology Society (JOGS) Annual Scientific Meeting, RCPI November 2018

1. McConnell R, O'Gorman T. A diagnosis of metastatic rectal cancer in pregnancy
2. McConnell R, MacNeil B, O'Gorman T. Management of a subsequent partial molar pregnancy after a previous pregnancy associated Spontaneous Coronary Artery Dissection

British Maternal & Fetal Medicine Society Brighton, April 2018

3. McConnell R, O'Gorman T. A diagnosis of metastatic rectal cancer in pregnancy
4. McConnell R, MacNeil B, O'Gorman T. Management of a subsequent partial molar pregnancy after a previous pregnancy associated Spontaneous Coronary Artery Dissection

Postgraduate Study Day Lectures

January 2018

Title: BioInnovate - needs led innovation in Obstetrics and Gynaecology
Speakers: Brendan Staunton and Barry McCann, BioInnovate Ireland, NUI Galway

April 2018

Title: Targeted Anti-D administration: An Irish perspective
Speaker: Dr Ciara McCormick, Irish Specialist Registrar Training Scheme, Portiuncula Hospital, Ballinasloe, Co Galway

May 2018

Title: Periviability
Speaker: Dr Brendan Murphy, Consultant Neonatologist, Cork University Maternity Hospital, Cork

September 2018

Title: Gestational Trophoblastic disease – a national follow-up programme
Speaker: Dr John Coulter, Consultant Gynaecological Oncologist, Cork University Maternity Hospital, Cork

October 2018
Title: Every contact counts - a new HSE initiative
Speaker: Mr Greg Conlon, Health Service Executive

November 2018
Title: Fertility preservation for the transgender population
Speaker: Dr Yvonne O'Brien, Assistant Master, The Rotunda Hospital, Dublin

Undergraduate Student Awards

Henry Hutchinson Stewart Medical Scholarship 2018

- Jessica Lowry: 1st prize in Obstetrics & Gynaecology
- Jennifer Timon: 2nd prize in Obstetrics & Gynaecology

21st ANNUAL WESTERN Obstetrics and Gynaecology Society Postgraduate Meeting

12th October 2018
Theme: Education, Research and Clinical Practice

- 13.00 Introduction – Perinatal statistics from the NUI Galway Academies / Saolta Group Hospitals
  Dr Geraldine Gaffney, NUI Galway / Galway University Hospital
- 13.05 "Perinatal statistics from Mayo University Hospital"
  Dr Hilary Ikele - Consultant Obstetrician Gynaecologist
  Mayo University Hospital
- 13.35 "Perinatal statistics from Galway University Hospital"
  Dr Tom O'Gorman - Consultant Obstetrician Gynaecologist
  Galway University Hospital
- 14.05 "Perinatal statistics from Letterkenny University Hospital"
  Dr Matt McKernan - Consultant Obstetrician Gynaecologist
  Letterkenny University Hospital
- 14.35 "Perinatal statistics from Sligo University Hospital"
  Dr Heather Langan - Consultant Obstetrician Gynaecologist
  Sligo University Hospital
- 15.05 "Perinatal statistics from Portiuncula University Hospital"
  Dr Marie Christine de Tavernier - Consultant Obstetrician Gynaecologist
  Portiuncula University Hospital
- 15.30 Coffee break
- 16.00 "Clinical and Strategic Aspects of Neonatal Care in Saolta Group Hospitals" Dr Ethel Ryan - Consultant Neonatologist / Group WCH Clinical Director
- 16.30 "Overview of Perinatal Care in Saolta Group Hospitals"
  Professor Michael Geary - Consultant Obstetrician Gynaecologist
  Rotunda Hospital Dublin

Parent Education Report

Ms Carmel Connolly

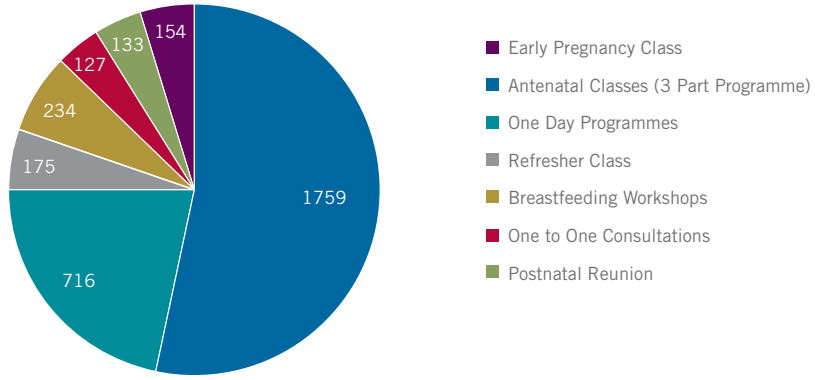
Introduction

Birth is a normal physiological process. The parent Education Department provide multidisciplinary education programmes to expectant parents and their families. The philosophy of the team is to promote, protect and support normal childbirth and to strive to provide high quality programmes that help and empower women and their partners to make informed choices based on the best evidence available.

In 2018 the demand for Antenatal Classes continued to increase. Extra One Day Programmes were required to meet this demand. 4 One Day Programmes were required in May and October, 3 in July August, September, and 2 in the remaining months .In total 28 One Day Programmes were facilitated. Antenatal Breastfeeding workshops remain popular. One to one support in the area of perinatal mental health continues to increase every year. Many of these women need repeat visits due to the complexity and sensitivity of their illness. 104 Postnatal classes were facilitated and Refresher programmes were populated very quickly.

The challenges of the size of venue, waiting lists and resources remain. The team continually redesign programmes to meet the service user's needs.

Parent Education Attendees for 2018



Actions to meet the population needs of the Maternity Strategy 2016-2026

- **Communication** –To improve how we communicate information to our women and their families.

Achievements

1. Launch of www.uhgmaternity.com
   - Following on from the design and scoping phases in 2017 the project 'An Beatha Nua' the web-based Multilingual Maternity Information Portal reached the implementation phase. The portal was launched and went Live on the 1st of May 2018.
   - This is a Quality Improvement project which used Lean Six Sigma Methodology .The result is a one-stop Information Portal on pregnancy, labour, and parenthood. In addition, an on-line booking system for antenatal classes and links to Community Groups and blogs are included.
   - It is number one on the Google search engine with hits from United Kingdom, United States of America, Australia, India, France, Germany and Spain. Phase two is already in progress with submissions for funding for video clips on a virtual labour ward tour, Hypnobirthing, and meeting the Multidisciplinary team. Following the implementation of the portal 96% of service users surveyed stated that they would recommend the Maternity Information Portal to a friend.
2. Attended HSE National Workshop with other disciplines to develop a National Antenatal Education Standard (Nurture Programme HSE).
3. Certificate of Recognition "Prevention of Infant Falls Poster" – Dublin Castle
4. Celebration of Midwives Day
5. Participation in Whose Shoes Workshop

Antenatal Education Programmes 2018 (Attendees)

	Number of classes	Jan	Feb	Mar	Apr	May	Jun	July	Aug	Sep	Oct	Nov	Dec	Total
Early Pregnancy Class	12	12	8	19	11	10	13	15	12	15	13	9	16	**154**
Antenatal Classes (3 part Programme)	36	144	151	137	151	155	126	149	159	135	141	150	154	**1759**
One Day Programmes	28	62	47	45	53	91	37	93	52	62	80	60	33	**716**
Refresher Class	12	15	15	19	15	11	13	16	15	14	16	14	12	**175**
Breastfeeding Workshops	16	52	20	9	14	23	21	30	13	22	30	0	0	**234**
One to One Consultations	127	17	18	12	7	7	5	13	7	6	10	8	17	**127**
Postnatal Reunion	104	8	12	3	10	10	12	9	7	7	8	10	7	**133**
Tours	1889	166	155	144	150	186	118	196	153	149	176	157	139	**1889**

6. Participation in Remembrance Day Ceremony
7. One Midwife achieved Diploma level in Hypnobirthing

Indications for 1:1 sessions

- Referral from the Multidisciplinary Team
- Mental health issues
- Previous traumatic experience
- Language barrier
- Social Alert
- Transfers from other Maternity hospitals
- Fetal Assessment clinic
- Surrogacy
- Late Booker

Conclusion: Plans going forward 2019

- Phase II of the Maternity information portal will include:
  - Virtual tour of the Maternity Department
  - Meet the Multidisciplinary Team
  - Multilingual Development
- Early Pregnancy Information Evening To create awareness of Maternity and Community Services for women and their families
- Development of an Outreach Hypnobirthing Programme

Community Midwives

Ms Jennifer Duggan

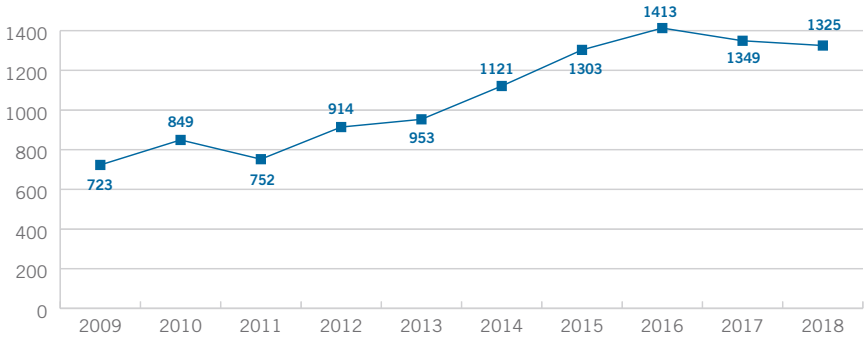
2018 – Team WTE 5.5
The Community Midwives offer midwifery led care at University Hospital Galway. The team provides antenatal Clinics at six sites across Galway city and county, namely Tuam, Oughterard, Doughiska, Athenry, Gort and UHG. An Early Transfer Home service within the geographical area of Galway city to Claregalway and Oranmore runs 365 days a year. These services allow the pregnant woman and her new baby to be cared for and supported by experienced midwives, at home and at locations convenient to them in their community.

The Community Midwives provide care in line with The National Maternity Strategy (2016) supported care pathway, for normal-risk mothers and babies. The midwives aim to give choice to women, educating and supporting them in planning and preparing for their birth. The supported care pathway aspires to normalise birth with the goal to achieve a positive birth and breastfeeding experience. The team work alongside multidisciplinary healthcare professionals, who facilitate assessments and escalation in care required.

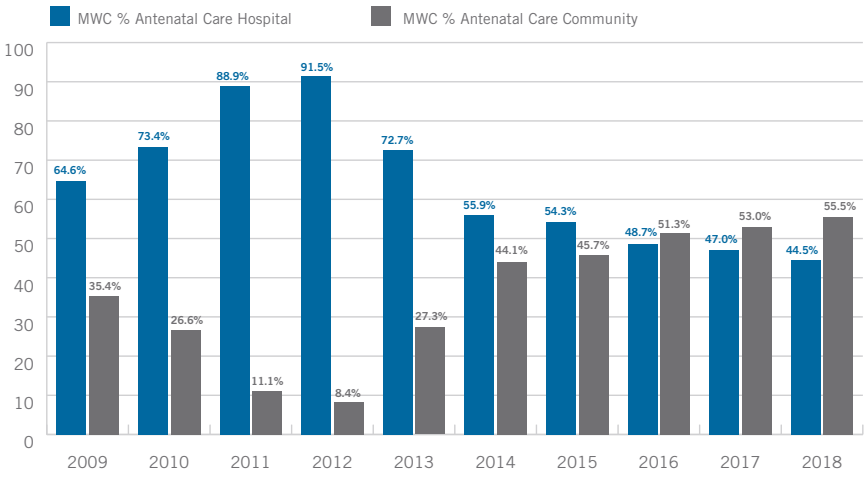
In 2018, the Community Midwives began offering cervical membrane sweeping to women, to aid in establishing the birth process after term gestation. This allows the women to remain in the supported care pathway, providing safe, high quality, continuity of care.

The Community Midwives are in the process of expanding the team through the National Women's and Infants Health Programme (NWIHP). Goals for 2019 include establishing a sixth outreach clinic facilitating all midwife led antenatal care in the community and progression of the Candidate Advanced Midwife Practitioner post with the aim of "Normalising Birth" at UHG.

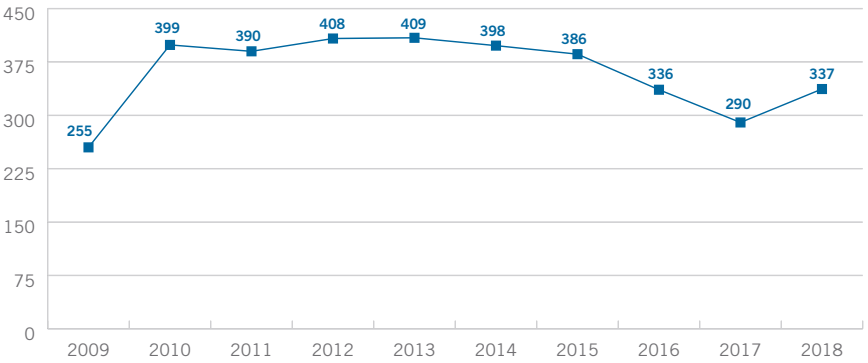
No. Women who attended Midwives Clinic



Midwives Clinic - Location Attended



No. Women Discharged with ETH



In 2018, 1325 women attended Community Midwives Antenatal clinics; this represents 47.2% of all women who birthed in UHG this year. Of this cohort just over half (55.5%) were reviewed at out-reach clinics, the remaining were seen on campus at UHG.

The Early Transfer Home service expedites maternal and infant discharge to the community (within 24 hours) while providing experienced midwifery and breastfeeding care to the women in their own home, until postnatal day 5. In 2018, 11.8% of women availed of this service which resembles figures from previous years.

Midwifery Report

Ms Helen Murphy

2018 has been a very busy year for the staff here in Maternity and I would like to take the opportunity to thank all the staff for their commitment in providing excellent care and a great service to all the women and their families.

I would like to welcome all the new staff and congratulate all the new CMM2 s in post and welcome the student midwives from NUIG in both the Higher Diploma and Undergraduate programme.

In August 2018 we had a HIQA inspection, an audit of compliance with the implementation of the multidisciplinary clinical handover in maternity, acute and children's hospital services as set out in the National Clinical Guidelines. ISBAR3 was implemented within the Maternity Department following this audit.

The Maternity Department had the first National Compliance Audit on Maternal Sepsis Management completed in UHG in August 2018. The audit highlighted some areas for improvement; an action plan was developed and implemented. Overall the outcome of the audit was very positive.

University Hospital Galway (UHG) held the first ever Irish Whose Shoes Workshop in May 2018. Over 50 people attended the event which included members of the public, volunteer groups, obstetric and neonatal consultants, midwives both local and national, and allied health care professionals. The event was supported by the Senior Hospital Management Team and was funded under the Nursing and Midwifery Service Improvement Innovation Initiative from the Nursing Midwifery Planning and Development Unit, HSE West/Mid-West, along with the Maternity Department in UHG. The event aimed at improving women's experience of maternity care by building on local relationships, and enhancing existing relationships within the maternity services at UHG.

Building works commenced in 2018 on a new location for the Early Pregnancy Assessment unit and Ambulatory Gynaecology. The introduction of the new Ambulatory Gynae service is a key priority for the Women's and Children's Directorate.

May 2018 saw challenges in the Colposcopy service due to the cervical check controversy. The publically funded out of cycle smear testing saw an increase in the number of women referred to the Colposcopy unit. The continued support of both the clinical and clerical staff has ensured the high quality service in Colposcopy has been maintained.

In 2018 redecoration of the Maternity department started, the long corridor was painted and pictures were put up on the walls to promote breastfeeding and skin to skin contact. Some of the rooms on labour ward have been repainted and refurbished.

What's up Mum televisions have been placed within the Antenatal Clinic. This multimedia information resource for expectant and new mothers gives both pregnant women and new parents expert advice from HSE Midwives, Obstetricians and Paediatricians. It includes short films on topics such as antenatal care in pregnancy, breast feeding and bathing babies. The feedback from parents in response to this initiative has been very positive.

In 2018 a monthly Departmental Meeting was introduced. This meeting is an opportunity for all members of the Multidisciplinary Team to come together and discuss what is working well within the department and areas that need improvement. Attendance at this meeting is high and has had a very positive effect on team working and communication within the department.

The introduction of a weekly Senior Midwifery Management meeting attended by the Director of Midwifery and Assistant Director of Midwifery, Practice Development Midwife and the CMM3, CMM2, CMM1, Clinical Skills Facilitator and Clinical Placement Coordinators, this meeting is an opportunity for the midwives to bring any concerns they may have to the senior midwifery management team. Information is shared in relation to changes within the student midwifery curriculum and concerns identified by the student midwives, metrics and staff training and any updates from the DOM/ADOM are discussed.

The Quarterly staff forum is ongoing and this meeting facilitates all staff within the maternity department an opportunity to meet with the senior midwifery team and get updates on any developments in the department.

Postnatal ward (St Angelas)

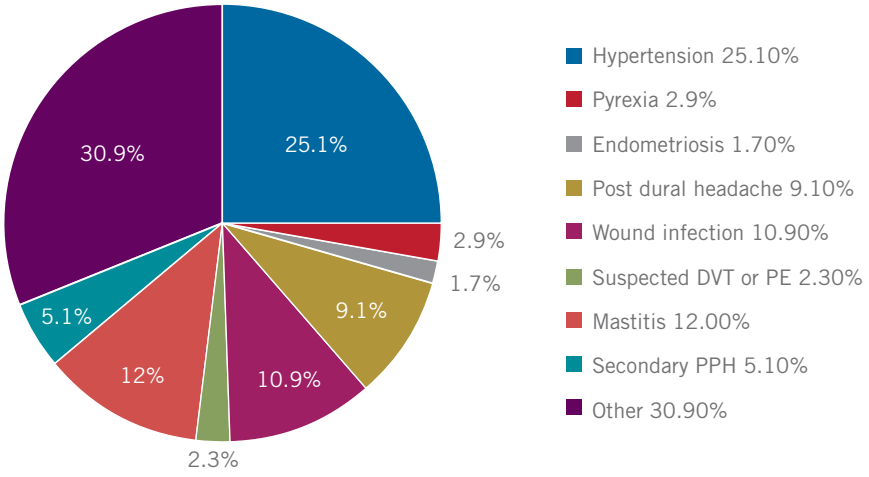
Ms Tracy Sugrue

St Angelas ward consists of 30 maternal and infant beds. The midwives on St. Angelas (postnatal ward) are part of the multidisciplinary team that provide postnatal care to women and their infants. This involves caring for women including high risk patients, promoting and supporting breast feeding providing parenting support, education and teaching.

- Multidisciplinary team members working in the postnatal ward include Obstetricians, Paediatricians, Physiotherapists, Lactation Consultant, Early Discharge Team, Social Workers, Teen Parent Project officers, Newborn Hearing Screening and PHN Liaison Officers.
- In 2018 there were 2858 births at Maternity Department GUH. 2805 women gave birth. All came through the postnatal ward. 35.4 % of these were caesarean section births. The increasing rates have had an impact on the workload of the midwives as these patients are of a higher dependency and their stay in hospital is considerably longer.
- A combination of high risk pregnancies, complicated deliveries and a rising caesarean section rate increases the number of women requiring a higher level of care in the postnatal period.
- An epidural rate of 45.7 % adds to the high dependency workload post delivery
- Two Midwives on the postnatal ward have completed their lactation consultancy. In 2019 it is planned that the Lactation consultants will provide a five day postnatal Breastfeeding class on the ward, this may assist to increase breastfeeding rates on discharge which in 2018 were 66.1%, it is hoped to increase this considerably in 2019.
- There is a focus on reducing supplementation rates and this being audited monthly at present. Supplementation rates for 2018 were 22.6%.
- The development and implementation of an infant safety guideline is in progress which promotes safe sleep and focuses on infant safety within the unit. Posters are displayed at every bedside with regard to safe positioning of infant.
- Postnatal discharge classes are held every Monday, Wednesday and Friday. We have breastfeeding and physiotherapy classes three days per week also.
- Environmentally, improvements are continuing throughout the ward. All lighting has changed to LCD which is more ambient for the mothers and infants in our care. We are currently in the process of painting the ward. We have upgraded and replaced equipment basics and are currently changing all the beds to electric ones over a phased time frame.
- All 6 bedded rooms have been eradicated to 4 bed spaced rooms leading to more comfort for mother and infants, and better resting conditions to promote a better recovery period.
- The visiting policy is currently under review and will be changed in response to the needs assessment carried out of all our new mothers.
- Audits include: Monthly metrics. Breastfeeding and supplementation rates. Postnatal readmission rates. Fortnightly IV cannualation and catheter care audits. Three monthly Hygiene audits.
- All infants receive a high level of assessment and observation in the postnatal period, with specific policies in place for those with individual risk factors. All babies at risk are monitored using the NEO-EWS chart with prompt follow up as required. The midwives on St Angelas Ward provide non-invasive testing for hyperbilirubinaemia in newborn infants Transcutaneous Bilirubin Meter (TCB) therefore reducing the number of infants who require Serum Billirubin Tests. As part of this initiative the staff of St Angelas and the Paediatric Out Patient Department developed a pathway for infants requiring follow-up investigations once discharged. Once the infant is discharged, they may need to return to a temporary room used by the Paediatric team in St Angelas ward, for a repeat TCB up to 48 hours after discharge.
- This reduces the risk of infection to the infant by avoiding delays in the Emergency Department, and mothers have access to early discharge home improving the patient flow in St Angelas Ward
- Policies have been updated on Hypoglycaemia and NEO-EWS and babies are now discharged at 24 hrs of age following 2 hourly NEO-EWS over 12 hours.
- A policy for GBS and High risk factors has been implemented for infants; they now have NEO-EWS 2hourly for 12 hours and a further 12 hours in hospital for observation.
- All infants with CDH are referred for an ultrasound within 2 weeks as per national guidelines and are seen at a new Orthopaedic/Physiotherapy clinic for follow up.
- Neonatal Newborn Bloodspot Screening (NNBS) is carried out on babies prior to discharge with the remaining number referred to the community. There is a close link with the newborn screening laboratory in Temple Street Hospital and St Angela's postnatal ward in the follow up of additional neonatal screening if required. Over the Christmas period all infants return to St Angela's for NNBS.
- Newborn Hearing Screening office is onsite in St Angelas and is available throughout the seven days per week, with babies receiving screening prior to discharge home.
- Early Transfer Home Service, led by the Midwives clinic, have been instrumental in assisting mothers who wish to be discharged early.

- On discharge from the ward a summary of care is generated by the midwifery staff and forwarded electronically to the PHN's and a hard copy is posted out to the G.P. The midwives on St Angela's ward and midwifery management work closely with health care professionals in the community and the multidisciplinary network.
- All OPD appointments including referrals for counselling de-briefing post delivery are arranged from the ward.
- There were 175 postnatal readmissions in 2018, compared to 140 readmissions in 2017.

Postnatal Readmissions 2018



Breastfeeding in UHG

Ms Claire Cellarius

Providing quality lactation and breastfeeding care is an essential part of our hospital's maternal-newborn service. The National Infant Feeding Policy for Maternity and Neonatal Services 2017 provides the evidence based guidelines to implement best practice to promote, support and protect breastfeeding. All staff have access to this policy, which is available on Q-Pulse documentation module.

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 HseLand.ie
- Three of our midwives successfully completed the International Board Certified Lactation Consultant exam.

Lactation Services available at UHG

- Mother-baby inpatient breastfeeding support
- Referrals from GPs and PHNs
- Consultations with Paediatrics and NICU
- Outpatient clinic referrals for antenatal women with specific queries
- Weekly drop in clinic to support mothers with breastfeeding challenges
- Staff training and auditing of practice
- Telephone breastfeeding support

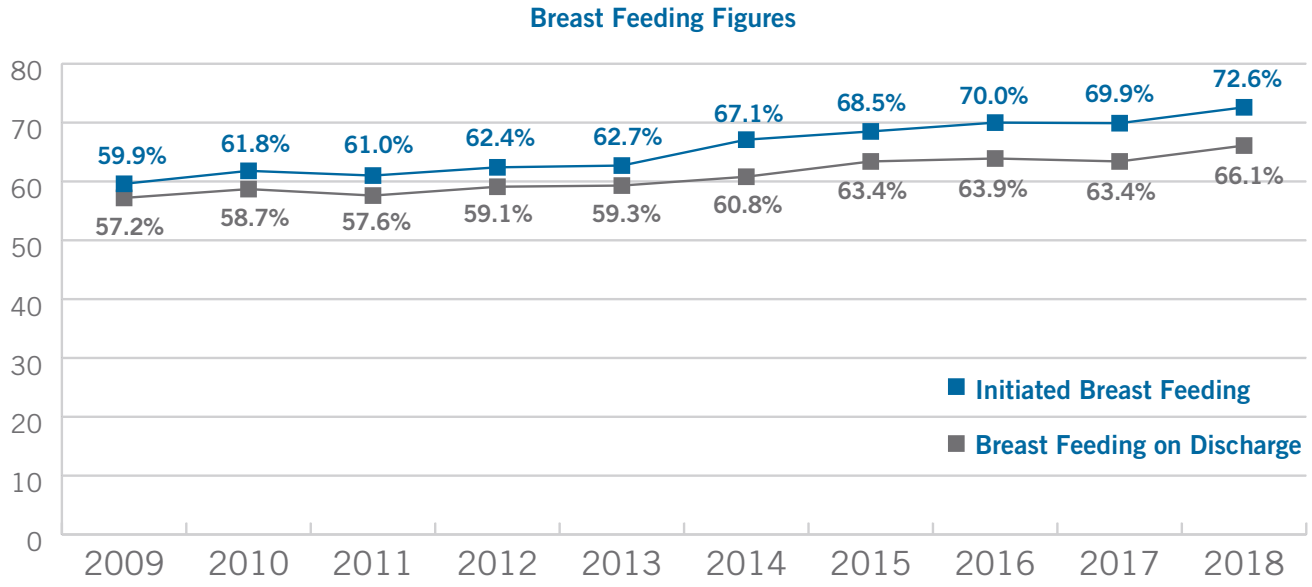
Our breastfeeding drop in clinic is held every Tuesday afternoon which offers skilled help and support to mothers experiencing feeding difficulties. The attendance rate has increased in 2018 by 8% with a total of 351 attending.

Breastfeeding for any length of time is worthwhile and while rates in UHG are gradually improving we hope to support more mothers to breastfeed and to breastfeed for longer.

As part of our National Breastfeeding Awareness week 1st to 7th October 2018 we invited Transition Year students from local secondary schools to an information session about the importance and benefits of breastfeeding. It was a fun interactive learning event where the students also got to meet and ask questions to a new breastfeeding mother. The initiative which is held yearly receives very positive feedback.

Other activities for National Breastfeeding week include a promotional and information stand in the hospital main foyer, local radio interview and staff quiz with lots of spot prizes.

Our HSE national breastfeeding website www.breastfeeding.ie is an excellent resource for all breastfeeding information and community support groups.



Antenatal and Gynaecology Clinics Report

Ms Siobhan Page and Ms Fidelma Kenny

The Maternity/Gynaecology Outpatients Department continues to ensure the provision of evidence based, women/family centred midwifery care. We aim to provide an efficient service that is safe and accessible. 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

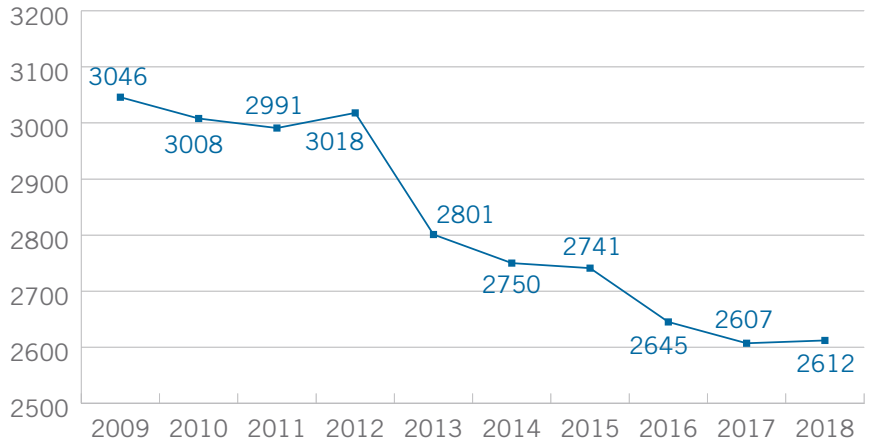
In 2018, 2612 women booked for antenatal care an increase of 5 on the previous year (see table 1).

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

The numbers of women having GTTs has increased dramatically due to the revised criteria and this as well as every woman having Antenatal Profile Bloods has increased the activity in the antenatal clinics.

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.

Antenatal Bookings



High Risk Anaesthetic Clinic

This clinic takes place every Wednesday with a Consultant Anaesthetist. Referral to the Anaesthetic clinic is made by Consultant. 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.

The waiting time for an appointment for these clinics is less than one year- however the Gynaecology /Oncology patients are prioritised with earlier appointments at approximately 6 weeks.

There are two fertility clinics per week; there is currently no waiting list for these clinics

Midwives Clinics

This continues to be a popular choice for women. If complications arise during pregnancy the midwife will refer the women to the obstetrician.

Gynaecology Ward (St Monicas)

Ms Pauline Tarpey

St Monicas ward is predominately a surgical ward and has a capacity of 15 inpatient beds with 4 additional trolleys for day case surgery. This ward specialises in early pregnancy, gynaecology and Gynae Oncology. It has high levels of clinical activity and significant patient turn over volumes with care ranging from major surgical cases to brief intervention. The philosophy of care on this ward is to provide holistic women centred care that is both efficient and accessible to all women.

St Monicas ward also works closely with the Post Anaesthetic Care Unit (PACU), patients may be referred to PACU for close observation following major surgeries, depending on co morbidities and acuity. There is a dedicated two-bed recovery area on the ward which helps staff monitor patients closer while maintaining privacy and dignity for the women. This allows staff to care for women receiving epidural analgesia, providing increased options for analgesia during the post-op period.

We work closely with our Bereavement Midwife in providing excellent care, advice and support for all woman experiencing pregnancy loss.

The continued support of the Clinical Nurse Specialist in Gynae Oncology service is an invaluable resource. She works directly with the patients and their families to help ease the patient's journey in difficult times. She provides a link between the gynaecology and oncology services and is an excellent support and point of contact for women.

The majority of admissions are surgical patients, as highlighted below. Some of the Challenges facing St Monicas ward going forward are the waiting lists for women requiring Gynae oncology services due to limited time and access to the theatre in Maternity Unit. Occasionally additional time and theatre space are provided by the Main hospital which can lead to challenges with ward capacity and caseload.

St Monicas Admissions in 2018

Months	ED	ELECTIVE	NON ELECTIVE	Grand Total
2018-01	21	105	28	154
2018-02	17	112	44	173
2018-03	27	119	41	187
2018-04	24	121	46	191
2018-05	17	139	50	206
2018-06	5	109	43	157
2018-07	19	137	34	190
2018-08	16	102	42	160
2018-09	13	112	43	168
2018-10	13	116	34	163
2018-11	13	134	47	194
2018-12	20	87	36	143
Grand Total	**205**	**1393**	**488**	**2086**

Maternity Admissions

Ms Annemarie Culkin

The admissions/emergency department for obstetrics and gynaecology facilitates elective and emergency admissions.

Referrals are received from Consultants, NCHDs, GPs, Public Health Nurse's, Midwives Clinic and self referral. The number of women cared for in this department has continued to rise over the last few years. The department is open 5 days per week. Monday - Friday, 8am - 5 pm.

In order to alleviate the bottle neck that exists in Maternity Admissions during times of high levels of activity, MDAU accommodation will be used where and when appropriate.

7535 women attended the department in 2018, 3378 were booked Gynae, elective admissions and 4377 were acute presentations. This data is represented on the chart below. See diagram I.

Early Pregnancy Assessment Unit (EPAU)

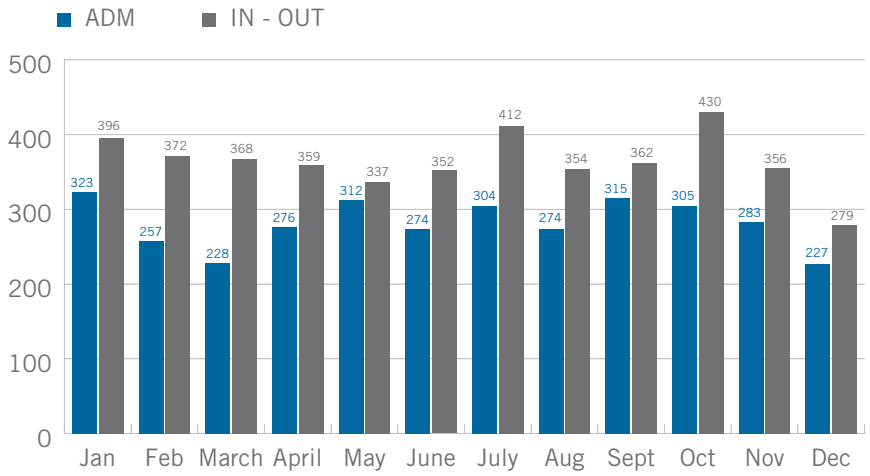
The EPAU is located within the Maternity Admissions Department. It provides care, support and advice to women who develop complications during the first 13 weeks of pregnancy. EPAU is staffed by a team which includes a lead consultant, NCHD's, midwives, sonographers and a clerical officer, a bereavement counsellor is available on request. The unit is open four mornings a week providing women with scheduled appointments along with managing emergency referrals and inpatients referrals.

Staff provide women with information and support in a sensitive and caring manner; explanations are supplemented with written information leaflets.

Referrals are accepted from
- GPs: Where there are complications of early pregnancy.
- If there is a previous history of two or more miscarriages, previous ectopic or previous molar pregnancy.
- Consultant and NCHDs. All referral are now by email or post.

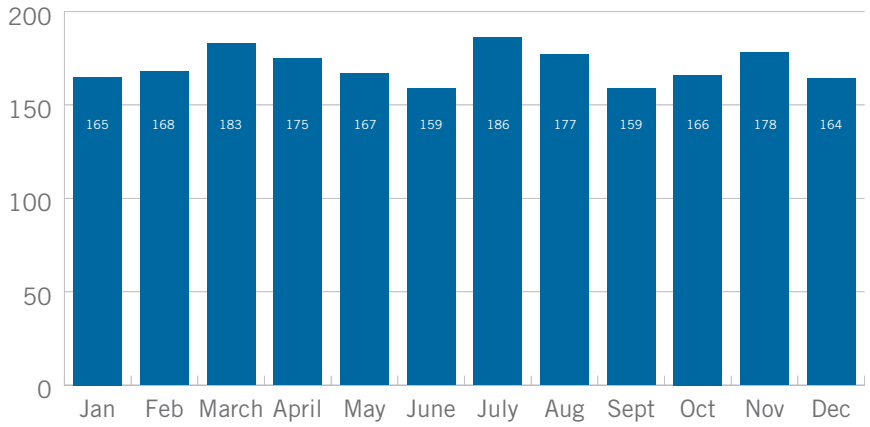
2047 women were reviewed in the EPAU in 2018. EPAU will be relocate to the wing beside St. Monica's Ward in2019. See diagram II

2018 Admissions and In - Out Numbers



2018	Jan	Feb	Mar	April	May	June	July	Aug	Sept	Oct	Nov	Dec
ADM	323	257	228	276	312	274	304	274	315	305	283	227
IN-OUT	396	372	368	359	337	352	412	354	362	430	356	279
TOTAL	**719**	**629**	**596**	**635**	**649**	**626**	**716**	**628**	**677**	**735**	**639**	**506**

Early Pregnancy Stats for 2018



2018	Jan	Feb	Mar	April	May	June	July	Aug	Sept	Oct	Nov	Dec
	165	168	183	175	167	159	186	177	159	166	178	164

New Patients 1373 Review Patients 674 Total 2047

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.

Conditions Managed in MDAU:

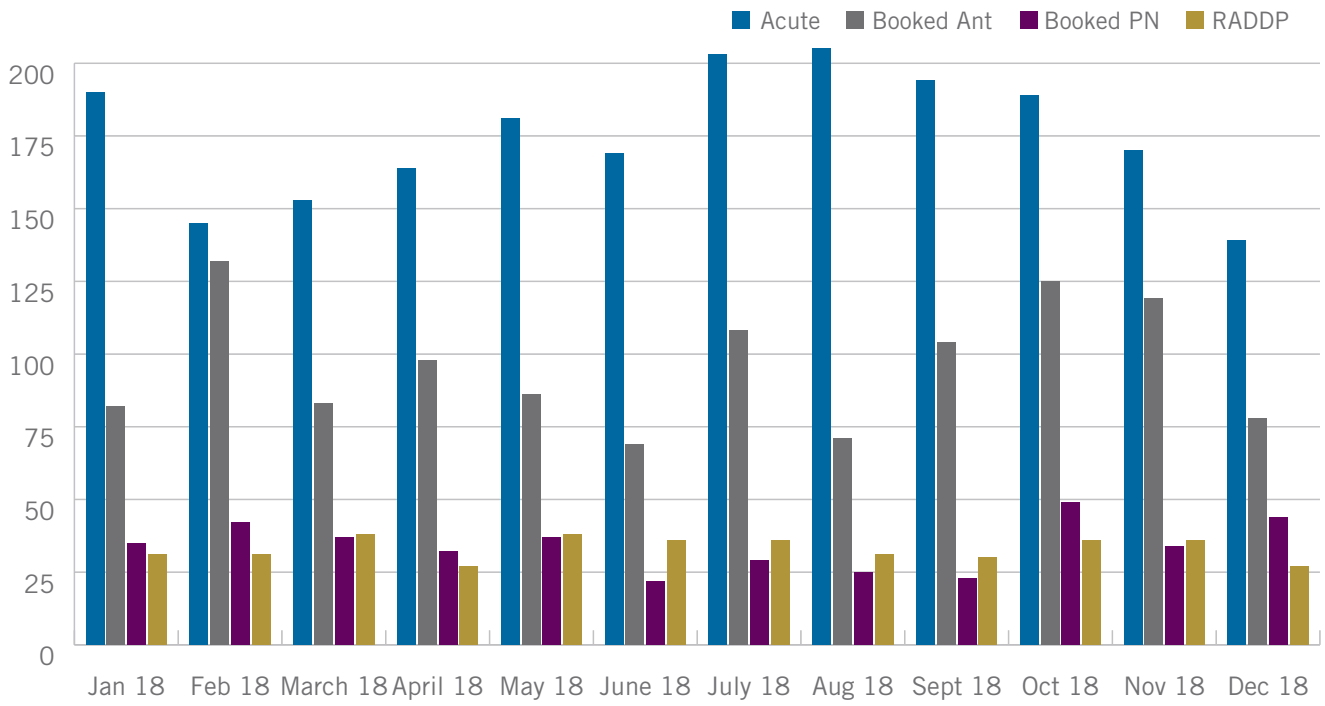
- Hypertension disorders of pregnancy: including mild and moderate hypertension and chronic hypertension controlled on medication.
- Fetal conditions: including reduced fetal movements, fetal growth restriction, and multiple pregnancy fetal assessment.
- Maternal Complications: including obstetric cholestasis, postnatal readmission, hyperemesis, venous thrombosis assessment.
- Drug Administration: IM Steroids, Routine Antenatal Anti-D Prophylaxis
- Women who attend the hospital acutely 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. See diagram III.

2018 Maternity Day Assessment Unit (MDAU) Stat



2018	Jan	Feb	Mar	April	May	June	July	Aug	Sept	Oct	Nov	Dec
ACUTE	190	145	153	164	181	169	203	205	194	189	170	139
BOOKED ANT	82	132	83	98	86	69	108	71	104	125	119	78
BOOKED PN	35	42	37	32	37	22	29	25	23	49	34	44
RADDP	31	31	38	27	38	36	36	31	30	36	36	27

Obstetrics & Gynaecology Physiotherapy

Ms Debbie Fallows

Introduction

Physiotherapy activity levels continued to increase in 2018. Over the last 5 years, antenatal musculoskeletal referrals have increased by 33%, and postnatal referrals by 61% in spite of a stable birth rate. As a result of these increases, patients referred to physiotherapy from gynae clinics with pelvic floor dysfunction had variable waiting times from 7 to 12 months.

1. Postnatal

- A total of 321 postnatal patients were referred to physiotherapy in 2018. The majority of postnatal patients were referred with pelvic floor dysfunction.
- In addition, 774 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.
- 43 patients were treated following 3° or 4° perineal tears.

2. Antenatal

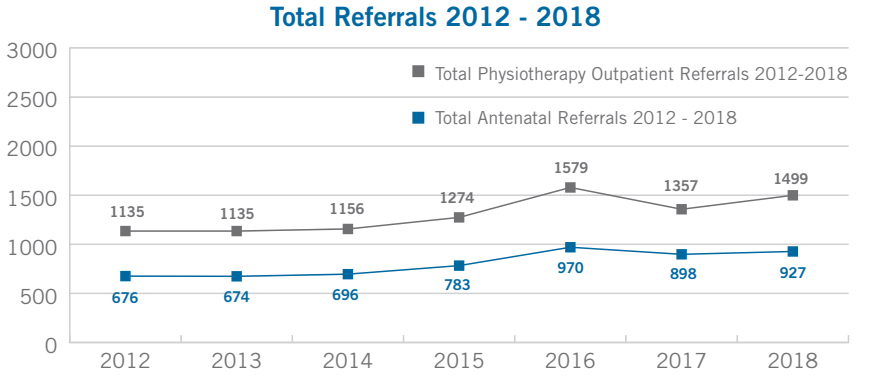
- A total of 927 antenatal patients were referred for physiotherapy in 2018, representing a further increase of 3% from 2017. Due to this continued growth in activity, a weekly exercise-based workshop takes place to help patients manage their pelvic girdle pain.

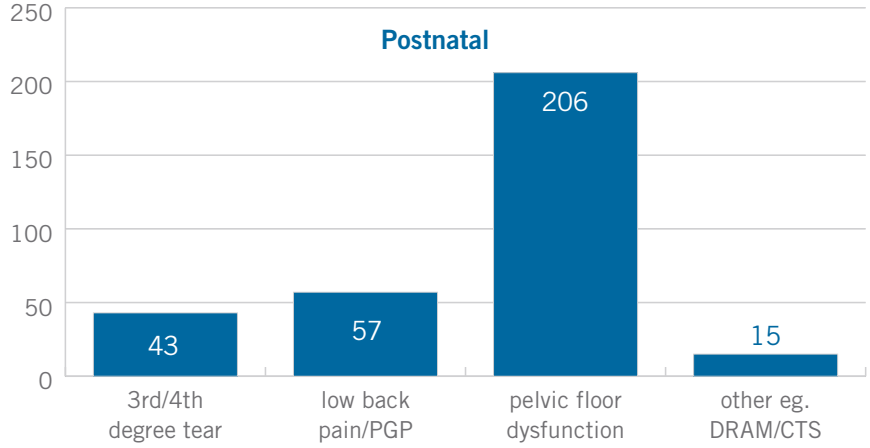
3. Gynaecology

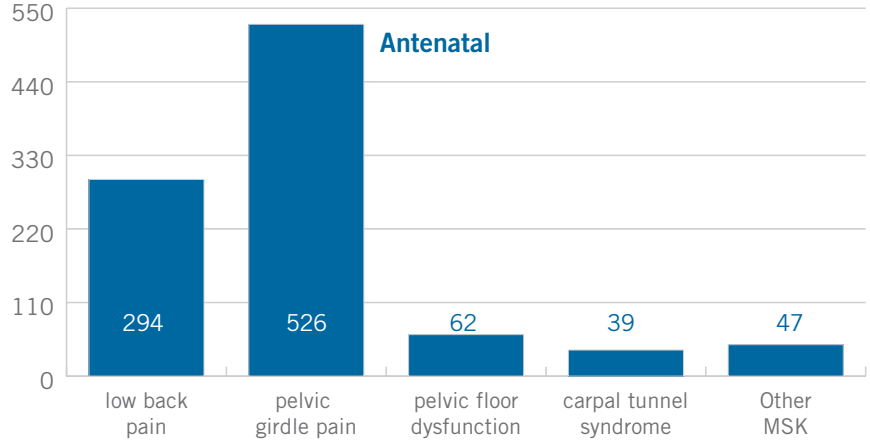
- A total of 251 patients were referred from gynaecology clinics in 2018 (20% more than 2015 figures). Of these, 99 (40%) were seen by a physiotherapist directly from the Urogynaecology clinic.

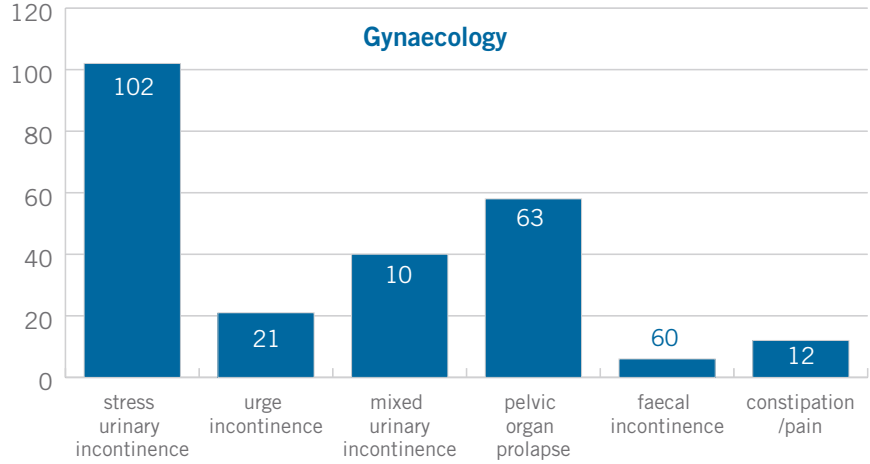
Group Education Sessions

Group Physiotherapy sessions	Numbers attending in 2018
Antenatal education session	2097
Early postnatal education sessions	595
Postnatal review session	73
Pelvic Girdle Pain Session	343









Paediatric Physiotherapy Report

Ms Aoife McCarthy

In 2018, there were major changes to the paediatric Physiotherapy team. After almost 40 years, Ms Breda Cunningham retired in her post as clinical specialist in paediatric Neonatology in April 2018. We welcomed Ms Anne Duignan into this post in November 2018.

In 2018, we received 642 new patient referrals and a total of 703 patients were reviewed by the paediatric physiotherapy team. This is reduced since 2017 (n=1284) and is likely attributed to the absence clinical specialist in neonatology from April to November with no cover for this service. In 2018, there were 2138 staffing contacts with paediatric patients in the inpatient, outpatient and clinic setting.

A major service develop project that took place in 2018 was the physiotherapy led infant hip screening clinic. This was established as an MDT quality in action initiative in March 2018. As part of this, a new GUH pathway was established to standardise care if infants with risk factors for DDH in line with national guidelines, research and clinical expertise. By cohorting this group of patients into a physio led clinic; a secondary aim was to up free up outpatient paediatric consultant appointments and ultimately reducing the paediatric waiting list. In 2018, 220 patients were seen in 9 months, which created an additional 220 paedaitric consultant clinic slots.

The paediatric physiotherapy team consists of 2.5 WTEs; 1.0 WTE Clinical Specialist, 1.0 WTE Senior Physiotherapist and 0.5 Staff grade physiotherapist

The following services are offered by this team;

1. Inpatient services

Paediatric patients with medical and surgical presentations are reviewed on

- Any patient with an orthopaedic, respiratory and neurology condition on St Bernadettes Ward
- Outreach service for an patient <16yrs on any ward in UHG
- St Clare's neonatal unit: Neonatal screening for babies born at <32 weeks gestation, <1000g birth weight and infants presenting with birth asphyxia, Grade 3 or 4 IVH or PVL, Term Asphyxia/Stroke/ hyptonia, Congenital Infections and Complex neurodevelopment babies
- St Angela's post-natal ward for newborns on with musculoskeletal conditions.

New referrals: 186
Staff contacts: 636
Return Visit: 440

2. Outpatient physiotherapy

- MSK service for Children 0-16 years : patients are referred by consultants in GUH and nationally.
- Respiratory Patients: OPD service for children that present with complex respiratory conditions that require specialist physiotherapy input e.g. Neuromuscular Disease, Brochiectasis, recurrent RTI's and chronic atelectasis . 35 patients accessed this service in 2018
- Neuro-developmental Delay:
  - an enhanced surveillance follow up for preterm infants is offered by the clinical specialist
  - Assessment for children with gross motor delay to identify potential long term needs of patients

New referrals: 208
Staff contacts: 910
Return Visit: 729

3. Clinics

- Weekly Ponseti clinic for the management of Congenital Talipes Equinovarus is being run by Physiotherapy at a weekly trauma clinic in Merlin Park Hospital under clinical governance of Mr William Curtin and Ms Ciara Egan, Consultant Orthopaedic Surgeons.
- Monthly Infant hip Screening clinic
- Quarterly Upper limb MDT Clinic with Orthopaedics (Mr O'Sullivan), Paediatrics, Occupational Therapy and Physiotherapy (PCCC and Acute).

New referrals: 547
Staff contacts: 1315
Return Visit: 768
No of pts: 590

Nutrition & Dietetic Department Report

Ms Ana O'Reilly-Marshall

Overview

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 Neonatology, Cystic Fibrosis, Diabetes and General Paediatrics.

Staff

- Ana O'Reilly-Marshall – Senior Dietitian Neonatology / Paediatrics (0.8WTE)
- Fiona Curley – Senior Dietitian Cystic Fibrosis / Paediatrics (Jan-March 2018)
- Mary Connolly – Senior Dietitian Cystic Fibrosis / Paediatrics (appointed to CF post July 2018)
- Rachael Langan – Senior Dietitian Paediatric Diabetes (0.5WTE).
- Edel Barrett – Dietitian Obs & Gynae / General Paediatric OPD

Inpatient Dietetic Services to WAC

There is a dedicated inpatient dietetic service for Neonatology and Cystic Fibrosis. The Paediatric dietetic service to St Bernadette's ward was restricted during 2018 due to inadequate dietetic resources to meet referral demand.

Inpatient Statistics

- Paediatric services generated 54% of total WAC inpatient dietetic referrals.
- Neonatology service generated 38% of all inpatient dietetic referrals and 70% of inpatient consultations reflecting the intensive dietetic support required by this long stay patient population.
- The total number of Obs & Gynae referrals is constant, however the complexity and number of patients requiring parenteral nutrition has increased 5-fold from 2017.

Outpatient Dietetic Services to WAC

Dedicated out-patient dietetic services are provided to Neonatology, Cystic Fibrosis, Diabetes 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 10%.
- Three CHOICE structured education courses for children and adolescents with Type 1 Diabetes were delivered jointly by the RL and Clinical Nurse Specialist during 2018.
- Total CF Paediatric patient caseload increased by 24% overall with 16% of new referrals generated from Newborn Screening Service (NBS)
- The highest demand for dietetic support in general paediatric clinic was from Allergy (38% referrals) and Faltering Growth (34% referrals) diagnoses.

Challenges

The current 2 WTE dietetic allocation is an insufficient resource to meet the increasing demands of the expanding WAC services and inadequate staffing in 2018 resulted in

- Implementation of prioritisation guidelines as a risk management measure in May 2018 for paediatric inpatient referrals with inpatients discharged before seen for the first time.
- An increased number of risk forms reported on Q-Pulse to highlight impact of deficits on patient care.
- A reduced number of General Paediatric outpatient clinics caused an increased waiting time to appointment from 17 to 30 weeks.
- Increasing demand from under-resourced paediatric services reduced service to Neonatology. NICU over-occupancy continued to draw under resourced dietetic services from Neonatal Follow Up clinics.
- No service provision to CF outpatients from March to July and limited inpatient service.

Fig.1 Total Inpatient Dietetic Referrals by Speciality

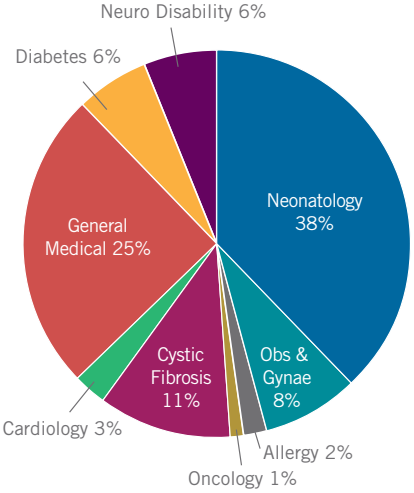
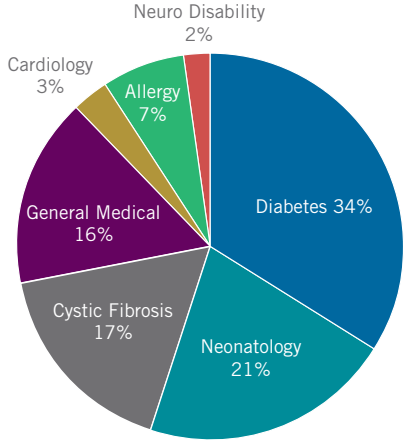


Fig.2 Total Outpatient Dietetic Referrals by Speciality



- No additional dietetic resources provided for CF NBS impacted the general Paediatric service.
- Patients attending the Paediatric Ambulatory Care Unit, opened in 2017, do not have dietetic support available impacting patient care.
- Inadequate dietetic resources in the community resulted in delayed transfer of Early Intervention Service (EIS) patients to primary care dietetic services increasing demand on acute services.
- Appointment of a Consultant Paediatric Endocrinologist in 2018 resulted in an increased number of referrals for patients under 5years of age i.e. those previously referred to other centres for insulin pump therapy, began to be accepted back to GUH plus all newly diagnosed children under five were commenced on insulin pump therapy in GUH. The current 0.5WTE Paediatric dietetic resource is only for children over 5years of age.

Key Achievements 2018

- AORM returned from a 1 year secondment with INFANT, UCC having gained clinical research skills, experience in the Maternal Newborn Clinical Management System, Nutritional Software development skills and expert training in the setting up and running of the Miris breast milk analysis system for Neonatal units.
- AORM continued to act as representative on the National Neonatal and Paediatric Parenteral Nutrition Steering Committee and contributed to the revision of the National Neonatal and Paediatric PN Guidelines due for publication in 2019.
- AORM developed an Infant Feeding Podcast for the medical student undergraduate programme.
- RL, as member of the National Paediatric Diabetes Interest Group, contributed to development of a comprehensive education resource in conjunction with National Diabetes Nurses group to help provide a uniform service to this client group in all centres in the Republic of Ireland.
- MC completed EVOLVE training and commenced using the EHR system for Paediatric and Cystic Fibrosis patients under the care of Dr Herzig.

Training / Education

- All staff contributed to student training of DIT/TCD BSc Human Nutrition and Dietetic undergraduates.
- RL presented posters on ‘CHOICE Education Programme in GUH’ and ‘Multidisciplinary Insulin Pump clinics in GUH’ at the Western Diabetes Study Day in conjunction with MDT.
- AORM presented at the 6th GUH Neonatal Study Day.
- AORM contributed to NCHD Postgraduate Education programme (4 sessions/year)

Acknowledgement

We would like to sincerely thank and acknowledge our colleague Fiona Curley for her dedication to the setting up and development of CF dietetic services in UHG from 2007- 2018. She was committed to providing a high-quality CF and Paediatric dietetic service to both children and adults during her time at UHG. We wish her all the best in her new role.

Medical Social Work Report

Ms Maeve Tonge

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 centred and 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. Out patients 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.

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.

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

The Department offers 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, termination and adoption, within the relevant legal guidelines. Bereavement support following termination of pregnancy is routinely offered.

Perinatal Mental Health

Medical Social workers are 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.

Perinatal Mental Health

Medical Social workers are 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.

Child protection

Mandatory reporting ensures that we all have a responsibility to protect children. Medical social workers will assist staff fulfil their obligations under this new legislation. 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-centred 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

Team

Maeve Tonge is the Senior on the WAC team with clinical work in in FAU, NICU and Paediatrics and provides upport 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 delighted to welcome Criona Healy and Michelle Ruddy to the team and grateful to Triona O Toole for her continued commitment and kindness to our families we work with.

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.

Teen Parents Support Programme (TPSP)

Ms Aileen Davies

Services:

The programme is located at Galway University Hospital 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. 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 2018 was 60.

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 (0.8WTE) one project worker (1WTE) and one project worker(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.

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 an outing for Mothers and babies in the Summer to Loughwell farm which was a great success. We piloted a baby bonding programme in collaboration with Westside Family support Services and a play therapist. Three of our young parents attended with their babies. It was well evaluated.

Midwifery Practice Development Unit UHG & School of Nursing and Midwifery NUIG

Ms Margaret Coohill and Ms Anne Fallon

1. Introduction

Midwifery programmes are provided by the School of Nursing and Midwifery, National University of Ireland, Galway (NUIG) in association with the University Hospital Galway (UHG), Portiuncula University Hospital (PUH), Mayo University Hospital (MUH) and Sligo University Hospital (SUH). The Midwifery Practice Development team for the Saolta University Hospital group provide support to students during their clinical placements. The team also support staff in professional development, multidisciplinary education and updating policy, guidelines, audit and clinical care pathways for the Saolta group.

1.1 Staff of Midwifery Practice Development Unit UHG

Practice Development Co-ordinator
- Margaret Coohill (UHG)
- Deirdre Naughton (UHG)

Allocation Liaison Officer
- Claire Fuller (UHG)

Clinical Placement Co-ordinators
- Carmel Cronolly (PUH)
- Frances Burke (MUH)
- Karlene Kearns (SUH)
- Barbara Bradley (UHG)
- Mary Reidy (UHG)
- Marie Sheedy (UHG)
- Dawn Whittaker (UHG)

Administrator
- Geraldine Mc Hugh (UHG)

Midwifery Clinical Skills Facilitator
- Heather Helen (UHG)

1.2 Philosophy of Midwifery Care

The School supports the philosophy that 'Midwives recognise pregnancy, labour, birth and the post-natal period as healthy and profound experiences in women's lives' (NMBI 2015 p. 12). Midwifery care is provided in partnership with the woman and in collaboration with other health care professionals.

1.3 Philosophy of Learning

The students are encouraged to adopt an inquiry based approach to learning, with an emphasis on clinical practice, in an environment that supports quality and a woman-centred approach to care. Midwifery programmes have been developed using a curriculum which is flexible, dynamic and practice based. In September 2018, a revised undergraduate midwifery curriculum was implemented in line with the *Midwifery Registration Education Standards and Requirements* (NMBI 2017).

2. Midwifery Education

2.1 The Higher Diploma in Midwifery

In March 2018, twelve students commenced the eighteen month Higher Diploma in Midwifery programme at University Hospital Galway.

2.2 Bachelor of Midwifery Science September 2018

2018 Yr 1 Class: 19 midwifery students commenced the four year programme with clinical placement in UHG, MUH, PUH and SUH.

2017 Yr 2 Class: 22 midwifery students continued with midwifery placements in all four sites and specialist placements in general theatres in UHG and PUH. Medical and surgical wards were undertaken at UHG.

2016 Yr 3 Class: 18 midwifery students continued with midwifery, neonatal and mental health placements in UHG with some placements in other sites. These students also had a clinical placement in the Midwife led service in the community attached to UHG.

2.3 Clinical Teaching

Student midwives must successfully complete both clinical and theoretical components of the programme, to be eligible to register as a midwife with An Bord Altranais agus Cnáimhseachais na hÉireann. Clinical teaching is primarily provided by midwives/preceptors, with support from the clinical placement co-ordinators from the Practice Development team and lecturers from the School of Nursing and Midwifery (NUIG).

2.4 Community midwifery placements

These placements are achieved by allocation of students to:
- The Midwife Led Antenatal Clinic UHG.
- Midwife Led Outreach Antenatal Clinics UHG.
- Midwife Led Early Discharge Home service at UHG.

2.5 Assessment Process for Student Midwives

Theoretical and clinical assessments are ongoing throughout the academic year. Theoretical modules are assessed using a variety of methods: course work, reflective essays, examinations, MCQs, poster presentations and OSCEs.

Clinical practice is assessed by achieving clinical competencies, as outlined by An Bord Altranais agus Cnáimhseachais na hÉireann and the School of Nursing and Midwifery NUI Galway. Clinical competencies are assessed by midwives/ preceptors, in collaboration with the clinical placement co-ordinators and link lecturers as appropriate. A national NMBI competency assessment tool was implemented in September for the 2018 first year students.

2.6 Postgraduate Diploma in Public Health Nursing

The Child and Maternal Health module was undertaken as part of the Postgraduate Diploma in Public Health Nursing at NUIG. Students were facilitated to undertake the clinical component of this module in UHG Maternity Unit, Portiuncula, Castlebar and Sligo University Hospitals.

3. Professional Development Courses

3.1 Fetal Monitoring Workshops:

Facilitated by practice development team, clinical midwives and obstetricians. The aim of these workshops is to facilitate mandatory multi-professional training in fetal monitoring requirements.

3.2 Neonatal Resuscitation Provider Course:

Facilitated by neonatal instructors for all midwifery, neonatal and medical staff on an ongoing basis to meet mandatory neonatal resuscitation requirements.

3.3 Practical Obstetric Multi-professsional Training (PROMPT):

Facilitated by practice development team, clinical midwives and obstetricians.

The aim of these workshops is to facilitate mandatory, multi-professional training in the management of obstetric emergencies.

3.4 Perineal Suturing Workshop:

Facilitated by the practice development team.

This workshop is designed to facilitate practitioners to acquire or update their knowledge and skills on perineal assessment and repair.

3.5 High Dependency Maternity Care Module:

This postgraduate (level 9) module, continued in 2018. The aim of this module is to provide education for midwives on high dependency care needs, for women requiring level 1 care during pregnancy and childbirth. It runs as a stand alone option or credits awarded can be accumulated towards other postgraduate courses, and is available to midwives nationally.

Additional Study days provided in 2018:

Neonatal and Midwifery Overview; Gynaecology and Women's Health; Bereavement and Neonatal Study Day.

3.6 Multidisciplinary Policy, Guideline, Clinical Care Pathways and Audit committee

The purpose of these committees is to facilitate consistency and quality of maternity, early pregnancy, gynaecology and neonatal care through standardisation of policies, guidelines, care pathways and audit for the Saolta maternity hospital group.

3.7 Education Committee

Educational needs of staff are identified and relevant education sessions are organised to support professional development.

Sexual Assault Treatment Unit (SATU)

Dr. Andrea Holmes, Dr. Joanne Nelson, Ms. Maeve Geraghty, Ms. Clare Mahon

Attendance re: Area

- There were 97 attendances at the Galway SATU, an increase of 12 (14%) from 2017
- 89 (92%) reported incidents took place within the Republic of Ireland
- 7 (7%) reported incidents took place outside the Republic of Ireland
- 1 (1%) incident locations were not applicable

Attendance re: Month, Day and Time of Day

- October was the busiest month in 2018 with 12 (12%) patients presenting during this period
- Saturday was the day of the week that most incidents 30 (31%) occurred
- 72 (74%) incidents occurred between the hours of 20.00 - 07.59hrs

Type of Reported Sexual Crime, Assailant, Relationship to Assailant

- 80 (82%) were recent sexual assaults
- 90 (93%) cases involved a single assailant
- 6 (6%) cases involved multiple assailants
- 24 (23%) cases, the alleged assailant was a stranger

Gender, Age Profile, Referral Source

- 93 (96%) patients were female and 4 (4%) patients were male
- The mean age was 27 years of age, the youngest <14 years of age and the eldest was >70 years of age
- An Garda Síochána referred 58 (60%) patients; 23 (24%) patients self-referred and 15 (15%) patients were referred by others (RCC, GPs, ED etc.)

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

- 56 (58%) patients reported the incident to An Garda Síochána, of these;
- 51 (91%) reported within 7 days, of these;
- 46 (82%) reported within 72 hours and 37 (66%) of these reported within 24 hours

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

- 16 (16%) patients had a FCE without initially reporting to An Garda Síochána of these;
- 1 (50%) patients made a formal complaint and the kits were released to An Garda Síochána
- A total of 7 Forensic kits (Option 3) were destroyed in 2018

Psychological Support Worker in Attendance

- 61 (63%) patients had the opportunity to speak to a Psychological Support Worker at the first SATU visit. 23 (24%) patients did not have the opportunity to speak to a Psychological Support Worker as there was no volunteer available to attend SATU. 2 (2%) people declined the opportunity to speak to a Psychological Support Worker

Physical Trauma

- 55 (57%) patients had physical injuries, of these; 52 (54%) had superficial trauma
- 2 (2%) injury required follow-up in hospital and 1 (1%) was hospitalised due to injury

Alcohol and Drug Use

- 68 (70%) patients had consumed alcohol in the previous 24 hours of these;
- 46 (47%) patients had consumed >6 standard drinks of alcohol
- 12 (12%) patients had taken recreational drugs prior to the reported incident
- 7 (7%) 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

- 71 (73%) patients stated a sexual assault occurred
- 19 (20%) were unsure whether a sexual assault had occurred

Emergency Contraception (EC)

- 36 (97%) female patients presented within 120 hours of the incident of these;
- All patients who required EC received it

Sexually Transmitted Infection Prophylaxis and (STI) Screening

- 77 (79%) patients received Chlamydia prophylaxis
- 59 (61%) commenced Hepatitis B immunisation programme
- 2 (2%) patients received Post Exposure Prophylaxis (PEP) for HIV

Follow-up Appointment for Sexual Health Screening

- 63 (65%) patients were given a follow-up appointment for STI screening
- 38 (86%) patients attended first follow-up appointment
- 12 (12%) were referred for an appointment elsewhere
- 3 (3%) were SATU to SATU referrals

Outcome of Sexual Health Screening

- 2 (4%) patients had a positive result for gonorrhoea
- 1 patient tested positive result for Hepatitis B

Referrals to TUSLA

- Of the 24 patients who attended SATU aged under 18, 20 (84%) had a first referral made to Túsla

Child and Adolescent Sexual Assault Treatment Services (CASATS) Galway Executive Summary

Attendance at Galway CASATS

- There were 76 requests for CASATS services in 2018
- There were 75 attendances at the CASATS, Galway. 1 patient did not attend
- Referrals were received from the following counties: Galway (17), Limerick (13), Tipperary (11), Clare (9), Dublin (4), Donegal (4), Roscommon (4), Mayo (3), Sligo (3), Westmeath (3), Laois (2), Leitrim (1), Northern Ireland (1), DNA (1).

Attendance re: Month and Time of Day

- October was the busiest month with 14 cases presenting in this month
- Thursday and Friday were the busiest days with 14 examined on those days
- 14 (were seen out of hours (between 16.00-08.00 or over the weekend)

Gender, Age Profile, Referral Source

- 56 patients were female, 19 patients were male The youngest patient was less than 1 year old and the eldest patient was 17 years old
- 42 patients were referred by An Garda Síochána, 24 patients were referred by Social Workers (Túsla), 6 patients were referred by a Hospital Consultant, 3 patients were referred by a GP and 1 patient was a second opinion request

Acute and historical examination

- 10 patients were examined for an acute forensic examination
- 65 patients had non forensic examinations

Support Worker in Attendance

- 37 patients were supported by a CARI (Child and Family Accompaniment Volunteer) and 1 patient was supported by a Rape Crisis Centre Volunteer

Follow up appointments

- 4 patients attended for follow up appointments

Quality & Patient Safety Department

Ms Gemma Manning

Incidents, complaints and positive feedback are reported by all staff on the Q-Pulse computerised reporting system. There is a steady increase in reporting in the Womens & Childrens Directorate (table 1).

22 Preliminary Assessment Reports (PAR's) were completed in 2018 by medical and midwifery staff following reported incidents and on review by the directorate team when more information and outcome for the patient is necessary to close out the incident and report to the National Incident Management System (NIMS). Recommendations from these reviews are presented to staff through "Just Take 5" which happens at handover at 8am in the morning and at the 12 midday "Safety Pause".

Saolta University Health Care Group Womens & Childrens directorate Serious Incident Management Team (W&C SIMT) was established in October 2018. W&C SIMT is a group wide multidisciplinary team. The chairperson of the W&C SIMT is the Saolta University Health Care Group Clinical Director for Quality & Patient Safety and vice chairperson is the Saolta University Health Care Group Quality and Patient Safety Manager.

Table 1 - Incidents reported

2016	916
2017	1053
2018	1206
General Incidents	1169
Medication incidents	37
Perinatal incident	397
Other	180
Staff Shortage	84
Unplanned events	65
Equipment /Device	40
Documentation	35
Health & Safety	34
Communication	32
Treatment	27
Peri procedure	30
Medication incident	37

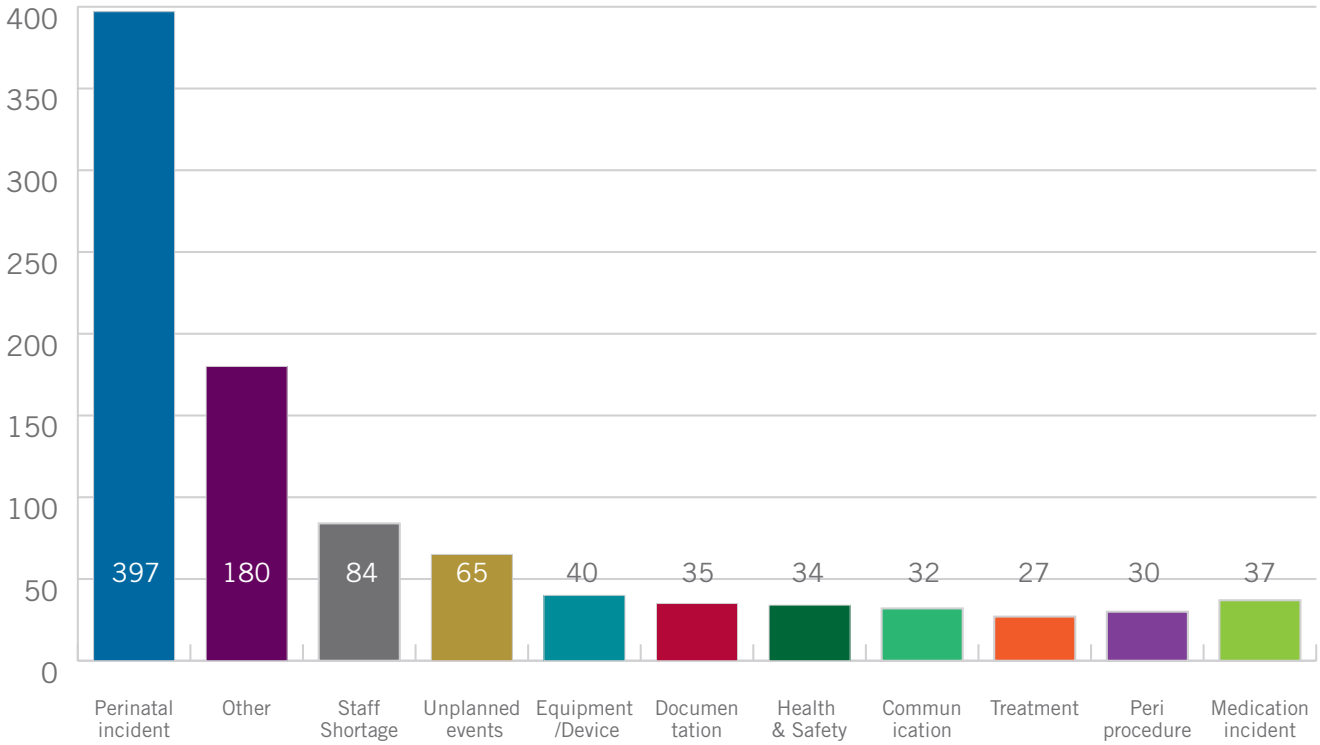
At this meeting serious incidents from the 5 maternity Hospitals are presented and discussed and the appropriate monitoring and management approaches are decided. Significant progress has been made in 2018 in sharing of all review findings and learning from adverse incidents has been a key priority.

Maternity Patient Safety Statements (MPSS) are collated and available on the hospital web site monthly. All Obstetric incidents reported to the National Incident Management System (NIMS) are recorded and provide information for management and clinicians who provide maternity services in relation to a range of patient safety issues. The 5 Maternity hospitals within the Saolta Group share discuss and compare the MPSS's monthly at the Maternity Services Strategic Group (MSSG) meeting.

Womens & Childrens UHG Quality & Patient Safety Improvement Team meet bi monthly and have carried out the self assessment to the 8 themes of the National Standards for Safer Better Maternity Services and Quality Improvement Plans from this self assessment is ongoing, continuous improvement process.

The Local Maternity Services Implementation Group (LMSIG) in W&C UHG continuously review the recommendations for reports, internal and external, an implementation plan is ongoing, progress with this plan is recorded on the Maternity Services Strategic Group (MSSG) Database which is shared with the

Incidents reported 2018



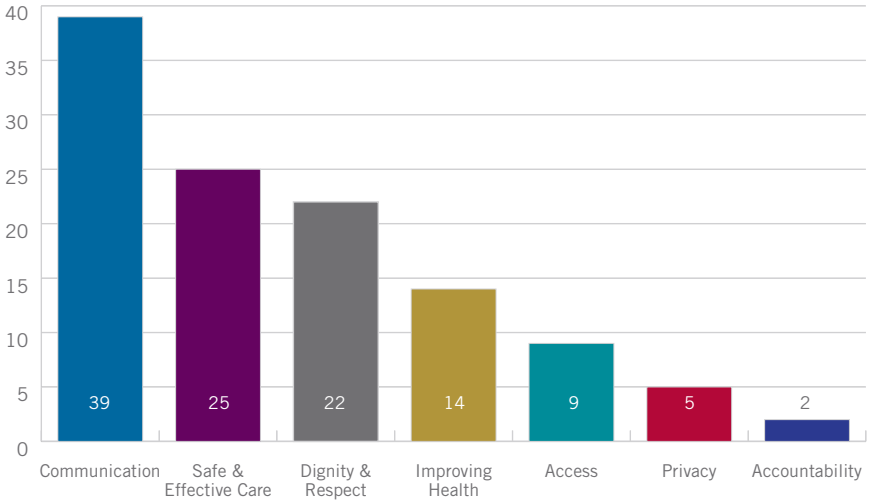
other maternity hospitals in the group. Progress reports are discussed at the MSSG monthly meetings.

Womens & Childrens Directorate has all policies, procedures, guidelines and audit (PPG'S & A) on the document and audit management module of Q-Pulse; National Guidelines and W&C Group wide PPG's. There are currently 106 Saolta Group Womens & Childrens Directorate guidelines on the active register of Q-Pulse.

Development, introduction, review, implementation and education of guidelines in UHG is managed through the Midwifery Practice Development Unit. There is a monthly UHG PPG's & A team meeting where local guidelines are reviewed and discussed. This local group feeds into the W&C Saolta Group PPG's & A meeting.

Table 2 - Complaints reported	74
Written	59
Verbal	14
YSYS	1
Communication	39
Safe & Effective Care	25
Dignity & Respect	22
Improving Health	14
Access	9
Privacy	5
Accountability	2

Complaints reported 2018



Service Users Feedback:

Patient feedback throughout the department is collected on the Quality of Service Comment Cards and these cards continue to be a source of information for quality improvements. The analysis of the comment cards is presented at the Departmental meeting held monthly and the dissatisfaction with the service from the patient's perception is highlighted and discussed and corrective actions identified. Positive feedback is also presented and helps to improve the service.

Complaints (table 2) received are discussed at the directorate team meeting and managed through the Q-Pulse complaints reporting module and NIMS Complaints Management System (CMS). Identified trends and improvements are communicated to staff via "Just Take 5" and staff meetings.

"Quality & Safety of Service in this Department is Everyone's Business and Embraces all Aspects of Care"

Letterkenny University Hospital

Ms Evelyn Smith

Letterkenny University Hospital provides healthcare services to the people of Co. Donegal, serving a population of over 161,000 people. The catchment area incorporates patients residing in Co. Donegal, north of Laghey/Pettigo. It is a 320-bedded general hospital which provides a broad range of acute services on an inpatient, day case and outpatient basis. The hospital has a 35-bedded maternity unit with a 4-room labour ward and a decommissioned theatre and recovery area.

Introduction

The Women &Infant's Directorate in Letterkenny provides care for the needs of the multi-cultural female population of Donegal. We strive to offer a service that supports and empowers women. We endeavour to improve services and maintain a high-quality, family-centred service that offers women advice, choice, information, control and continuity of care. The Directorate acknowledges the use of the word 'family' to refer to significant others as identified by the woman.

Letterkenny University Hospital Women &Infants Services aspires to improve the health and well-being of the population we serve by providing person centred, safe and effective care.

The Directorate strives to be valued for its expertise in the provision of quality Women &Infant's services and to positively impact on the lives of those we encounter.

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.

We are committed to, through our Mission statement to:

- Providing high quality care for those we serve with a focus on clinical excellence and patient safety and continuous improvement through clinical education and research.
- To ensure that communication with service users and their families/ support persons following an adverse event is undertaken in an empathetic, informed and timely manner.
- To ensure that staff working in our service are consistent in their processes in relation to the application of the principles of Open Disclosure.

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 sixth 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 2018, there were 1,691mothers who delivered 1,716 babies, showing an increase in numbers from 2017.

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

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.

Gynae Inpatient

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 2018

- Further development of KPIs and Quality Assurance Reports
- KPI compliance with early dating scans & Anomaly Scans
- Clinical Handover &Sepsis National Audits completed
- Midwifery Led Pilot Development
- Post-Menopausal Bleeding Clinic
- IMEWS training
- Metrics
- Care Bundle audits
- PROMPT training
- Advanced CTG training
- Neonatal Resuscitation
- Staff training in care of the critically-ill maternity patient
- Funding Sourced IT project-Upgrade MIR system
- Donegal Breastfeeding Forum
- Sepsis training
- Breast Feeding Volunteers

Challenges 2019

- Implementation of Maternity Strategy 10-year vision
- Benign Gynae Surgery
- HPV Services
- Progression Planning Urodynamics
- Maintain and develop services within current budgetary restraint
- Maintain a commitment to practice development and ongoing professional development
- Maintain a commitment to auditing our services
- Maintain ongoing training and professional development for all staff.
- Recruitment of Midwives
- Recruitment of Shift Leaders
- Development of Posts
- Infrastructure Development

Our annual report is an evolving process. It is anticipated that the report will become more comprehensive each year.

I would like to thank all our staff for their support, hard work and commitment to the Service throughout 2018.

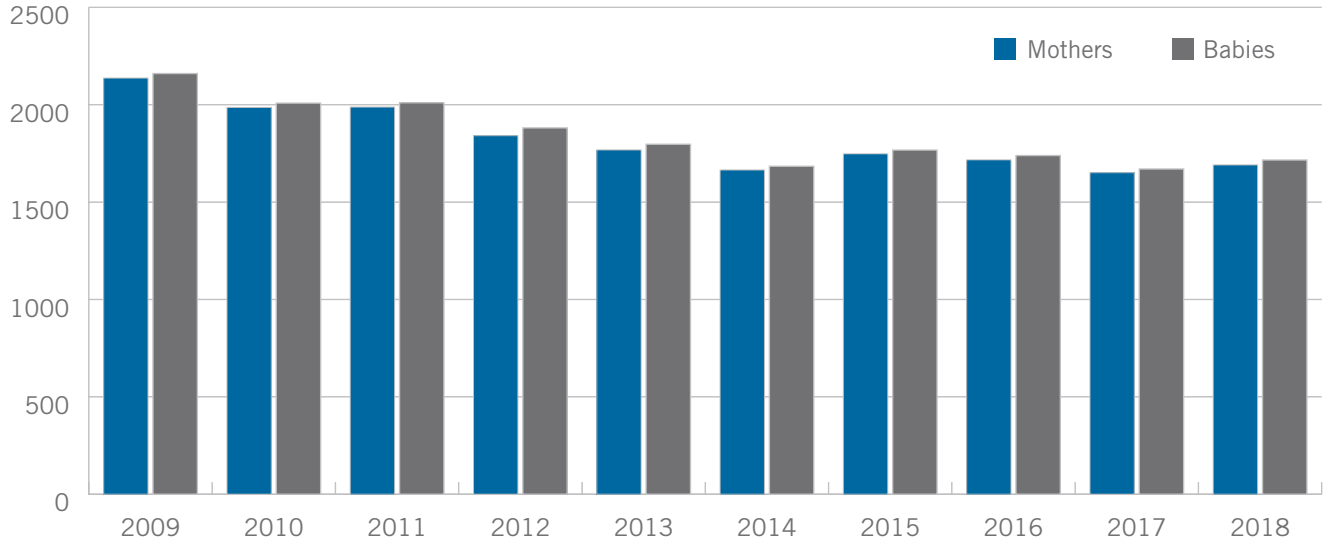
Maternity/Neonatal/Gynaecology services are supported by a team of allied health professionals - Social Workers, Dietician, Pharmacist, Physiotherapist, and Occupational Therapist - and also by core services within LGH:

- Administration
- Ambulance
- Bed Management
- Chaplaincy
- Catering Department
- Central Supplies
- Clinical Practice Development
- Consumer Services
- Health Promotion Department
- Health and Safety Department
- Household Services
- Infection Control and Prevention
- Information Technology
- Laboratory Services
- Laundry Services
- Library
- Medical Records
- Occupational Health
- Portering Service
- Quality and Risk Department
- Radiology
- Security
- Technical Services
- Theatre Services

Statistical Summaries Report

	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Total Number of Mothers	2,137	1,986	1,988	1,841	1,768	1,665	1,748	1,717	1,651	1,691
Total Number of Babies	2,160	2,008	2,010	1,881	1,797	1,684	1,767	1,739	1,670	1,716

Total Number of Mothers & Babies over the last 10 years



Obstetric Outcomes (Mothers)	Primigravida	Multigravida	Total	%
Spontaneous Onset			794	46.90%
Induction of Labour	194	259	453	27.3%
Epidural Rate			317	18.7%
Episiotomy			311	18.4%
Caesarean Section	247	385	632	37.4%
Spontaneious Vaginal Delivery	655	195	850	50.2%
Forcepts Delivery	3	0	3	0.1%
Ventouse Delivery	147	55	202	11.9%
Breech Delivery			44	2.6%
Total (Number)	**591**	**1100**	**1691**	**100%**

Obstetric Outcomes (Babies)	Primigravida	Multigravida	Total
Spontaneous Vaginal Delivery			850
Forceps Delivery			3
Ventouse Delivery			202
Breech Delivery (Singleton)			44
Breech Delivery (1st Twin)			
Breech Delivery (2nd Twin)			
Caesarean Section(Babies)			655
Total (Number)			**1716**

Multiple Pregnancies by Year	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Twins	23	22	22	40	29	19	19	22	19	25

Perinatal Deaths 2018	Total
Stillbirths	8
Early Neonatal Deaths	1

Parity	%
Para 0	34.90%
Para 1	33.70%
Para 2	19.60%
Para 3	7.70%
Para 4	2.50%
Para 5	1.10%
Para 6	0.30%
Para 7	0.20%
Para 8	0.10%
Para 9	0
Para 10	0
Total	**100**

Perineal Trauma	Total
Intact	407
Episiotomy	311
2nd Degree Tear	340
1st Degree Tear	106
3rd Degree Tear	19

3rd Stage Problems	Total	%
Primary PPH	44	
Manual Removal of Placenta	26	1.5%

Shoulder Dystocia	Total	%
Shoulder Dystocia	8	0.50%

Age of Delivery 2018	Total	%
14-19yrs	27	1.6%
20-24yrs	170	10.0%
25-29yrs	337	19.9%
30-34yrs	590	34.9%
35-39yrs	470	27.8%
40-44yrs	93	5.5%
45>	5	0.3%
Total	**1691**	**100.0%**

Gestation at Delivery 2018	Total	%
<28 weeks	4	0.2%
28 - 31+6	7	0.4%
32 - 36+6	79	4.7%
37 - 39+6	758	44.8%
40 - 41+6	817	48.3%
> 42 weeks	27	1.6%
Total	**1691**	**100.0%**

Birth Weights	Total	%
1000-1999gms	25	1.5%
2000-2999gms	267	15.8%
2500-2999gms	8	0.4%
3000-3999gms	1153	68.1%
4000-4499gms	221	13.1%
4500-4999gms	40	2.4%
5000-5499gms	2	0.1%
Total	**1716**	**100.0%**

Induction of Labour	Primigravida	Multigravida	Total	%
2009	254	292	546	
2010	226	290	516	
2011	205	273	478	
2012	202	267	469	
2013	206	261	467	
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%

B.B.A	Primigravida	Multigravida	Total
2009	0	5	5
2010	1	6	7
2011	1	4	5
2012	3	4	7
2013	0	3	3
2014	1	4	5
2015	1	4	5
2016	0	7	7
2017	1	6	7
2018			8

Mode of Anaesthesia for CS	
Spinal	511
Epidural	44
Combined spinal	34
General Anaesthetic	43
Total	**632**

Neonatal Unit

Ms Kate Greenough

The staff of the neonatal unit aim to provide high-quality, evidence-based care to neonates in a safe and friendly environment.

There were 1,691 babies born in Letterkenny University Hospital in

2018, of which 321 were admitted to the neonatal unit.

The unit has 10 cots in total, 2 of which are for intensive care and 8 for high dependency / special care. There is a room used for isolating babies when required and a parents' room is also available.

Infants are admitted from the labour ward, postnatal ward, theatre and other hospitals, or may have been born outside hospital.

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
- ShapeSocial reasons

Treatments available in the neonatal unit include Short-term Ventilation, CPAP, Low Flow Oxygen Therapy, IV fluids, IV Antibiotics, TPN and Initiation of Therapeutic Cooling Therapy.

- 49 babies required CPAP
- 12 babies were ventilated
- 14 babies had congenital malformations
- 16 babies were transferred to other hospitals
- 9 babies were transferred from tertiary centres for ongoing care
- Some care orders were invoked in the unit and we provided care for these babies prior to discharge.

Specialist Services on site include: Audiology and Ophthalmology screening, MRI scans and Ultrasound facilities. The Multidisciplinary teams include a Paediatric dietician, the Social work team, Physiotherapists, Radiographers, Orthopaedic team and the Paediatric Link nurse. The staff in the neonatal unit liaise, 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.

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.

In 2018, staff attended NNU Study Day in Galway

Other training 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.

Gestational Age of Admissions

Gestational age	n	%
24 - 27+6 weeks	6	1.86%
28 - 31+6 weeks	9	2.8%
32 - 34+6 weeks	27	8.4%
35 - 36+6 weeks	61	19.0%
≥37 weeks	218	67.9%
Total	**321**	**100.0%**

Baby Weight on Admission to NICU / SCBU

Weight	n	%
500-999g	3	0.93%
1000-1499g	8	2.49%
1500-1999g	20	6.2%
2000-2499g	53	16.5%
2500-2999g	56	17.4%
3000-3499g	83	25.8%
3500-3999g	63	19.6%
4000-4499g	29	9.0%
≥4500g	6	1.86%
Total	**321**	**100.0%**

Fetal Assessment Unit and Early Pregnancy Clinic

Ms Geraldine Gallagher

Midwife-led Unit

Midwife Sonographers:
Geraldine Gallagher CMS
Louise Gallagher CMS
Katriona McCarthy CMS

Service provided Monday - Friday
8am - 6pm

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

A total of 6184 scans were performed of which 1674 were anomaly scans and 1808 were dating booking scans. 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 66 Referrals to Holles Street National Maternity Hospital
- 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.

Prophylactic Anti D at 28 weeks was also introduced by the team in July 2017 and is timed in conjunction with their ANC appointment and total for 2018: 294.

Apart from the Fetal Assessment Unit a formal Early Pregnancy Clinic continues with a morning clinic from 11am – 1pm, Monday – Friday. Obstetric Registrar led clinic with all scans performed by midwife sonographers.

Total number of ultrasound scans performed in 2018: 827

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.

Postnatal Report

Ms Mary Lynch

Our Postnatal unit consists of 25 beds. The midwives working in the maternity unit rotate on a four-monthly basis to postnatal, antenatal, and labour wards. Midwifery team members working in Postnatal include CMM, midwives, student midwives and HCAs trained in midwifery modules.

The postnatal ward provides a 24-hour postnatal service where staff endeavour to provide holistic and empowering care to mothers and newborn babies. The CMM and midwives are part of the multidisciplinary team which provides postnatal care, including supporting infant feeding, parenting support, education and teaching.

The MDT working in Ppostnatal in cludes,Obstetricians,Paediatricians , Physiotherapists, Social Workers, Teen Parenting and Newborn Hearing Screening. We also work closely with health care professionals in the community including PHNS and GPS.On discharge from the ward, a summary of care is generated by midwifery staff and forwarded to the PHN and GP

There were 1,716 babies born in 2018, with a Caesarean section rate of 37.4%. This impacts on the ward, as these women require a higher level of care in the postnatal period. Midwifery staff are required to have a high level of evidence-based knowledge and clinical skills to provide a competent, safe standard of care. The IMEWS observation tool is used and The Sepsis Predisposition and Recognition(Sepsis 3) form was continued in 2018. Postnatal Readmissions and Postnatal reviews are provided on the ward.

All infants receive a high level of assessment and observation with specific policies in place for those with individual risk factors, i.e. Diabetic Mother,PROM, and Group B strep

Breastfeeding/ Lactation

Promotion and support for breastfeeding is a key component of care throughout the unit. Maintaining this high standard is very challenging in the current climate, due to severe demands in the clinical area.

Breastfeeding and skin-to-skin contact are supported by midwives and student midwives as part of our commitment to ensuring best practice and standards in promoting breastfeeding. All our staff have received 18 hours of breastfeeding training and regularly attend 4-8 hour updates. We facilitate rooming-in on the postnatal ward, with good breastfeeding outcomes. Our breastfeeding on discharge rate has increased to 46% in 2018 an increase of 1%.Our initiation rate for 2018 was 56%

On discharge from hospital, all breastfeeding mothers are given contact details of Support Services within the hospital and community care area and of breastfeeding support groups in their own area.

We also provide a 24-hour telephone advice helpline to all breastfeeding mothers and a weekly, hospital-based, drop-in clinic.

The Introduction of a Breastfeeding Volunteer Programme to support Mothers & Staff on the Postnatal Ward at LUH duiing 2017 and continued throughout 2018 has proved very successful for both stakeholders with very positive feedback and increased breastfeeding rates on discharge.

The need to have additional support for breastfeeding mothers was identified by the hospital breastfeeding committee in their action plan for 2016. Recognising the role of volunteer breastfeeding support, a plan was developed to introduce a breastfeeding volunteer programme. The plan was supported by the Director of Midwifery, hospital management, staff, La Leche League and Donegal Breastfeeding Forum. The project commenced in April, 2017, to provide support and information to breastfeeding mothers and this service is currently available 2 mornings per week. Qualitative information has been gathered from mothers, midwives and volunteers to evaluate the project.

Bereavement

- Butterfly Room design commissioned and work commenced/completed Dec 2018
- Training provided for Midwives in CNME “Perinatal Loss in Maternity Setting”
- Counselling offered post-delivery
- Chaplaincy service available
- Feileacain services available
- Cool Cot available

Perinatal Mental Health

- Counselling available
- MDT approach with Psychiatric Services
- Staff training in perinatal mental health

Antenatal Education Report

Ms Geraldine Hanley

The demand for Antenatal Education Classes continued throughout 2018. The Antenatal Education Co-ordinator (CMM2) co-ordinates and facilitates antenatal and postnatal education programmes. The programme provides a woman-centred, multi-disciplinary approach, acknowledging pregnancy and birth as a normal life event. This is a comprehensive and interactive programme that aims to empower women and partners to make informed choices. Pregnant women, partners and students avail of the antenatal classes.

Comparison with 2017 figures shows an increased attendance at all sessions for 2018 with exception of the teenage group. A causal factor related to the drop in teenage group attendance appears to be an increased demand for 1-1 sessions in this specific group. Overall, there was a significant increased demand for one to one consultations throughout 2018, particularly in the area of Perinatal Mental Health, often requiring repeat 1-1 visits or collaboration with Mental Health Services. The Antenatal Education service links closely with specialist services including Social Work Department, Pregnancy Counselling, Mental Health Services and the Fetal Assessment Unit. The antenatal education programme continues to be held in an external venue at Donegal Women's Centre. The weekly hospital Breastfeeding Drop-in Clinic continued throughout 2018 with a slight increase in attendance.

Achievements in Service Provision

- Provision of a comprehensive woman-centred antenatal education programme.
- Increased one to one antenatal education sessions to meet demand.
- Perinatal Mental Health training of midwife educator to further meet the demands of vulnerable women and their families.
- Promotion, Protection and Support of breastfeeding.
- Incorporation of a blended Hypnobirthing model into the antenatal education programme.

Breastfeeding Promotion and Supports Available

- Promotion, Protection and Support of breastfeeding is a key part of parent education, this continued throughout 2018, based on the WHO/UNICEF recommendations for breastfeeding.
- The hospital based 'Drop-in' Breastfeeding Support Clinic continues to run weekly, alongside a daily breastfeeding telephone helpline service.
- A 'Breastfeeding Peer Support Volunteer Programme' commenced in April 2017. Two breastfeeding support volunteers from La Leche League continue to offer breastfeeding support on the postnatal ward, on a twice weekly basis. Qualitative feedback continues to be very positive.
- National Breastfeeding Week was celebrated with an information stand made available outside the maternity unit in the hospital for staff and members of the public.
- A targeted information session was developed and offered to local Transition Year students in collaboration with local schools.
- Donegal Breastfeeding Forum Group continues to support breastfeeding locally.

Source of Referrals to Antenatal Classes

- Antenatal Clinic,
- Fetal Assessment,
- Self Referral,
- Public Health Nurses,
- Medical Social Work,
- Teen Parent Support Programme (TPSP)
- In Patient Referral
- Diabetic Antenatal Clinic

Multidisciplinary Collaboration

The Antenatal Education Co-ordinator works closely with the following groups:

- Donegal Parent Hub/Child and Family Health Initiative
- Teen Parent Support Programme (TPSP)
- Health Promotion Department
- Donegal Alcohol Forum
- SAOLTA Breastfeeding Forum
- Donegal Breastfeeding Forum

As a result of these collaborations many other projects have been developed and highlighted such as The Alcohol & Pregnancy Practice Change Initiative 'Prescription for a Healthy Pregnancy' with phase two currently being planned.

Challenges

- While there were many achievements throughout the year, it is recognised that the service needs additional resourcing to provide optimum service.
- The allocated 19.5 hours per week doesn't allow for provision of other targeted classes such as; Early Pregnancy classes, Twin Pregnancy Classes and Antenatal Breastfeeding Workshops.
- The availability of a mobile phone to communicate with specific service users would also be of benefit. Teenage service users request to communicate by text message and there continues to be a significant number of service users who are registered as deaf and use phones or
- I-pads to communicate during sessions.

2018 Attendance at Antenatal Education Sessions

ANTENATAL EDUCATION	CLIENTS	SUPPORT PARTNERS	TOTAL ATTENDANCE
Weekday Sessions	153	0	153
Evening Sessions	150	150	300
Refresher Sessions	82	35	117
Postnatal Reunions	45		45
Teenage Group Sessions	6	6	12
1:1 Antenatal Class Sessions	180	170	350
Tours of Maternity Unit	670	645	1315
Breastfeeding Drop-in Clinic	40	5	45
1:1 Antenatal Clinic Education	852	852	1704

Colposcopy Clinic Report

Ms Regina McCabe and Ms Patricia Hirrell

Staff Complement

Consultant Colposcopist
Prof Edward Aboud. Director of Colposcopy
Dr Sally Philip. Sr Registrar/ Colposcopist
Dr Farhat Shireen Sr 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 Maureen Quinn/Ms Donna Black 0.5 WTE

Office Administrators
Ms Tanya Graham Full time
Ms Susan Shields 0.5 WTE

The Colposcopy service at Letterkenny University Hospital is consultant led. There are two 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 and a Staff Nurse undertaking their Colposcopist training with BSCCP.

Clinic Attendances

First visit attendances showed an increase in 2018 on the previous year, 682 in 2018 compared to 654 first visits (2017)

The clinic is contracted by the National Cervical Screening Programme (NCSP) to see 500 first visits per year.

Patients are offered appointments within the recommended waiting times. We continually facilitate changing of appointments by offering times to suit work and other commitments.

Quality Assurance and MDTs

In 2018 we continued to hold CPC/ MDT meetings at 3 month intervals to discuss complex cases requiring team discussion and management planning. These meetings are supported by the Cytopathology laboratory, MedLab and 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.

Changing the test for cervical screening

The introduction of the HPV test as a primary screening test which was planned to be introduced in Ireland by the end of last year 2018 has had to be delayed following the CervicalCheck crisis which broke in April 2018. A HSE Steering Group, Clinical Advisory Group and HPV Project Team are in place and are processing the planning for the move to HPV primary screening and the implementation process.

The HPV test is for the presence of infection by HPV types associated with the development of cervical cancer. Having the virus is necessary for developing cervical disease, HPV testing is better than a current smear test at identifying those at risk and will offer an additional level of accuracy and reassurance.

Cervical Check

Women in Ireland have been understandably very worried following the apparent failures in the CervicalCheck programme in particular, women's anxiety due to the ongoing delays in reporting of their smear test results. In some cases women are waiting up to 32 weeks to be informed of the result.

The National Screening Service are actively trying to address the delays in getting smear results to women, caused by the backlog of smears.

From May 1st 2019 cervical samples taken in Colposcopy clinics nationally will be processed at The Coombe Laboratory. Coombe Women and Infants University Hospital. Dublin. It is hoped that this will help reduce result waiting times for cervical smears taken in Colposcopy clinics.

The Colposcopy service in LUH observed a marked increase in the numbers of new referrals from GP's in May and June 2018, particularly clinically indicated referrals. It is now anticipated that on foot of HPV screening being introduced and the possible impact arising from the RCOG audit, recommended by the Scally enquiry, that our service may experience a 40% increase in referrals.

Notwithstanding, the Colposcopy service LUH have worked very hard to continue to meet the waiting time targets for referrals as recommended by CervicalCheck.

The office administrative staff consistently review appointment places and aim to fill vacant slots as they arise through patient cancellation or postponement.

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.

Summary of Colposcopy Clinic Activity 2018

New Referrals		Follow Up / Treatment	
Attended	Did Not Attend	Attended	Did Not Attend
682	30	1068	181

Urodynamic Report

Ms Lorna Baldrick

The Urodynamic service continues to see Pessary referrals for assessment and fittings of specialised silicone devices for prolapse and complex procidentia. However it is planned in 2018 that specially trained senior Physiotherapists in Women's health will start to see the non complex cases- Service commenced mid 2018

The new Nexam Pro Urodynamic machine was commissioned early in 2017. Configuration of reports and tracings has changed and is now in a very interpretable and professional format.
Urogynae patient numbers have reduced now as new patients presenting with Urinary symptoms are being seen in the Gynae outpatient clinics.
In January 2018 reconfiguration of Urogynae afternoon clinics from 1 every 3rd week to 4th week allowing for an extra Gynae clinic.

The service has been allocated a .5 Health Care assistant

Succession planning for skilling additional staff to support Urodynamics-ECC submission

Urodynamics Unit Annual Stats 2018

2018	Clinics	Ward Referrals	Uroflow CMG Studies	Attended Urogyn Clinic	Pessaries	DNA	Total Attended
January	13	10	35	7	14	4	66
February	12	10	23	6	10	5	49
March	9	12	28	Bank holiday 0	14	4	64
April	12	14	29	8	17	3	68
May	9	12	24	6	13	3	64
June	12	10	24	7	19	4	60
July	11	12	25	6	17	4	60
August	8	10	18	0	23	3	51
September	8	12	18	2	23	3	55
October	12	13	32	0	15	3	60
November	13	15	34	0	14	2	63
December	9	14	15	0	14	2	43
Total Urodynamic Numbers	**128**	**144**	**305**	**42**	**193**	**40**	**703**

Mayo University Hospital

Ms Andrea McGrail and Ms Sile Gill

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.

We are constantly looking at ways to improve the service we provide to our women. In 2017 we introduced hypnobirthing as a regular part of our antenatal education classes. This service was nominated for a Saolta award.

The launch of the Pregnancy loss and Bereavement booklets took place in Mayo University Hospital on 13th November 2018. They were launched by Dr. Brid Carroll ICBN (Irish Childhood Bereavement Network) and Alice Anderson IFH (Irish Hospice Foundation). The launch was a very successful event attended by all the parents involved in their development and staff from the wider hospital community. Staff and family voiced that they valued the opportunity to come together to showcase their work to the wider community. The launch was part of a Mayo University Hospital event for Irish Childhood Bereavement Week. The launch encompassed an education day provided by Centre of Nursing and Midwifery Education Mayo/Roscommon, called 'Childhood Bereavement and Loss, Empowering Families and Healthcare Professionals.

Unfortunately we are still lacking in some key posts in midwifery, audit, lactation, practice development, clinical skills and advanced midwife practitioner roles but we are hopeful that these posts will be approved by our 2019 report. One of our midwives has been successful in the recruitment process for Perinatal Mental Health Midwife so we hope to have her in position shortly.

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.

2018 saw the introduction of the Pregnancy options service and we have a CMM2 appointed to develop and manage this service.

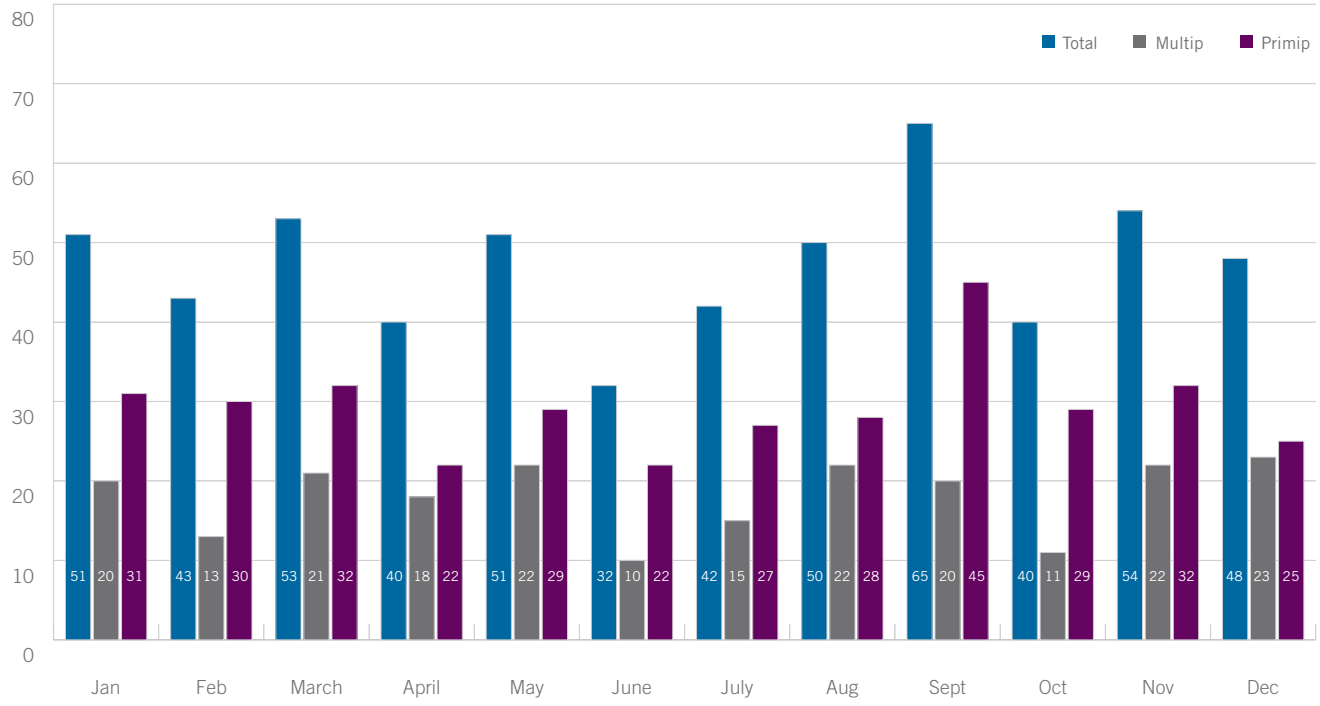
We continue to have a peer review safety meeting Mon - Friday in the maternity ward meeting room. This is attended by Day / Night staff Obstetricians Midwives and students. All cases in the previous 24 hours are discussed, patients that were seen out of hours in ED or labour ward. The day's work is discussed and any high risk patients, staffing issues or other concerns are addressed. Any women attending with a known fetal abnormality is highlighted to staff.

On Thursday we are joined by the Paediatric team and all babies' that required admission to SCBU 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

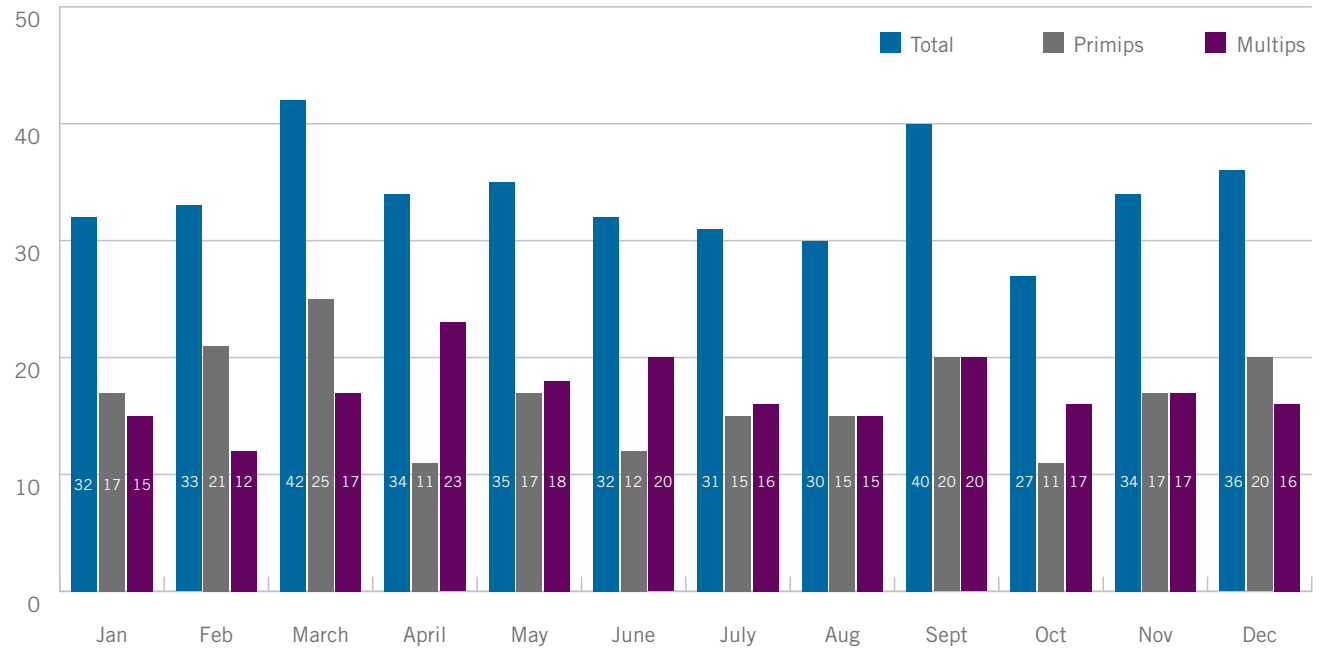
In 2018, 1,506 babies were delivered to 1484 women at MUH, showing a slight decrease in numbers from 2017. Our delivery rate by caesarean sections continues to increase in line with national trends.

	Robson	Number of Mothers Delivered	Number of Caesarean Section	%
1	Nulliparous , Single. Cephalic > 37 weeks in spontaneous labour	235	63	26.8%
2	Nulliparous , Single , Cephalic >37 wks induced or caesarean before labour.	216	115	53.24%
3	Multiparous (excluding previous c/s) Single , cephalic, >37 weeks in Spontaneous Labour	392	3	7.6%
4	Multiparous (excluding previous c/s) Single , cephalic, >37 weeks induced or C/S before labour.	216	35	16.2%
5	Previous C/S , Single , Cephalic,> 37 weeks	288	253	88%
6	All Nulliparous Breeches	28	28	100%
7	All Multiparous Breeches Including previous c/s	31	30	96.7%
8	All multiple pregnancies Including previous c/s	22	13	59%
9	All abnormalities including previous c/s	7	7	100%
10	All Single , Cephalic < 36 weeks (Including previous c/s	49	22	44.9%
		1484	**569**	**Overall Percentage of C/S 38.3%**

Caesarean Sections 2018



Inductions of Labour



Obstetric & Gynaecological Surgery Report

Ms Elaine Finnegan and Dr Hilary Ikele

Procedure	Total
LSCS	569
Caesarean Section and Tubal Ligation	3
Caesarean Section and Bilateral Salpingectomy	37
ERPC	83
Laparotomy for Ectopic	2
Laparoscopy Surgery for Ectopic	10
Perineal Repair postpartum	29
Manual Removal of Placenta	17
Operative Vaginal Delivery in Theatre	41
Cervical Smear	7
Colposcopy	8
LLETZ	6
Punch and Wedge Biopsy of Cervix	1
Cervical Polypectomy	1
Hysteroscopy and D&C	67
Endometrial Polypectomy	5
TRC Polyp	8
TCR Fibroid	0
TCR Endometrium	5
Hysteroscopic Morcellation Polyp	9
Hysteroscopic Morcellation Fibroid	2
Endometrial Ablation	5
Total Abdominal Hysterectomy	8
Subtotal Abdominal Hysterectomy	0
Vaginal Hysterectomy	13
Intrauterine Coil Insertion	38
Intrauterine Coil Removal	21
Laparoscopic Tubal Ligation	4
Diagnostic Laparoscopy	12
Laparoscopy and Dye Test	7
Intravesical Botox	8
Vaginal Scan	6
Unilateral Oophorectomy/Salpingectomy (Laparotomy)	7

Procedure	Total
Unilateral Oophorectomy/Salpingectomy (Laparoscopy)	7
Bilateral Oophorectomy/Salpingectomy (Laparotomy)	2
Bilateral Oophorectomy/Salpingectomy (Laparoscopy)	5
Ovarian Cystectomy (Laparotomy)	2
Ovarian Cystectomy (Laparoscopy)	3
Other Operative Laparoscopy	8
Anterior and Posterior repair	13
Anterior Repair	7
Posterior Repair	5
Vault Prolapse/Enterocoele Repair	1
Excision of Vulval/Vaginal Cyst	0
Bartholin's Cyst/Abscess	5
Vulval Biopsy	4
Vaginal Wall Biopsy	0
TVT	1
TVTO/TOT	1
Cystoscopy	18
Blood Patch	6
Post Partum Haemorrhage	9
Ovarian Drilling	1
Fentons Procedure	1
Colpocleisis	0
Manchester Repair	0
Myomectomy	3
EUA Gynaecology	14
Insertion of Shirodkar Suture	0
Removal of Shirodkar Suture	1
Hysteroscopy	25
Insertion of Ring Pessary	2
Removal of Ring Pessary	3
Trans Abdominal Scan	3

Paediatric Report

Dr. Hilary Stokes

Paediatric Ward

The paediatric ward offers an inpatient, day case assessment and elective review services to children up to their 15th birthday, with an additional cohort of patients aged 16-18 years under the care of other disciplines primarily adult physicians. While paediatric activity in the Emergency Department continues to rise steadily each year (8115 juvenile presentations in 2018, representing a 4% increase in activity from 2017). In contrast, the number of admissions to the paediatric ward demonstrates a decline of 17% from 2017 to 2018. This decline in admission rate to the paediatric ward is in line with other units similar to ours.

8115 children aged up to 15th birthday attended the ED in 2018. This number represents the total, unselected caseload of children up to 15th birthday. The total number of admissions to the paediatric ward, from this unselected care group and under the care of the paediatricians was 1109 (1336 for 2017).

The data in this year's report below includes those teenagers aged 15 to 16 years, who were admitted under consultant physicians or surgeons, and will in future years represent the adolescent cohort under the care of the paediatricians.

The Paediatric ward is utilised by 4 Consultant Paediatricians, 4 Consultant Surgeons, 4 Orthopaedic Surgeons, Consultant Physicians, and weekly visiting services namely Dental and ENT.

Daily Teaching Handover with required attendance by all paediatric doctors and medical students and the introduction of the 'Safety Huddle', following completion of the 'SAFE Collaborative' training are embedded activities to enhance the culture patient safety and good quality care provision.

Total Admissions to Paediatric ward in 2018 = 1109

Table 1 – 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	

Table 2 – New and review attendances by Paediatric Consultant MUH 2018

Outpatient Clinics	New Patients	Review Patients
Consultant A	315	1077
Consultant B	117	642
Consultant C	271	1415
Consultant D	312	1384
Total	**1012**	**4482**

Paediatric Decision Unit

The Paediatric Decision Unit (PDU) opened in late August 2017 within the footprint of the existing ward. The commencement of activity in this newly opened ambulatory care unit, represents a significant change in the configuration and the workings of the paediatric ward. This innovation sought to improve quality and safety, through efficient care delivery based on the accepted international model of care and to address significant challenges to the safety and sustainability of existing patient services, and the changing trends in children's admission to hospital.The PDU provides a short stay service for the assessment, observation and treatment of children & young people (C&YP), for up to 6 hours, with a consequent reduction in unnecessary overnight admissions.

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 operational from 0900 – 22.00 Monday to Friday. 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.

Of the 8115 children who presented to the ED in 2018, 1500 children in the mild to moderately unwell category were managed in the PDU. Conversion rate averaged 11%. 2019 sees the expansion of PDU activity through longer opening hours, and a pilot project providing Direct GP Access is currently underway.

In addition to the 1500 children in the unscheduled care group managed on the PDU in 2018, a further cohort of 764 children were offered planned care, for assessments and review appointments and from urgent GP referrals.

Paediatric Outpatient Service

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

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

The clinics provided are outlined in Table 1

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 97 children in the paediatric diabetic service, 4 aged <5 years. The provision of a pump service had been highlighted as a requirement, and in 2018 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, totaling 16 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 7 days per week, 0800-1600.

Emergency Department (ED)

Paediatric patients represent 21% of all ED attendances in the ED. Total paediatric attendances was 8115. 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 opening times has lessened but not eliminated this difficulty. The ED requires significant modification to its footprint to address the separation of children from adults.

Women's and Children's Directorate Academic Report

Professor Michael B. O'Neill

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. Special study modules in Paediatrics are available in neonatology.

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 6 SHO (of whom 3 are Basic Specialist Trainees from the National Paediatric Program, 2 are Family Practice trainees and 1 stand-alone post). This complement is modified depending on trainee numbers and preferences. The Registrar complement is 7 (2 SPR and 6 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 1) 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. Compulsory attendance with sign is required for all Consultants and NCHDs.

The Paediatric Educational timetable

Monday	Tuesday	Wednesday	Thursday	Friday
X ray conference 2/month Dr M Browne 8.30-9.00 am	**Neonatology** Dr Letswithi, with 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
Tutorial 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		

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.

Department of Paediatrics

Professor 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 Program RCPI (member)
4. Member Specialty Training Committee Faculty of Paediatrics RCPI
5. Member SAFE team Mayo University Hospital
6. Clinical Lead Department of Paediatrics Mayo University Hospital

Dr. Hilary Stokes

1. Associate Clinical Director Women's and Children Mayo University Hospital
2. Strand Lead Paediatrics Mayo Medical Academy, Mayo University Hospital
3. Lead Consultant RCPI SAFE program at Mayo University Hospital
4. HSE National Clinical Directors Executive Skills Development Programme 2018/2019.Course Participant
5. Open Disclosure Workshop for Clinical Directors 2018 -2019. Course Participant

Department of Obstetrics and Gynaecology

Dr Meabh Ni Bhuinnean

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
5. Trainer - WHO Reproductive Health Program, Values Clarification for HSE staff in preparation for the provision of Abortion Services in Ireland

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

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
5. Consultant trainer of the year award for a small hospital 2018 by the committee of anaesthesia trainees and the training committee of the College of Anaesthetists Ireland.

Publications

1. Biesty LM[1], Egan AM, Dunne F, Dempsey E, Meskell P, Smith V, Ni Bhuinneain GM, Devane D. Planned birth at or near term for improving health outcomes for pregnant women with gestational diabetes and their infants. Review article Cochrane Database Systematic Review. 2018.
2. Laparoscopic-assisted transverses abdominis plane block as an effective analgesic in total extraperitoneal inguinal hernia repair: a double blind, randomised controlled trial. Mughal A, Khan A, Rehman J, Naseem H, Riaz M, Waldron R, Duggan M, Khan W, Barry K, Khan I Z.Hernia, 2018 Dec;22(6):1123

National Presentations

1. Preparing to Partner at Mayo University Hospital: A study of institutional preparedness for whole system patient-experience advisor integration. McGrath F, Moran S, Bracken R, Casey J, Staunton F, Curtis J, Fallon E, Donohoe C, Rivoire E, Ni Bhuinneain M. Person-centredness Research and Implementation in Health and Social Care Conference, Dublin. Ireland and Health Promotion Annual Conference, NUI Galway.
2. Rooney DJ, McGuire PJ, Ni Bhuinneain M A General Gynaecology Service & Endometrial Cancer: A Pilot Analysis of Performance.
3. Hamid A, Kasha S, Branagan A, Stokes H. Leukemia Cutis – A Rare Manifestation of ALLIPA Dec 2018
4. Lane C, O'Neill MB. An Unusual Case -Ascites in a two year old child. IPA . Dec 2018
5. Elbardy Ali M, Salama M, O'Neill MB. Lumbar Puncture and the Paediatric Patient. One Hospital's Experience. IPA Dec 2018.
6. Keegan K, Sarani ZA, O'Neill MB. Are Clinical Prediction Rules in Paediatrics Validated. IPA Dec 2018.
7. Elbrady M, Reidy B, Stokes H, O'Neill MB. Incident Reporting and the Non-Consultant Hospital Doctor. IPA Dec 2018.

National Invited Lectures

1. National Women and Infants Health Program Annual Study Day. Ambulatory Gynaecology at Mayo University Hospital. Ni Bhuinneain M.
2. 3rd ESTHER Ireland Partnership Forum. Presentation and Panel Member: what can Ireland learn from global health partnership? Ni Bhuinneain M. RCPI, Dublin, Ireland.

3 The Paediatric Decision Unit - From Concept to Fruition. Presentation at RCPI, Faculty of Paediatrics Study Day 2018. Stokes H.

Regional Presentations

1. Presentation at the Western Anaesthesia meeting, Westport April 2018 AAGBI Guidelines: The use of blood components and their alternatives. Duggan M.
2. Roadmap for Organisational excellence, from the bedside to management team'. Stokes H. (Also shortlisted for presentation to the National Selection Panel for HSE Health Service Excellence Awards 2018 - HS member).

Colposcopy Service Report

Ms Ita Lynskey and Dr Ulrich Bartels

There were 1341 appointments issued by the Colposcopy clinic in 2018, of which 612 were first appointments, 422 new patients attended. The DNA (Did-Not-Attend) rate was 9% amongst first visits and 13% for follow up appointments. Our over-all DNA rate was 11%. 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 – April 2018 our Colposcopy service experienced 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 thus delay 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, assuring them the effectiveness of cervical screening programme.

Combined Cytology and High Risk HPV test continues to be provided by Med Lab Pathology to post treatment women at six months and if negative are discharged for follow up by GP for 1 smear test in 12 month. 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.

Histology services continue to be provided by Mayo University Hospital laboratory. A total of 259 biopsies were preformed of which 108 were excision biopsy (LLETZ treatment) with 151 diagnostic biopsies. 84% of the LLETZ treatment had CIN on the histology which meets Cervical Check standard (>80%).

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 staff continues within the Colposcopy service. In September 2018 our Colposcopist in MUH completed the BSCCP reaccreditation process. 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.

Antenatal / Postnatal Report

Ms Mary Sammon

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.

We have two ward managers and a cohort of nineteen staff members working as part of a large team.

The Antenatal/Postnatal ward provides a 24-hour service where staff 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.

There were 1,484 mothers delivered and 1,506 babies born in 2018 with 569 caesarean sections performed for the year. Older mothers, more complicated pregnancies and increased section rates have all increased care levels needed for 2018.

This impacts on the ward, as these women require a higher level of care in the postnatal period.

All midwifery staff are required to have a high level of evidence-based knowledge and clinical skills to provide a competent, safe, standard of care.

The IMEWS and ISBAR tools are used in the provision of care.

In 2018 all infants receive a high level of assessment and observation in the postnatal period, with specific policies in places for those with individual risk factors i.e.

1. Diabetic mothers
2. Group B Strep.
3. PROM
4. Metabolic Screening.
5. Newborn Screening
6. EWS for at risk babies.
7. Screening for early detection of congenital heart disease in newborn infants.

The safety pause that was introduced continues in 2018 with a daily bedside handover of mother and babies care with involvement of all midwifes.

This safety pause is also used to communicate and highlight any high risk issues and ensure all staff are aware of the plan of care for individual mothers. In 2018 this has helped us to prioritise the safest care for women and families.

In 2018 staff attended various training and education to ensure ongoing safe practice.

Department of Anaesthesia

Dr Ciara Canavan

Overview

In 2018 the Department of Anaesthesia at Mayo University Hospital provided anaesthesia services for 569 patients undergoing Caesarean Section, 42 patients in theatre for instrumental delivery, 265 patients for gynaecology procedures and 432 labour epidurals.

Staff consist of 7 Consultants, 6 Registrars and 6 SHOs. 6 of these NCHDs rotate to MUH from the College of Anaesthetists 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 a weekly High Risk Antenatal Anaesthesia Clinic for all patients meeting OAA/AAGBI criteria for referral antenatally by the Obstetricians or Midwives.

In 2018 1484 mothers gave birth to 1506 babies. Of these 432 (29% of all mothers) had an epidural for labour which is the same percentage as last year. 569 (38%) had a Caesarean section of whom 217 were nulliparous and 352 were multiparous. 274 (48%) were elective and 295(51.8%) were emergencies. (17 Category 1).

Operative Anaesthesia

General anaesthesia was provided for 30 women (5.2% 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, patient request, antepartum haemhorrage, previous spinal surgery. Four patients required spinal anaesthesia for Caesarean section due to failure of epidural top up, seven patients required spinal converted to General Anaesthetic due to inadequate analgesia or distress, five patients required epidural converted to General anaesthesia due to inadequate anaesthesia.

Anaesthesia was also provided for suture of vaginal tear, insertion of Bakri balloon, instrumental delivery, manual removal of placenta, post partum haemorrhage, removal of cervical stitch and examination under anaesthesia.

In total 753 patients received anaesthesia care in the obstetric theatre in 2018 with 247 being outside of normal working hours.

Epidural analgesia was complicated by nine recognised dural punctures (2%), four patients required a blood patch for post dural puncture headache (one post spinal anaesthesia).

Remifentanil PCA guidelines were reviewed and updated in 2016 and the technique was used for one patient who was unsuitable for epidural analgesia in 2018.

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 eight Obstetric patients who require HDU care in the combined HDU/ICU ward. Reasons for admission included post partum haemhorrhage, prolonged anaesthesia during management of post partum haemhorrhage, diabetic ketoacidosis and pre eclampsia.

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 2019

- To continue with our drive to promote "family centred Caesarean section" as the routine approach at MUH and to extend this to partners remaining in recovery.
- The Saolta Epidural policy will be implemented superceding our current policy.
- To formalise the High Risk Antenatal clinic with a dedicated Consultant session allocated.

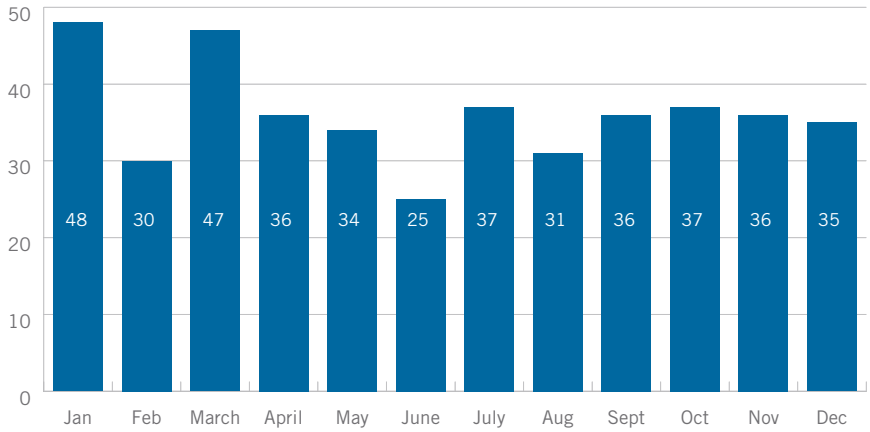
Aims to implement recommendations of National Maternity Strategy

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.

Labour Ward Epidurals (total 432)



Antenatal Education Report

Ms Frances Burke and Ms Maura McKenna

Introduction

The Antenatal Education Service now tailors the education and support of parents in pregnancy in order to meet their needs.

The desired outcome is the safety of mother and baby and the wider family using Maternity services and planning delivery in Mayo University Hospital.

We continue to work with the wider multidisciplinary team and strive to link with team members to improve our services. It is a service that not only provides education but provides supports for families in difficult pregnancies.

The Childbirth Education Service is run by two midwife educators within Mayo University Hospital.

Our partners in this service include ultrasound sonographers, social work / pregnancy counselling, health promotion dental, speech and language therapy, physiotherapy, anaesthetics, obstetrics • Road Safety Authority, Western Region Drug and Alcohol Task Force, Mayo travellers community health workers and the full midwifery team .

Sources of Referrals to Antenatal Classes

- Antenatal Clinic
- Perinatal Unit
- Self-referral
- Consultant referral
- Public Health Nurses
- Medical Social Work
- Teen Parent Support Programme
- Inpatient referral
- Diabetic Clinic

Service Provision

The primary service provision is twice weekly blocks of four classes monthly for first-time parents. With the inclusion of the hypnobirthing service, we now have blended these techniques into all classes to educate parents on useful ways to relax for birth. The two methods of hypnobirthing used in the classes are Marie Mongan and Judith Flood.

Second time parents are welcome to join hypnobirthing sessions and partners are encouraged for all classes.

Other classes provided include:

- Breastfeeding
- Twins
- One-to-one advocacy/ education/ young parents and special time for support sessions.

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.

The education service has maintained links with families attending tertiary units and where they may need special preparation for poor expected outcome in their pregnancy. 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:

- Pregnancy
- Birthing
- The immediate postnatal period
- Feeding
- Baby care
- Demands of parenthood
- Postnatal supports available

Information is also provided to inform parents where to source support and resources on discharge from hospital.

Breastfeeding

We continue to participate in the new national model on infant feeding initiatives. Mayo University Hospital participates in the Baby Friendly Health Initiative

The Education Service runs a standalone breastfeeding antenatal class where parents are helped to prepare for breastfeeding their babies. Attendance for this session has increased over the last few years and it is currently one of our most popular classes.

The Education Service has strong links with the Association of Lactation Consultants

National Breastfeeding Awareness Week 2018 was celebrated with a breast feeding awareness day for transition-year students, similar to 2017.

Information stands were available in the main foyer in the hospital for staff and members of the public. We held a breastfeeding support group in the Community and some of our breastfeeding mothers and babies attended Aras an Uachtarain for Ms. Sabina Higgins' breastfeeding awareness event.

One-to-one breastfeeding support has been given by phone, ward visits, ED 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.

Attendance at Antenatal Classes

- Blended Classes = 609 Women and Partners
- Twins classes = 11 families
- Breastfeeding classes = 185 women
- Special need education for poor outcome = 60 visits
- One-to-one Sessions = 125

Conclusion

This service provides for the needs of all patients and their families using Mayo University Hospital maternity services. It is constantly reviewed and changes to meet patient and service needs.

As always we remain positive and committed to quality and excellence for this service and work closely with the Multidisciplinary Team.

Early Pregnancy Unit

Ms Runagh Burke

Early Pregnancy Statistics for 2018

	Jan		Feb		Mar		Apr		May		June		July		Aug		Sept		Oct		Nov		Dec		Total	
	N	R	N	R	N	R	N	R	N	R	N	R	N	R	N	R	N	R	N	R	N	R	N	R	N	R
Total attendances in the EPU	40	28	45	26	33	29	61	33	41	41	53	41	45	37	59	66	58	46	37	24	53	31	41	20	566	422
Total no. 1	**68**		**71**		**62**		**94**		**82**		**94**		**125**		**104**		**61**		**8**		**61**		**82**		**988**	
Total viable intrauterine pregnancies diagnosed	24		23		23		26		20		24		36		35		22		29		22		24		308	
Total complete miscarriages diagnosed	8		10		11		6		13		18		9		14		6		8		2		12		117	
Total incomplete miscarriages diagnosed	2		1		3		4		7		4		0		1		0		1		3		4		30	
Total missed miscarriages	8		6		6		8		7		7		13		6		3		10		7		11		92	
Medical	3		1		1		3		3		3		6		2		1		2		1		4		30	
Surgical	2		4		1		2		2		2		4		4		2		4		4		6		37	
Conservative	2		1		4		3		2		2		2		1		0		4		2		2		23	
Total ectopic pregnancies diagnosed	0		0		0		1		0		1		2		1		2		1		0		1		9	
Total pregnancies of unknown location diagnosed	3		7		4		8		10		10		8		9		5		4		4		6		78	
Total molar pregnancies diagnosed	0		1		0		0		1		0		1		0		0		0		0		0		3	
Total miscarriage misdiagnosis errors	0		0		0		0		0		0		0		0		0		0		0		0		0	
Total number of written complaints	0		0		0		0		0		0		0		0		0		0		0		0		0	
Total CIS forms submitted in the first trimester	0		0		0		0		0		0		0		0		0		0		0		0		0	
No. of cases reported to CIS	0		0		0		0		0		0		0		0		0		0		0		0		0	
Total no. of pregnancies unknown viability	12		12		5		15		10		17		13		11		7		11		14		15		142	
Total no. of BHCG levels recorded	12		18		17		129		29		35		36		29		19		26		13		21		284	

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

Referral Criteria.

- Abdominal Pain with positive pregnancy test
- PV bleeding
- Previous Miscarriage x 2
- Previous Ectopic Pregnancy
- Previous Molar Pregnancy

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.

Medical Social Work Department Report

Ms Ann Doherty

The Medical Social Work Department of Mayo University Hospital has provided practical and emotional support to the Women & Children's Health Division for the last 17 years. We comprise 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 also have a duty system in operation to cover high priority cases across the hospital.

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 and our referral rates in this area has risen. When a baby in Mayo University Hospital is diagnosed with a very severe foetal abnormality that is going to lead to death of the child 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. When parents feel connected to a strong support system, it is easier to navigate the daily challenges inherent with having such a sad diagnosis.

Bereavement Counselling and psychological support is provided to parents when a baby or child dies either through miscarriage, stillbirth or illness, neonatal death or termination. Bereavement support is also offered in relation to unresolved grief around a previous loss of a baby when a woman or couple present again with a healthy pregnancy.

Our service offers comprehensive assessment of a patient's social, emotional, environmental and support needs and offers support around long term care issues alongside counselling support where there is a diagnosis of serious or chronic illness. Crisis intervention, mediation and counselling is offered for various personal and family difficulties. We refer to and liaise with services and patients linked with drugs services and or mental health services, and we offer support in relation to parenting and/or childcare issues. Our service offers liaison, advocacy and support in relation to accessing various services and we provide basic information regarding social welfare, entitlements, birth registration etc.

In the last year we have noticed that referrals of concealed pregnancy have reduced. A decrease in our teenage pregnancy referrals reflect a national reduction in the number of teenage pregnancies and an increase in the number of women referred who are over the age of 40 and who have conceived through IVF, and who are single. We have noted an increase in referrals to our service of high priority cases that are highly complex in nature with multiple issues with elements of child protection, mental health and with significant other social stressors e.g. addictions. In these we are involved in case conferences, court presentation, and professional workers meetings both in house and in the community and strategy meetings to facilitate safe discharge of our clients. As highlighted earlier there is an increase in referrals for counselling support around foetal anomaly. And a noted increase for women who seek counselling support in relation to their perceived experience of trauma in a previous pregnancy that is having an emotional impact on their current pregnancy.

Within the hospital setting as part of the multidisciplinary teams we play a role in the co-ordination of patient discharge planning, working closely with colleagues on the Women & Children's Wards and in liaising with Community Services, advocating for supports on behalf of our patients. We work closely with the Tusla, Child and Family Agency. We often refer to them to ensure couples with limited supports and experience with children receive follow up through a Family Support Worker or perhaps for parenting skills education. We also link very closely with them when there are concerns about a parent's ability to parent and protect and keep a child safe.

We have seen a rise in the number of women who report domestic violence to us and we are mindful that it can increase in pregnancy. Domestic violence is a very complex issue that affects numerous families and in our work in this area we discuss a plan of safety with women ensuring they are aware of the relevant community supports. Should a woman disclose domestic abuse, our social worker department will respond immediately and work with her to plan for her safety.

Working to enable clients to realise their rights, involves putting services in place to meet rights like the right to education, health care, housing, income and so on. In cases where a person is homeless we liaise closely with Mayo County Council to ensure their basic need of housing is met. We also link with Public Health Nurse and the Adult Mental Health services particularly when a woman has a history of mental health issues e.g. depression, personality disorder for example or a past history of post natal depression. Medical Social workers are 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 and provide support for women with anxiety, low mood, depression in these stages. We meet women of all ages from various socioeconomic and cultural backgrounds, undocumented women and women in direct provision to name but a few and provide practical support, advocacy, advice and liaison to relevant supports in the community.

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. Counselling and practical support is offered when a loss or a bereavement is experienced by a family on the ward.

Three Options Counselling

Within our Medical Social Work Department is a 3 options counselling service offering free counselling to women who find themselves faced with a crisis pregnancy. Post termination counselling support is offered as part of our service. We are a non-directive, non-judgemental service that offers women space to explore all options at any stage of the pregnancy and have support in coming to terms with their changed life circumstances and any decision they make about their pregnancy, whether it is to parent, to place for adoption or to terminate a pregnancy.

Paediatrics

We work as part of the multi-disciplinary 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 to enhance coping skills and participation in care, supporting attachment and bonding with caregivers and children.

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 complete initial assessments where a child protection concern is noted and we consult and liaise with hospital and community colleagues in relation to such cases. With the introduction of Mandatory reporting as part of Children's First, Medical Social Workers provide consultations for all hospital staff on concerns regarding child protection. We can assist staff members complete referrals to Tusla for further assessment.

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.

We attend the Saolta Children First Implementation Committee meetings, as well as the hospital's committee on Children First. We are in the vanguard of promoting the E-module training for staff on Children First and preparing for the hospital's obligation under the Children First Act 2015.

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 has enhanced collaboration between CNME Mayo Roscommon & MUH in the development and provision of inter-professional education programmes to support professionals and as such we have been involved in the provision of training on:

- Domestic and Sexual Abuse Disclosure
- Bereavement and Loss in early Pregnancy
- We have also participated in the development of a video for traveller health groups that informs of the support our service provides alongside our colleagues in the hospital and community.

Committees

The Medical Social Work Department was a founder member of the committee that has co-ordinated an Ecuminical Service of Remembrance for families who have suffered a loss through miscarriage or stillbirth, termination or at any age since 2002 and our department continues to be actively involved each year in its co-ordination. Approximately 300 people attend this service each year.

The Medical Social Worker for Women and children was the chairperson of the Committee for the role out of the National Standards for Bereavement Care following a Perinatal Loss in Mayo University Hospital in 2018. She formed subgroups of professionals from this main group to explore the development bereavement booklets relative to the type of loss experienced by parents ie early loss in pregnancy, miscarriage, stillbirth, fatal foetal abnormality, a late stage pregnancy loss, the loss of a baby post delivery and the death of a child. Key stake holder groups were liaised with and one to one interviews with parents and professionals were held. Focus groups were facilitated with bereaved parents to ensure the quality of the information produced held real meaning for parents who were bereaved. The aim was to provide quality literature that would act as a practical guide to parents and inform them of counselling supports, addressing the needs of parents as identified by bereaved parents. Our group has enhanced collaboration between CNME Mayo Roscommon & MUH in the development and provision of inter-professional education programmes to support professionals in the provision of bereavement care. Funding was applied for the booklets development and received from the Irish Hospice Foundation and Mayo University Hospital.

The launch of the booklets took place in Mayo University Hospital on 13th November 2018. They were launched by DR. Brid Carroll ICBN(Irish Childhood Bereavement Network) and Alice Anderson IFH(Irish Hospice Foundation). The launch was a very successful event attended by all the

parents involved in their development and staff from the wider hospital community. Staff and family voiced that they valued the opportunity to come together to showcase their work to the wider community. The launch was part of a Mayo University Hospital event for Irish Childhood Bereavement Week. The launch encompassed an education day provided by Centre of Nursing and Midwifery Education Mayo/Roscommon, called 'Childhood Bereavement and Loss, Empowering Families and Healthcare Professionals.

We presented a poster on their development at:

- The national Forum for Bereavement Care following Pregnancy Loss 2018.
- The Child and Family Nursing Conference held on the 10th April 2018 in University Hospital Cork.
- The End of Life Care Hospice Friendly Hospital Awareness day in Mayo University Hospital in May 2018.
- The Mayo University Hospital 4th Quality and Patient Safety Symposium, Commitment to Excellence on 11th October 2018.
- The launch of the booklets on 13th November 2018, launched by DR. Brid Carroll ICBN(Irish Childhood Bereavement Network) and Alice Anderson IFH(Irish Hospice Foundation).
- The IFH National Acute Network Meeting in Dublin on 6th November 2018.
- The Patient Engagement Education Day: Person Centredness and Patient Engagemment in MUH on 20th Nov., 2018, commended by Eleanor Riviore, International Independent Patient Engagement and Healthcare Advisor ,Canada.

The booklets have been shared with various hospitals and professionals following requests.

Other developments from this group has been the use of the National Bereavement Symbol in the Maternity Departments and the Paediatric Ward and bereavement Study days were developed in the Centre of Nursing and Midwifery Education Mayo/ Roscommon, for multi disciplinary teams to address educational gaps.

The Medical Social Worker is also a member of the End of Life, Hospice Friendly Hospitals Committee in Mayo University Hospital

The Medical Social Worker for Women and Children was also the Chairperson for the Committee on the Development of Hospital Policy around Domestic Violence in 2018.

Conclusion

As always we would like to acknowledge the support from our colleagues in Obstetrics & Gynaecology, Maternity, Labour, Special Care Baby Unit, the Ante natal department, Ante natal education, Chaplaincy and Paediatrics. 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.

Maternity Day Assessment Ward

Ms Marcella Gavin

The maternity day assessment unit (MDAU) is a service that provides care to pregnant women up to 42 days post natal. Women are asked to attend for additional monitoring and assessment to ensure optimal care. Some women may attend the unit just once, while other may attend regularly during their pregnancy.

The aim of the unit is to reduce the likelihood of admission to hospital, but sometimes this may still be necessary. Referrals are accepted from women themselves, General practitioners (GP's), Public Health Nurses (PHN), Peri Natal Unit, Antenatal Clinic (ANC), Obstetrians by phone or presentation at the unit. A visit to the unit often takes up to four hours.

The MDAU is a four bedded unit located in room 7 on the maternity ward. It is a Monday to Thursday service 09:00 to 17:00 hrs and Friday 09:00- 16:00hrs. Out of hours pregnant woment attend delivery suite for assessment.

Women are referred and seen for many reasons including but not limited to the assessment for:

Hypertensive disorders of pregnancy

- Mild/Moderate Hypertension
- Pre Eclampsia
- Chronic Hypertension controlled on medication

Fetal conditions and Fetal monitoring

- Reduced fetal movements
- Fetal growth restriction
- Multiple pregnancy fetal assessment as clinically indicated
- Administration of Corticosteroids
- Breech presentation/Unstable lie
- External Cephalic Version (ECV)
- Cardiotocograph (CTG) tracing
- Others as clinically indicated

Maternal complications

- Obstetric Cholestasis
- Hyperemesis- for fluids/vitamins replacement and reviews as clinically indicated
- Venous Thromboembolism assessment and review
- Feeling Unwell
- Others as clinically indicated

Additional

- Spontaneous Rupture of Membranes (SROM)
- Pre Operative Assessment
- Antenatal Anti D
- Routine tests as indicated in Pregnancy
- Iron Infusions

Postnatal review

- Postnatal infections- LSCS Wound/ Perineal
- Mastitis
- Feeling un well
- SEPSIS
- Blood pressure monitoring

January	7	2/7 service in month
February	4	1/7 service in month
March	5	2/7 service in month
April	77	
May	112	
June	90	
July	120	
August	141	
September	120	
October	113	
November	148	
December	146	
Total number 2018	**1083**	

Obstetric Ultrasound Report

Ms Maura McKenna

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

1. Early Pregnancy Unit

- Mon-Thursday 8.30-10.30
- Fri- 8.30 – 12.30
- EPU cares for women in pregnancy up to 12 weeks gestation.

2. Perinatal Unit

- Mon-Wednesday 08.30-18.00
- Thurs 08.30-15.00
- 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.

Current Staff

- Siobhan Ryan CMS in Obstetric Ultrasound working 32 hours.
- Aisling Gill CMS in Obstetric Ultrasound working 20 hours.
- Maura Mc Kenna CMM2 Midwife Sonographer working 20 hours.
- Jenny Concannon Midwife Sonographer working 20 hours
- Dr. Israt working 3 hours

The Sonographer's Role includes:

- **Reporting and counselling**
  This takes considerable time especially when breaking bad news or telling parents their baby has an abnormality.
  It also has to take into account the many phone calls, queries and dealing with people calling into the department.
- **Planning care and follow-up**
  It also includes the time making appointments, making plans for the care of diabetic mothers, mothers expecting twins and mothers with underlying medical conditions. It is hoped to introduce an electronic appointments system to improve time management on clerical duties
- **Training and Supervising**
  It also includes the many hours of training, teaching and supervising ultrasound students. Elaine McGrath completed the Certificate Training Programme in UCD in 2018.
- **Developing and Creating**
  Patient information leaflet and consent form for second trimester Ultrasound scan have been developed and will go for print in summer 2019.

Equipment

All obstetric ultrasound examinations performed in the Department are done on Volusson E 8 Machines.

Reports are generated through the Viewpoint reporting system in Early Pregnancy and in 2018 the Viewpoint reporting system was commenced in perinatal, now all obstetric ultrasounds are reported on viewpoint.

Decontamination of semi invasive transducers within EPU and Perinatal ultrasound was commenced

The Tristel Trio Wipes System provides a full decontamination cycle, including traceability, in a matter of minutes.

This helps to increase turnaround of instruments and thus allows for increased numbers of patient assessed. It has been independently tested and complies with testing requirements set by European Norms. The Tristel Sporicidal Wipe destroys organisms of concern such as bacterial spores, mycobacteria, viruses, fungi and bacteria. Organisms tested include:

- Polyomavirus SV40 (surrogate of Human Papilloma Virus)
- Hepatitis B virus
- HIV
- Staphylococcus aureus
- Candida albicans
- Herpes simplex virus
- Hepatitis C virus
- Mycobacterium terrae (surrogate for M. tuberculosis)
- Vancomycin-resistant Enterococcus faecium

Funding for the Trophon System was approved in 2018

Figures for 2018

- 988 scans performed in the Early Pregnancy Unit.
- 4112 scans performed in the Perinatal Unit
- 743 scans performed in Ballina.
- There were several scans approx. 20 to emergency calls in Labour Ward, Maternity, A &E and Gynae ward
- In total 5863 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.

All ladies who present for booking are offered a dating scan before 14 weeks gestation and a second scan is offered before 22weeks

In 2018 - 1460 mothers had booking scan.

There were approx. 1464 routine second trimester ultrasound examinations performed.

52 were performed by Dr. Ni Bhuinneáin and her team

All women are given an appointment at booking for a second trimester routine ultrasound.

In 2018 referrals for further ultrasound scanning came from

- Antenatal Clinics ,
- Maternity ward ,
- Labour ward
- Maternity Day Unit...

Increased Surveillance was also offered to women who had:

- Existing medical conditions e.g. cardiac, epilepsy, thyroid condition,
- BMI over 35 ,
- Advanced maternal age,
- Previous C section
- Past history of pre-term delivery,
- Previous small baby
- Intrauterine death

220 mothers attended the Thursday morning Endocrine Antenatal Clinic of which 155 was Diabetics.

Surveillance for mothers with Diabetes is practised as per the DIP study and these women are offered scans at 12weeks, 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.

In 2018 there were 155 women monitored under these Diabetic criteria – these included 148. Mothers who had gestational diabetes, 3 mothers who had type 1 diabetes and 4 mothers who had type 2 Diabetes.

Surveillance for routine multiple pregnancy (usually Twins) pregnancy is as follows:

- 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 2018 there were 22 sets of twins delivered at MUH, not including 1 late miscarriages

- 22 sets of DCDA
- 01 set of MCDA
- 1 set of MCDA Twins were transferred out in the third trimester

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 2018 we referred 75 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

October 2018 the BMUS study day at UCD was attended by all five midwife sonographers.

Each Staff member within both EPU and the Perinatal Unit has continued to maintain their professional competencies throughout 2018 by attending mandatory study and local study days.

Antenatal and Gynaecology Outpatients

Ms Melanie Brady

Antenatal clinics

The maternity outpatients department continues to provide a safe and welcoming service to the women who attend. In 2018 we had a total of 5941 visits to our service.

The maternity antenatal clinic starts with a 12 week visit where the woman has a one to one consultation with the midwife. All aspects of her pregnancy are discussed and advice given she will also have the booking scan at the visit. Depending on the complexity or normality of pregnancy the midwife will outline her plan of care to her on this visit. If she needs to be referred earlier to see the consultant this is organised.

Our clinics run Monday – Thursday with one outreach clinic in Ballina on Tuesday. Our aim is to introduce more outreach services and midwifery led services but this would require more midwifery staff to facilitate the changes required. At our consultant led clinics we have the assisted model of care where the midwives review suitable women , currently we are moving to the supported model of care where the midwives will provide the antenatal care to the low risk women.

We provide a diabetic antenatal clinic every Thursday morning and this consists of Midwives, Diabetic ANP , Endocrinologist and Obstetric Consultant. Women with a positive GTT or known diabetic are seen every two weeks and have regular ultrasound surveillance. There are an increasing number of women attending this clinic and in 2018 there were 2400 visits from women with diabetes related to pregnancy seen.

Gynaecology Outpatient Clinics

Three gynaecology clinics area held weekly in MUH and one outreach clinic in Ballina..

In 2018 we facilitated a total number 2252 attending the gynaecology out patients clinic these included cytology clinic, colposcopy and general gynaecology clinics.

All referral letters are triaged by a consultant and prioritised into urgent, semi urgent and routine. Our gynaecology service is supported by our ambulatory gynaecology service and at triage those pathways of care are allocated as appropriate.

We have worked hard to achieve our level of new and review patient ratio as you see from our figures below,

- New Patients 860.
- Review Patients 1383.
- DNA Patients:406.

Ambulatory Gynaecological Unit Report

Ms Runagh Burke

Introduction

The unit continues to be the only operational ambulatory gynae service of its kind in the Saolta Group and is amongst the leading units in the country. The unit consists of the Early Pregnancy Service each weekday morning and also the Colposcopy Service.

Last year was a particularly difficult time for women's health in Ireland. Women understandably were concerned about their health especially in relation to their gynaecological health. Women attending clinics in the majority of cases just wanted to know that they were safe. Our ambulatory gynae clinics in most instances can give this reassurance to women on the same day that they attend. There was a decrease of 43% in 'DNA' appointments during the Summer months of 2018 in comparison to the Spring months. This may have been as a result of the cervical check controversy and women wanting to attend for their appointments.

The One Stop Clinic

Outpatient or 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 four consultants and their teams Monday- Thursday. There are currently six 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 6-10 patients are booked for each ambulatory gynae session.

Reasons for referral to the unit include:

- Heavy or irregular periods
- Investigation of Fibroids or polyps
- Postmenopausal bleeding
- Investigation of abdominal pain
- Intermenstrual bleeding
- 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, morcellation of endometrial fibroids and polyps and also endometrial ablation. 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 also widened with the last year with an increased % of women attending and being referred from Co. Galway and Co.Roscommon. At total of 306 women were seen in the one weekly Gynae OPD clinic. Many of these appointments will be see and treat cases also thereby woman attending this clinic in effect are treated as per an ambulatory gynae session.

A total of 1152 women were seen in ambulatory gynae clinics last year, being made up of new and review appointments. Off these women that attended the clinic a total of;

- 1016 Transvaginal Scans were performed
- 107 Hysteroscopies
- 17 Operative Hysteroscopies
- 383 Biopsies (including cervical polypectomies, endometrial and labial)
- 190 Mirena insertions
- 120 Mirena removals

New patients comprised of 902 and review patients were 250 (these figures are only the women attending the Ambulatory Gynae Clinic sessions

306 gynaecology outpatients seen also with biopsies, TVS's and IUS's inserted and/or removed.

988 women were seen in the Early Peregnancy Unit

854 Colposcopy patients seen

Total number of checked into Ambulatory Gynaecolgy Unit was 3,330 women in 2018

Operative lists in AGU 2018

The Truclear moscillator provides a minimally invasive option for women suffering from uterine bleeding due to abnormalities such as polyps and fibroids.. 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. Tissue can be removed for analysis. An operative hysteroscope is used to introduce the morcellating device into the uterus . Twelve of these procedures were carried out in the unit during 2018.

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. Four of these were carried out in 2018.

These are usually facilitated on one operative session per month. Total morcellating time of a polyp may take as little as 11 secs. In general a woman attending for the procedure will have everything completed in two hours, which is significantly less time than attending for a traditional day case procedure.

Challenges for the service

- The mix of the three services is a challenge at times to waiting times for the women attending the unit as certain clinics may 'run' over their designated times.
- Waiting list number are increasing and there will be a need for an extra clinical room and more clinic sessions for ambulatory gynae and also colposcopy. Recognising the need for prompt referral of post menopausal bleeding referrals an extra clinic session has commenced for these in the second half of the year.
- There is no direct clinical nursing manager assigned to the unit and also contract cleaning outside of clinics times has not been sanctioned for the unit
- The main challenge for the service at present is in obtaining extra clerical cover for the increased numbers of women attending the unit as whole.
- DNA rate is 19%. It is hoped that the increase in WTE of clerical cover will enable appointments to be phoned and confirmed in advance.

Conclusion

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.

Women's Health & Paediatric Physiotherapy Report

Ms Ogechi Nsoedo

Women's Health Physiotherapy Service

Women's Health physiotherapy in Co. Mayo incorporates various services for women with both obstetrics and urogynaecological conditions. It is a growing service and statistics has revealed an increased demand for women's health services in the County. A total number of 372 referrals were received for outpatient care in 2018. The service is currently delivered by 0.4 WTE senior physiotherapist and 0.5 staff physiotherapist.

Towards the latter half of 2018, there was a rise in waiting list times due to recruitment delays. However, in the last two months of the year 2018, following successful recruitment, we commenced our group education classes for women with various conditions.

The group classes continue to remain a successful initiative to reduce waiting lists. These classes educate and inform women on effective strategies/tips to manage their conditions independently. In total, 263 new patients were seen and 1,042 interventions were delivered by the Physiotherapy Department in Mayo University Hospital.

The new post-natal education programme in the local Primary Care Centre has been of great benefit to women. Feedback from mothers remains positive. Continuous efforts are being made to improve attendance of post- natal mothers within the County; as it still remains that approximately only 10% of mothers attending these classes. Another strategy our team are hoping to implement; is to provide the post- natal class session in strategic geographical healthcare centres to improve accessibility for post – natal mothers. This would require more staffing.

The physiotherapy service was unable to deliver on the antenatal education programme throughout 2018 (due to limited staff) and this is an area for development for the next year.

Paediatric Physiotherapy Service

The physiotherapy paediatric service in Mayo University Hospital has room for growth. It is currently being delivered by 0.6 WTE staff physiotherapist.

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 and public health nurses.
- Paediatric Normal Variance referrals across Co. Mayo.
- Physiotherapy referrals for all paediatric musculoskeletal and orthopaedic patients 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 877 referrals received for outpatient paediatric physiotherapy in 2018 with a total of 1,542 interventions.

Reflecting on the potential for growth of this service; the physiotherapy department in Mayo University Hospital has applied for a senior paediatric physiotherapist. This application was essential to meet the minimum quality and safety standards under the HIQA 2012 safer & better healthcare as well as the national standard for Neonatal services in Ireland (2015).

The senior physiotherapist would provide governance and leadership in planning and re-structuring of physiotherapy paediatric service in the County.

New Patients Seen Physiotherapy Treatments

2018	New Patients Seen	Physiotherapy Treatments
In-patients paediatrics	136	400
Out-patients paediatrics	398	786
Cystic Fibroses clinics	47	60
Asthma Clinics	296	296

Special Care Baby Unit Report

Ms Irene McNicholas and Ms Joan Falsey

Infants admitted by gestational age group	
Gestation (weeks)	Total Admissions 276
Less than 32	16
32 - 36	59
37 weeks and over	201
TOTAL	**276**

Total admissions from source	
Theatre	74
Delivery Suite	65
Maternity Unit	115
Other hospital	16
Paediatric Ward	0
Social Admission	4
BBA	2
TOTAL	**276**

Birthweight	
Less than 1500g	6
1501 – 2000g	16
2001g – 2500g	36
Over 2500g	218
TOTAL	**276**

Reasons for Admission	
Prematurity	56
Respiratory	75
Infection related	34
Gastrointestinal	5
Hypoglycaemia	38
Neurological	2 Passive cooling
Cyanotic Episodes	1
Low birth weight/IUGR	9
Infant of Insulin dependent diabetic	0
Congenital Abnormalities	7
From paediatric ward	0
Hypothermia	2
Maternal HIV infection	0
Cardiac	2
Social Reasons	4
Confirmed bactermia on blood cultures	0
Jaundice for phototherapy	17
Poor feeding	8
Drug dependent mother	1
Observation post instrumental delivery	4
Meconium Aspiration	4
Hyponutraemia	2
Scalp trauma	1
Anaemia	1
Drug error for observation(Konakion)	1
Immunoglobulin therapy	1
Post surgery	1
TOTAL	**276**

Very Low Birthweight 400g – 1500g	
Born in MUH & kept in MUH	0
Born in MUH & transferred to Regional Centre	4
Born in Regional centre & transferred back to MUH	4
Born in MUH and transferred back from regional unit	3
TOTAL	**11**

Gestational Age of Very Low Birthweight admitted to SCBU	
22 -24+6 WEEKS	0
25 – 26+6 WEEKS	0
27 – 28+6 WEEKS	2
29 – 31+6 WEEKS	9
32 WEEKS AND OVER	0
TOTAL	**11**

Birthweight of Very Low Birthweight admitted to SCBU	
Less than 501g	0
501 – 750g	0
751 – 1000g	0
1001 – 1250g	7
1251 – 2500g	4
TOTAL	**11**

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	0
751 – 1000g	0
1001 – 1250g	1
1251 – 1500g	3
TOTAL	**4**

Neonatal Deaths = 1 In Dublin Coombe 6/10/18 at 3 days of age, transferred to Coombe on day 1

Clinical Demographics of very low birthweight infants	
Male Gender	3
Female	5
Born in MGH	4
C/S	7
Antenatal Steroids	7
Multiple Gestation	1 set
TOTAL	**8**

Neonatal Transfers to Regional Centres	
Transfers by National Neonatal Transport Team	11
Transfers by SCBU staff	6
TOTAL	**17**

Neonatal Transfers from Regional Centres	
Transfers by National Neonatal Transport Team	0
Transfers by SCBU staff	17
TOTAL	**17**

ROP Screening	
Eye Checks in UCHG	6
Eye Checks in Dublin	2
Eye Checks in Sligo	1
TOTAL	**9**

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

List of CONGENITAL ABNORMALITIES = 7
Trisomy 21 x 3
Exomphalos x 1
Cleft Lip and palate x2
Ventriculomegaly x 1

Number of babies delivered in MUH IN 2018
Percentage of infants delivered that were admitted to SCBU – 18.2%

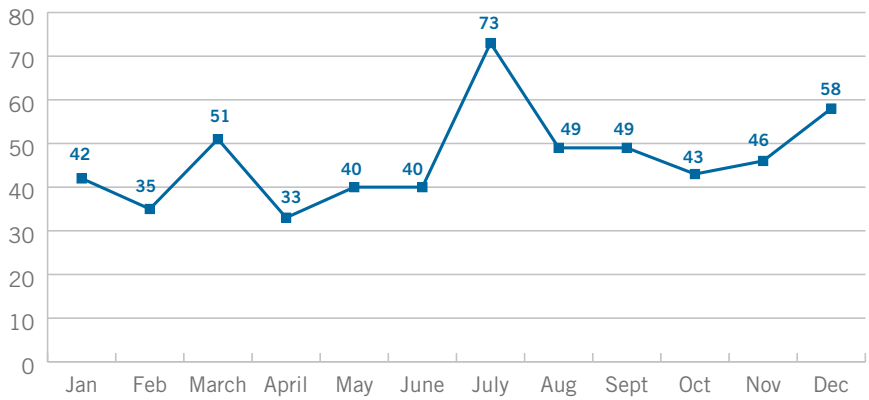
Quality & Patient Safety Department

Ms Grainne Guiry Lynskey

Women's Health and Children Directorate meetings are held on a monthly basis in Mayo University Hospital. There is a set agenda for review and discussions at these meetings to include Patient Experience and Midwifery Standards, 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.

Incident report trends are disseminated to all relevant stakeholders.

Women's Health and Children Directorate – January 2018 to 31st December 2018



Portiuncula University Hospital

Ms Siobhan Canny, Ms Anne Regan and Ms Priscilla Neilan

Introduction

The Women and Children's Clinical Directorate team in Portiuncula is please to present an overview of the clinical activity and services provided on the site. Throughout 2018 we have worked well as a team to progress to number of quality improvements within the department these include, the appointment of a bereavement support midwife this year this appointment has been central to developing pathways of care for women and their families who are experiencing loss in pregnancy. The refurbishment of the Maternity Ultrasound department, which included putting in an additional scan room with a high-end USS machine. We would like to take this opportunity to thank the staff working within the department and alongside us for their continued hard work dedication and support.

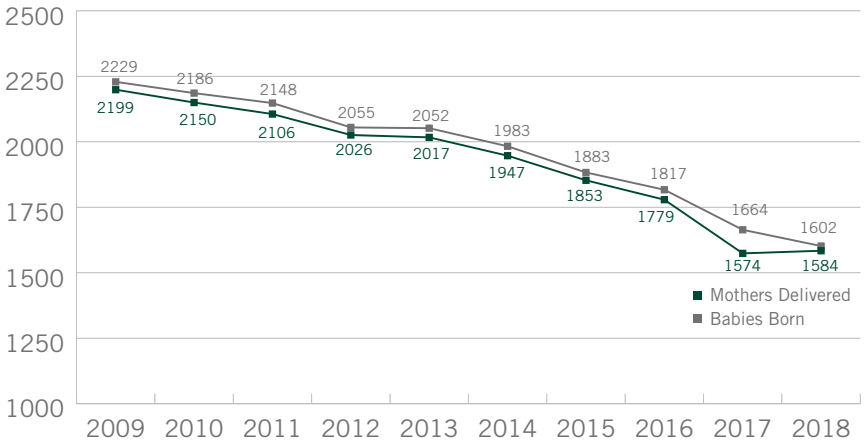
Clinical activity

n 2018 we saw a reduction of births from 2017 of 4.8% with 1602 babies born to 1584 mothers, there has been a drop in births year on year from 2009. This trend is in keeping with the national birth trends. There was a slight increase in the number of primigravida represented in the 2018 numbers with an increase of 20 births in the year. When reviewing where women who deliver in Portiuncula live we note that over 40% of women who deliver in our unit live outside of the geographical region of the Saolta hospital group.

The incidence of multiple births was 18, which is consistent with last year but interestingly this is half of what it had been in 2008. The rate of induction is unchanged from 2017. The rate of 3rd and 4th degree tears were unchanged as is the rate of episiotomy decrease observed in the episiotomy rate from 32.2% to 30.1%. at 30.1% when review the rate of episiotomy over a 10 year period a notable rise in episiotomies of around 10%, this requires further exploration. In 2018 there was a rise in the number of babies born before arrival to the hospital with 9 babies in total in the year compared with 5 babies in 2017, while the number remains low in comparison to the overall births the rise in incidence is notable.

	Primigravida	Multigravida	Total
Total Number of Mothers	545	1039	1584
Total Number of Babies	551	1051	1602
>24 weeks or >/= 500g			

Number of Mothers and Babies over the last 10 years



The mode of delivery for the majority is normal vaginal delivery rate with a rate of 48.3% with the caesarean section rate at 37% a slight rise from 2017. Instrumental delivery rates remain consistent with previous years. Our induction rate decreased by 1.4%. We note the mothers are of increasing age, with 10.8% of mothers now being over 40 years of age, the total number of mother between 35 and 39 is now the highest age group at 34.3%.

The rate of primary post-partum haemorrhage of over 1000mls has risen from 2.9% to 7.3%, this rise is attributed to the rise in the rates of caesarean section and in particular repeat caesarean section.

There was a significant reduction in the rate of women who had a vaginal birth following 1 previous caesarean section with 29 women achieving a VBAC in 2018 compared with 59 in 2017. The gestational age and birth weight are unchanged except for a slight reduction in the numbers of births born weighing between 4.5 and 4.99 kg. The perinatal mortality rate was unchanged from previous years.

Academic Achievements

Supporting Perinatal mental health module:

- 3 midwives commenced this course in UL

Clinical Supervision Supporting continuing professional development:

- 2 midwives and 1 CMM attended this course and were supported in the clinical setting.

Professional Certificate Examination of the Newborn:

- 1 CMM completed this course and 1 CPC commenced this course and were supported by the Paediatric Consultant team.

Neonatal Resuscitation Provider Trainer course:

- 1 CMM and 1midwife commenced this course.

	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Number of Mothers	2199	2150	2106	2026	2017	1946	1853	1779	1644	1584
Number of Babies	2229	2186	2148	2055	2052	1982	1883	1817	1664	1602

Statistical Summary

Obstetric Outcomes (Mothers)	Primigravida	%	Multigravida	%	Total	%
Spontaneous Onset	545		1039		1584	
Induction of Labour	183	33.6%	234	22.5%	417	26.3%
Augmentation	26	4.8%	25	2.4%	51	3.2%
No Analgesia	13	2.4%	64	6.2%	77	4.9%
Epidural Rate	336	61.7%	392	37.7%	728	46.0%
Episiotomy	215	39.4%	124	11.9%	339	21.4%
Caesarean Section	223	40.9%	357	34.4%	580	36.6%
Spontaneous Vaginal Delivery	154	28.3%	616	59.3%	770	48.6%
Forceps Delivery	18	3.3%	3	0.3%	21	1.3%
Ventouse Delivery	150	27.5%	63	6.1%	213	13.4%
Breech Delivery	2	0.4%	4	0.4%	6	0.4%

Obstetric Outcomes (Babies)	Primigravida	%	Multigravida	%	Total	%
Spontaneous Vaginal Delivery	154	27.9%	619	58.9%	773	48.3%
Forceps Delivery	18	3.3%	3	0.3%	21	1.3%
Ventouse Delivery	150	27.2%	63	6.0%	213	13.3%
Breech Delivery (Singleton)	0	0.0%	0	0.0%	0	0.0%
Breech Delivery (1st Twin)	0	0.0%	0	0.0%	0	0.0%
Breech Delivery (2nd Twin)	0	0.0%	1	0.1%	1	0.1%
Caesarean Section (Babies)	229	41.6%	365	34.7%	594	37.1%
Total	**551**	**100.0%**	**1051**	**100.0%**	**1602**	**100.0%**

Multiple Pregnancies	Primigravida	%	Multigravida	%	Total
Twins	6	1.1%	13	1.3%	19

Multiple Pregnancies by year	2009	2010	2011	2012	2013	2014	2015	2016	2017	2017
Twins	30	36	42	29	35	36	30	38	19	18

Perinatal Deaths	Primigravida	Multigravida	Total	%
Stillbirths	6	4	10	0.62%
Early Neonatal Deaths	0	0	0	0.00%

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

Parity	Number	%
Para 0	545	34.4%
Para 1	541	34.2%
Para 2	314	19.8%
Para 3	124	7.8%
Para 4	41	2.6%
Para 5	12	0.8%
Para 6	5	0.3%
Para 7	1	0.1%
Para 8	1	0.1%
Para 9	0	0.0%
Para 10	0	0.0%
Total	**1584**	**100.0%**

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

Age	Primigravida	%	Multigravida	%	Total	%
<15 years	0	0.0%	0	0.0%	0	0.0%
15-19 years	18	3.3%	0	0.0%	18	1.1%
20-24 years	62	11.4%	36	3.5%	98	6.2%
25-29 years	116	21.3%	131	12.6%	247	15.6%
30-34 years	190	34.9%	317	30.5%	507	32.0%
35-39 years	120	22.0%	423	40.7%	543	34.3%
>40 years	39	7.2%	132	12.7%	171	10.8%
Total	**545**	**100.0%**	**1039**	**100.0%**	**1584**	**100.0%**

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

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

Gestation at Delivery	Primigravida	%	Multigravida	%	Total	%
<24 weeks		0.0%	1	0.1%	1	0.1%
24-27 weeks		0.0%	3	0.3%	3	0.2%
28-31 weeks	1	0.2%	3	0.3%	4	0.3%
32-35 weeks	35	6.4%	49	4.7%	84	5.3%
36-39 weeks	376	69.0%	843	81.1%	1219	77.0%
40-41 weeks	133	24.4%	140	13.5%	273	17.2%
>42 weeks	0	0.0%	0	0.0%	0	0.0%
Total	**545**	**100.0%**	**1039**	**100.0%**	**1584**	**100.0%**

Gestation at Delivery	2016	2017	2018
<24 weeks	2	0	1
24-27 weeks	1	1	3
28-31 weeks	5	3	4
32-35 weeks	81	73	84
36-39 weeks	1348	1201	1219
40-41 weeks	342	366	273
>42 weeks	0	0	0
Total	**1779**	**1644**	**1584**

Birth Weights	Primigravida	%	Multigravida	%	Total	%
<1000g	1	0.2%	2	0.2%	3	0.2%
1000 - 1499g	1	0.2%	3	0.3%	4	0.2%
1500 - 1999g	5	0.9%	11	1.0%	16	1.0%
2000 - 2999g	101	18.3%	149	14.2%	250	15.6%
3000 - 3999g	378	68.6%	689	65.6%	1067	66.6%
4000 - 4499g	57	10.3%	163	15.5%	220	13.7%
4500 - 4999g	7	1.3%	30	2.9%	37	2.3%
5000 - 5499g	1	0.2%	4	0.4%	5	0.3%
Total Number of Babies	**551**	**100.0%**	**1051**	**100.0%**	**1602**	**100.0%**

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

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%

Perineal Trauma	Primigravida	%	Multigravida	%	Total	%
Number of vaginal deliveries	322		682		1004	
Intact	139	43.2%	220	32.3%	359	35.8%
Episiotomy	211	65.5%	91	13.3%	302	30.1%
2nd Degree Tear	74	23.0%	241	35.3%	315	31.4%
1st Degree Tear	21	6.5%	113	16.6%	134	13.3%
3rd Degree Tear	8	2.5%	7	1.0%	15	1.5%
Total	**453**		**672**		**1125**	

Incidence of Episiotomy	Primigravida	Multigravida	Total	%
2015	246	104	350	29.8%
2016	195	120	315	28.0%
2017	215	124	339	32.2%
2018	211	91	302	29.9%

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%

3rd Stage Problems	Primigravida	%	Multigravida	%	Total	%
Primary PPH (1000ml)		0.0%		0.0%	115	7.3%
Manual Removal of Placenta	6	1.1%	6	0.6%	12	0.8%

	Primigravida	%	Multigravida	%	Total	%
Shoulder Dystocia	0	0.0%	3	0.3%	3	0.2%

Robson Groups	n-CS	n-Women	%
Group 1 - nullip singleton cephalic term spont labour	51	252	20.2%
Group 2 - nullip singleton cephalic term induced or pre-labour CS	121	225	53.8%
Group 3 - multip singleton cephalic term spont labour	12	434	2.8%
Group 4 - multip singleton cephalic term induced or pre-labour CS	30	204	14.7%
Group 5 - previous CS singleton cephalic term	259	314	82.5%
Group 6 - all nulliparous breeches	39	41	95.1%
Group 7- all multiparous breeches	22	29	75.9%
Group 8 - all multiple pregnancies	14	18	77.8%
Group 9 - all abnormal lies	3	3	100.0%
Group 10 - all preterm singleton cephalic	29	64	45.3%
TOTAL	**580**	**1584**	

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

Breastfeeding Report

Ms Irene Mulryan

2018 saw an increase in our breastfeeding initiation rate from 61.8% to 63.33% (1.5%), thanks to the dedication of all the staff who work in and with the Maternity Services in Portiuncula. The rate of exclusive breastfeeding from birth to discharge decreased from 42.5% to 39% but there was an increase of 1.3% in the rate of any breastfeeding on discharge from the previous year. The skin to skin rate at birth is similar to 2018 at 80.7%.

One midwife completed the International Board-Certified Lactation Consultants exam and is registered as an International Board Certified Lactation Consultant.

During National Breastfeeding Week 2018 (1st – 7th October), we celebrated in Portiuncula University Hospital (PUH) with a coffee morning. Mothers, pregnant women and Clinical staff attended to mark the occasion and help spread the message that 'Every Breastfeed makes a difference'

Irene Mulryan commenced the position as CMM2 in Breastfeeding (24 hours/ week) in October 2018.

This is a pivotal role in Portiuncula University Hospital (PUH) in protecting, promoting and supporting breastfeeding through:

- Leadership, advocacy, and professional development, in the lactation field.
- Facilitating professional Breastfeeding study days to the clinical staff in Portiuncula and Public Health Nurses in the community.
- Supporting clinical staff in providing evidence based care to mothers on preventing, recognising and solving breastfeeding challenges.
- Focusing on the needs and concerns of the breastfeeding mother and baby.
- Providing telephone support to breastfeeding mothers in the community
- Outpatient referrals from community supports, i.e. GP, Public Health Nurse and Voluntary groups
- Facilitating a two hour 'Antenatal Breastfeeding Workshop' (option of a morning or an evening workshop) twice a month for antenatal mothers and their partners.
- Providing a drop in postnatal breastfeeding support group; twice a month in the Ballinasloe Health centre and follow up appointments in the hospital if required.

Gestational Diabetic Outcomes Report

Dr. Marie Christine De Tavernier and Ms Priscilla Neilan

The Diabetic Clinic is held weekly on Tuesday morning. 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. 132 Women were recorded as having Gestational Diabetes in their pregnancy at the time of delivery, data on those women can be found below.

Onset of Labour	N	%
S.O.L	31	23.48%
I.O.L	58	43.94%
Emer C/S	4	3.04%
Elec C/S	39	29.54%
Total	**132**	**100%**

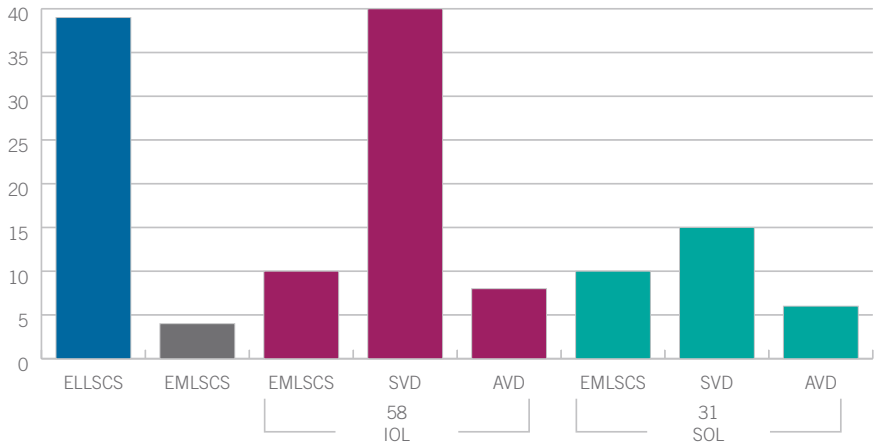
Gestation at Delivery	N	%
28-29+6/40 weeks	1	0.75%
30-31+6/40 weeks	0	0.00%
32-34+5/40 weeks	1	0.75%
35-36+6/40 weeks	7	5.32%
37-38+6/40 weeks	47	35.61%
39-39+6/40 weeks	64	48.48%
40-42/40 weeks	12	9.09%
Total	**132**	**100.00%**

Admission to SCBU	N	%
Yes	12	9.10%
No	120	90.90%
Total	**132**	**100.00%**

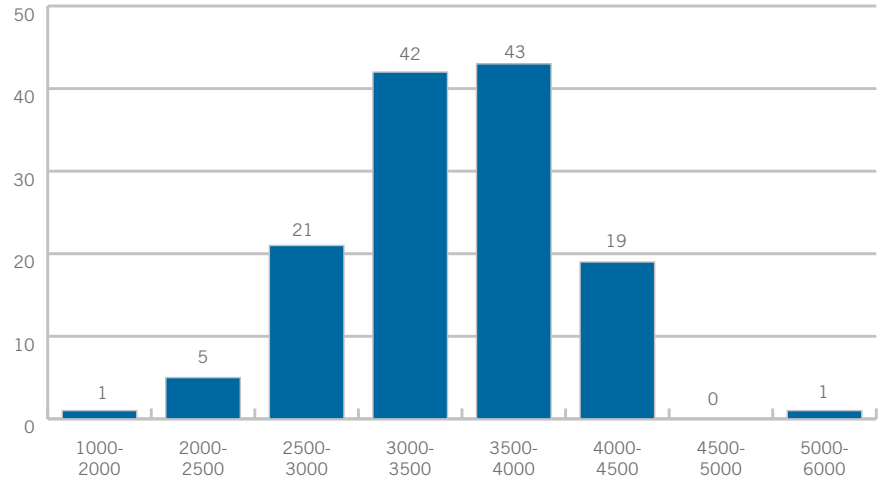
Treatment	N	%
Diet	12	9.09%
Oral	36	27.27%
Insulin	12	9.09%
Oral and Insulin	51	38.64%
Not Documented	21	15.91%
Total	**132**	**100.00%**

Parity	N	%
P0	39	29.54%
P1	47	35.60%
P2	32	24.24%
P3	9	6.82%
P4	2	1.52%
P5	1	0.76%
P6	2	1.52%
Total	**132**	**100%**

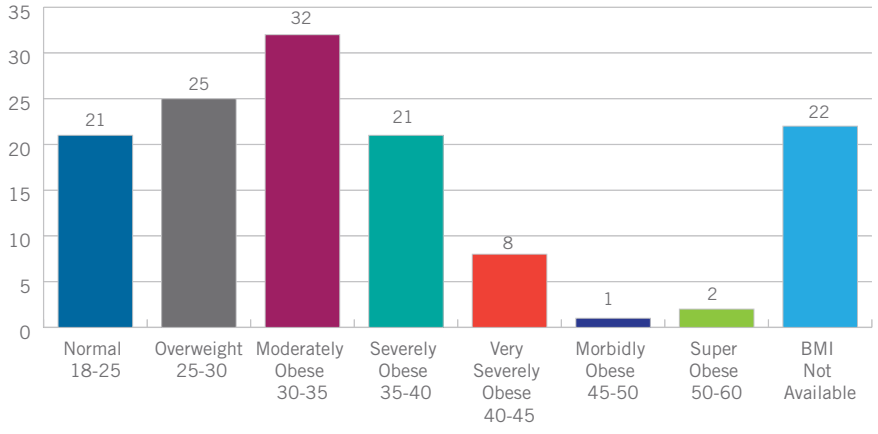
Mode of Delivery



Birth Weight



BMI



Feeding Method	N	%
Breastfeeding	81	61.36%
Artificial Feeding	50	37.88%
N/A	1	0.76%
Total	**132**	**100%**

Please note 1 infant IUD

Women's Health and Paediatric Physiotherapy Report

Ms Roisin O'Hanlon

The Women's Health 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:

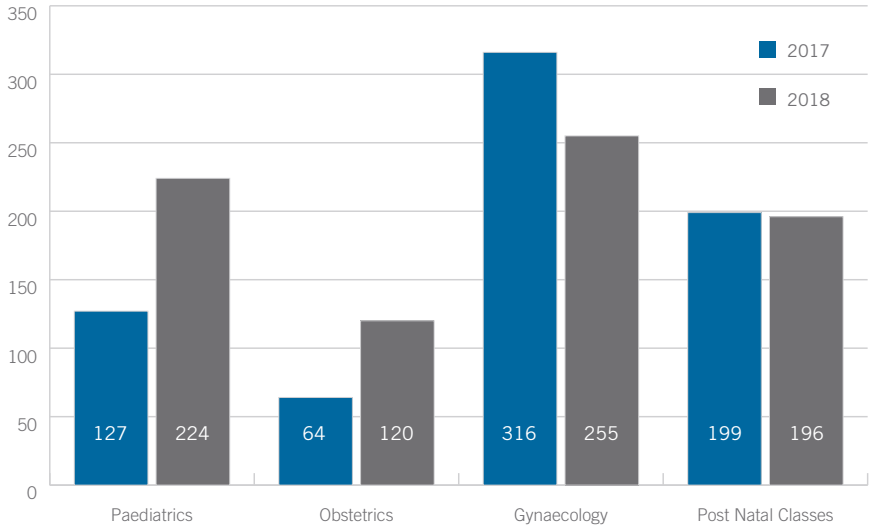
Antenatal

- MSK physiotherapy for pelvic girdle pain, carpal tunnel syndrome, back pain and other musculoskeletal problems presenting in pregnancy
- Antenatal classes (monthly)
- Continence care – bladder and bowel

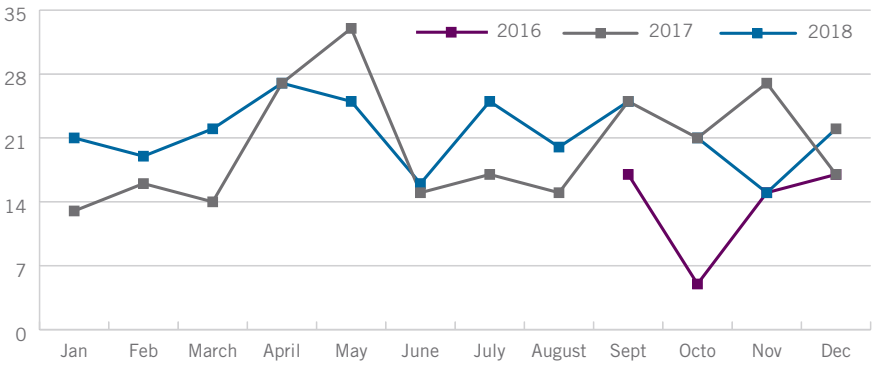
Post natal

- 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

Inpatients 2018



Maternity Referrals from Mid 2016 - 2018



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:

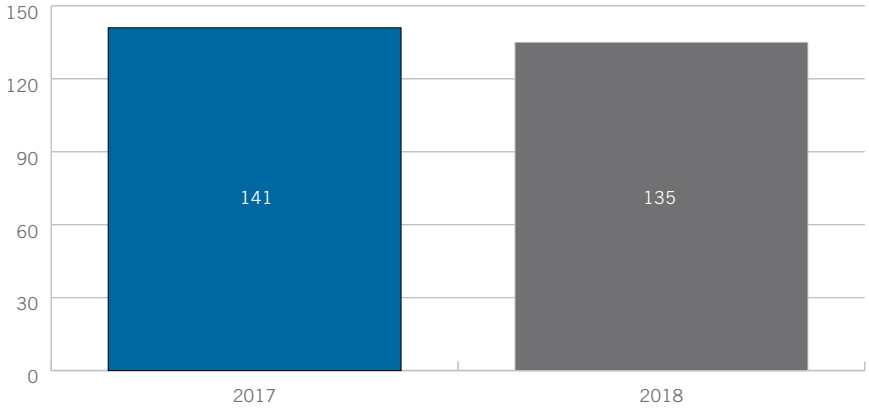
- Neonatal conditions: Erb's palsy, Congenital Talipes Equinovarus, Congenital Talipes Calcaneovarus, Neurological conditions (including congenital and acquired)
- Torticollis
- Respiratory
- Introduction of the physiotherapy post natal information booklet which includes information on prevention of 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.

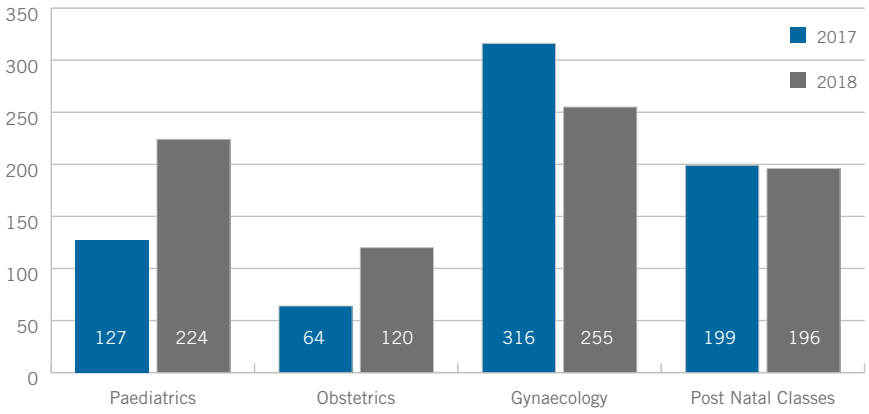
Outpatient physiotherapy is, in the main, related to MSK and Orthopaedic conditions. We also treat children with Respiratory conditions who are being followed through to adulthood and children with Rheumatological conditions who attend for infusions and have a physiotherapy review. We also see any referred 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 Out Patient Referrals 2017 - 2018



In Patient Activity



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 inadequate 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. Again this would is an integral part of the service plan for the coming year.

Neonatal Clinical Report

Dr Regina Cooke

During the year 2018, a total of 1602 infants were born at Portiuncula Hospital. 256 infants were admitted to the NICU for neonatal care following birth. This represents 15.9% of babies born at the hospital. In addition, 8 infants were admitted for ongoing care following initial care in a regional or tertiary unit.

The majority of infants (68.3%) 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 2018, 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 2018, 20 babies were transferred.

Our admission rates have remained at approximately 15% over the past 5 years. We have transferred out an average of 18 babies/year for specialist care in the past 5 years.

Gestational Age Of NICU (Inborn) Admissions 2018

Gestational age	n	%
<28 weeks	2	0.8%
28 - 31+6 weeks	2	0.8%
32 - 36+6 weeks	77	30.1%
>37 weeks	175	68.3%
Total	**256**	**100.0%**

Birth Weight of NICU (Inborn) Admissions

Weight	n	%
<1000g	2	0.8%
1001-1500g	0	0.0%
1500-2500g	59	23.0%
2500-4500g	187	73.1%
>4500g	8	3.1%
Total	**256**	**100%**

Source of Admission (including Transfers In) 2018

Source	n	%
Delivery Suite	63	23.9%
Theatre	87	32.9%
Post natal ward	106	40.1%
Tertiary Unit	8	3.1%
Total	**264**	**100%**

Transfers out for Tertiary Services by Diagnosis

Reason for Transfer	n
Prematurity	3
Cardiac	3
HIE / therapeutic hypothermia	2
Surgical	3
Sepsis	1
Respiratory	3
Neurology	1
Diaphragmatic Hernia	1
Other	3
Total	**20**

Transfers out for Tertiary Services by Destination

Destination	n
Galway University Hospital	1
OLCHC	9
CUH, Temple Street	0
NMH, Holles St	4
CWH	5
Rotunda	1
Total	**20**

Reason For Admission

Reason For Admission	n	%
Preterm <37weeks	36	13.6%
Respiratory Distress	74	17.8%
Hypoglycaemia	20	7.6%
Jaundice	20	7.6%
LBW	35	13.3%
Sepsis/ Rule out Sepsis	23	8.7%
Retrotransfer	8	3.1%
Other	48	18.3%
Total	**264**	

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

Paediatric Unit Report

Dr. Frances Neenan and Ms Karen Leonard

Introduction

This report includes details of clinical activity during the period January the 1st 2018 to December 31st, 2018 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 and the paediatric outpatient department. 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. 93% of all patients admitted to the ward in 2018 (1854) (Figure 1) were admitted from the Emergency Department. This total admission figure is down 114 patients from 2017, which is in keeping with a downward trend from the two previous years where admissions via ED were 1924 and 1878 respectively. This is probably reflective of different working patterns with better senior paediatric registrar cover resulting from a change to shift pattern. The average length of stay of patients on the paediatric ward was 1.95 days.

Surgical 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.

The Paediatric Day Ward

This is a busy unit run by two paediatric Nurses open Monday to Friday (Total of 1.5 WTE). Patients attend the day ward for phlebotomy, clinical review, radiological investigation and allergy testing. A total of 1098 patients were seen in the day ward this year, this shows a slight downward trend from previous years (Figure 4). The introduction of rapid access clinics in the outpatient department has reduced the number of urgent patients seen in the day ward setting.

Figure 1 - Inpatient Admissions to St Therese Ward

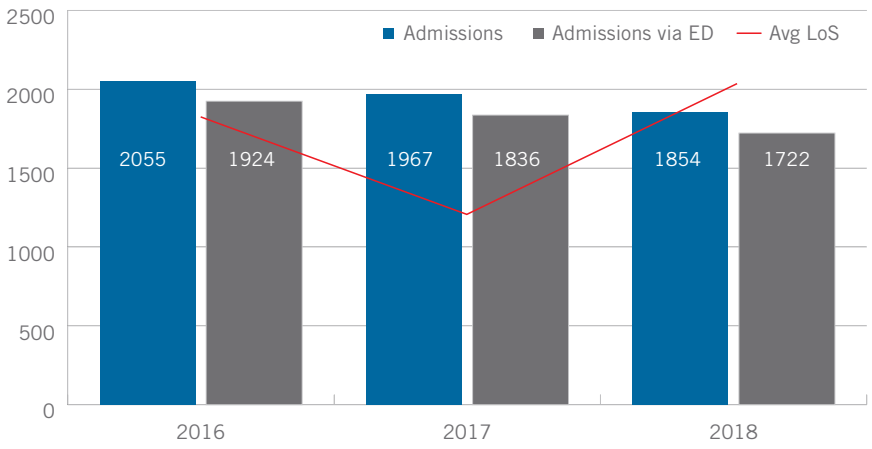


Figure 2 - Inpatient Admissions to St Therese Ward by Specialty

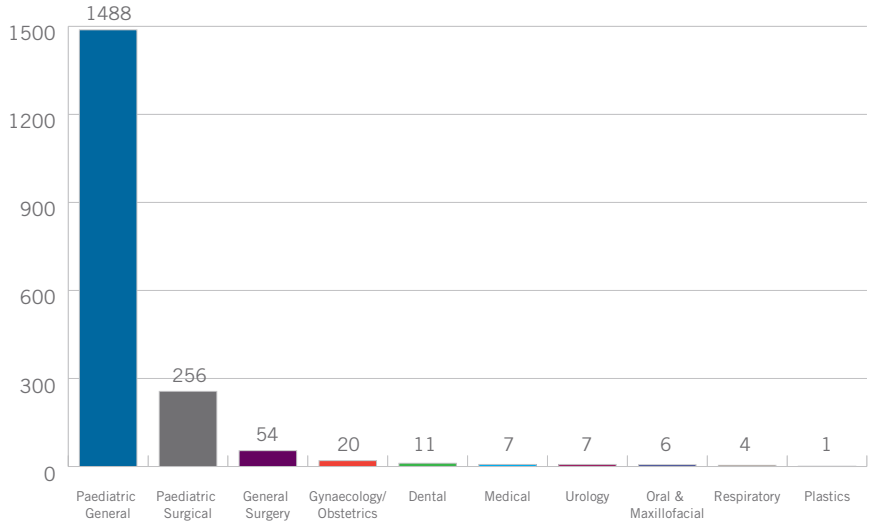
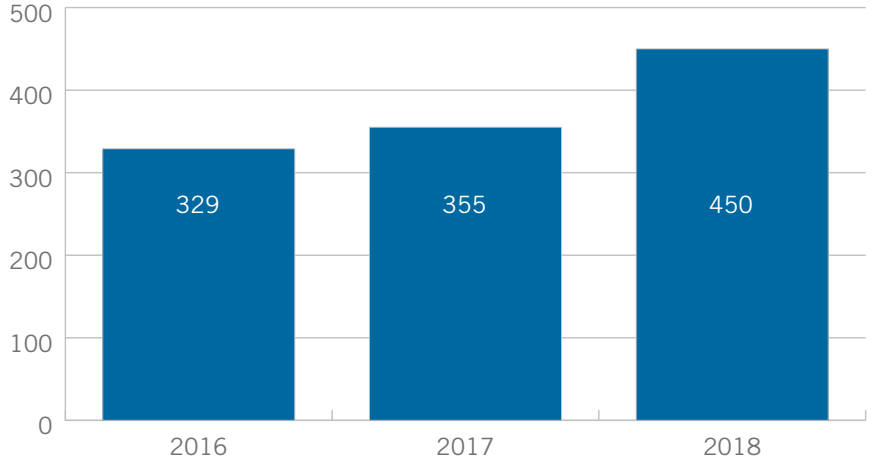


Figure 3 - Day Case Admissions to St Therese Ward



Paediatric day case admissions are continuing to trend upwards with 450 day case admissions in 2018 (Figure 3) showing a 26% increase on the numbers admitted in 2017. This reflects the pattern of shared care of complex chronic cases with Our Lady's Childrens Hospital Crumlin with patients getting admitted as day cases for IV infusions as part of their treatment .This includes patients from Oncology, Gastroenterology and Rheumatology. Paediatric day case admissions also include dental, maxillary-facial patients as well as patients needing sedation.

Paediatric ED Attendance Activity

During 2018 there were 6,662 attendances at the Emergency Department of children up to the age of 16 years, making up 26% of all attendances to the ED department in PUH. There is an admission rate from the Emergency Department of 25% (see figure 5). This figure is higher than expected and is caused by an inability to monitor patients response to treatment in the acute setting of the ED. There are plans to include a short stay observation unit into the footprint of the ward to address this particular issue in the coming year.

ICU Admissions

There were 8 children admitted to ICU during 2018. The causes for their admission are categorized as follows sepsis -2, neurology-3, respiratory-1 and endocrine-2. Three patients needed ventilator support and 4 patients were transferred to tertiary paediatric ICUs.

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 continuing to rise - see figure 6. Of interest also is the ratio of new to review patients seen at these clinics - the ratio for 2018 has remained stable at 2.8; this 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.

Figure 4 - Paediatric Day Ward Attendees

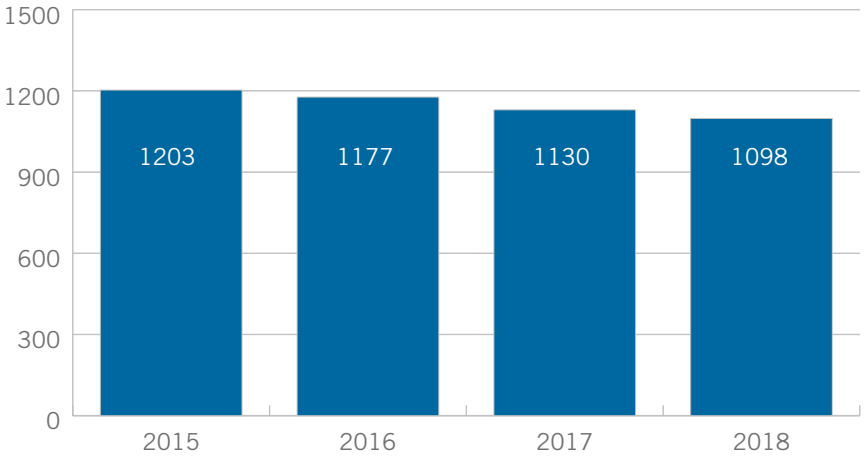


Figure 5 - % of Admissions from Emergency Department

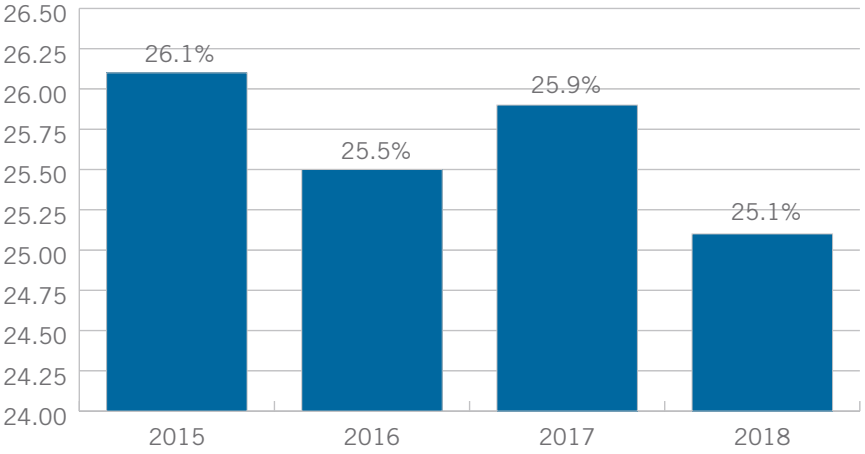
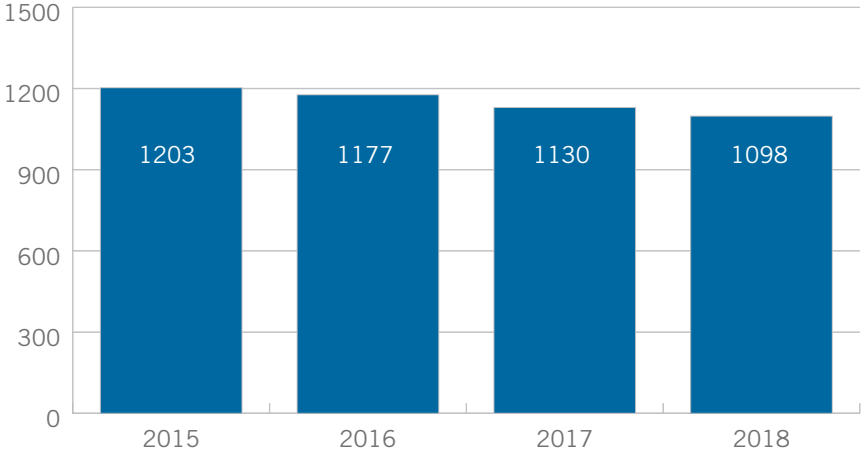


Figure 6 - OPD Paediatric Attendances



Social Work Department

Ms Caroline McInerney Layng

The maternity social worker is part of the multi disciplinary team delivering person centred care which also extends to the Ante-Natal Clinics, Early Pregnancy Unit, SCBU and Paediatrics. Activity levels remained constant with 451 individuals seen during the year.

A number of women presented with complex needs which required intensive support and care planning throughout their pregnancies. The following list reflects the range of diverse issues presenting.

- Unplanned/concealed pregnancy
- Underage/teenage pregnancy
- Changing family structures and relationship difficulties
- Diverse cultures
- Domestic abuse
- Emotional and practical stressors including homelessness
- Bereavement support for those experiencing pregnancy loss
- Diagnosis of fatal foetal abnormality
- Child born with a disability/life limiting condition
- Child protection and welfare concerns
- Addiction issues, substance abuse, mental health and self harm
- Neo natal withdrawal syndrome

Services Provided

The maternity social worker provides counselling, emotional support and practical information to women and their partners promoting a positive parenting experience. Assessment and identification of psychological and psycho-social needs is a key role in social work intervention from ante natal through to the post natal phase. The service is focused on and responsive to women and their individual needs. Referrals are made to relevant health and social care services and community supports based on identified needs.

The service has an integral role in the co-ordination of care and support to at risk groups, including the identification and assessment of child protection and welfare concerns. This extends to monitoring the level of attendance and engagement throughout the ante natal stage. Close working relationships are maintained with Tusla to monitor the safety and welfare of children. This involves attendance and submission of reports for strategy meetings, case conferences and court cases.

In collaboration with the bereavement team, the maternity social worker also provides support to women and families who experience pregnancy loss. The team participated in the annual remembrance service, perinatal bereavement group and the end of life committee.

Additionally, the maternity social worker contributed to early ante natal classes and other working groups including the Traveller Midwifery Group, promoting positive engagement and respect for different ethnic, social and cultural values. Regular meetings continued with the homeless support services providing continuity of care for vulnerable service users.

Women identified at risk of domestic abuse through the routine enquiry are referred to the social worker for support, advice and safety planning. Links are maintained with local domestic violence services to support women and families at risk of abuse.

The social work team attended relevant education and training to enhance knowledge, skills and competence, ensuring a high standard of professional practice to service users.

The team provided clinical placements for students of the Masters in Social Work Programme in NUIG and TCD.

I would like to thank Marie Finn, maternity social worker and all the other members of the social work team for their continued enthusiasm and commitment to provide a quality, person centred service. Finally, I would like to acknowledge the support of our community services, PUH Management team and the extended multi disciplinary team.

Ballinasloe Crisis Pregnancy Support Service

Ms Caroline McInerney Layng

Activity Levels

Individual Clients Seen	Appointments Attended
98	161

The highlight of the year was our 15 year celebration; providing a valuable local service to the hospital and community. The occasion provided an opportunity to showcase the counselling and support service available to women presenting with crisis pregnancy and other diverse and complex issues.

Consistent with previous years referrals were predominantly received from the maternity unit, ante natal clinics and the early pregnancy unit. The service responded to women ranging in age from 15 to 49 years, with varied complex social issues. These included financial and accommodation stressors, health complications, relationship difficulties, bereavement and concealed pregnancy. Women were supported in their decision making through non judgemental and non directive counselling, accessing support in both the hospital and outreach office.

The service was proactive in organising and participating in promotional events; NCHD induction days, local GP Training scheme and the annual Athlone IT Health Fair.

I would like to thank the HSE Sexual Health & Crisis Pregnancy Programme for their continued support and extend our appreciation to hospital management and the multidisciplinary care teams.

Quality and Patient Safety

Ms Lisa Walsh

The Saolta Women's and Children's Directorate Department in Portiuncula University Hospital (PUH) has continued to review and develop its quality and safety framework. Regular multidisciplinary meetings are 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 2018, the Integrated W&C Directorate meetings (PUH and UHG- University Hospital Galway) were rolled out and 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 W&C Serious Incident Management Team meeting (SIMT); review of local policies and procedures; staff development.

Furthermore, incidents are reported 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.

With regard to the implementation of recommendations from maternity department reviews, a local implementation board continued to meet regularly throughout the year. In addition, a working group, which established in 2017, continued to meet with membership inclusive of maternity and general managers and service users, to discuss progression of the action plans associated with the recommendations of individual case reviews detailed in the External Independent Clinical Review of the Maternity Services at Portiuncula Hospital (cases occurring 2008 – 2014).

The National Standards for Safer Better Maternity Service were published in 2016 and self assessment against these standards has been progressed. Self-assessment against the National Safer Better Healthcare Standards with regard to paediatrics and general wards taking gynaecological patients commenced in 2017, with a focus on Themes 1 (Person Centred Care and Support) and Theme 5 (Leadership, Governance and Management).

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.

Staff training on the use of Q-Pulse is provided on an as required basis by the contracted service for Q-Pulse administration and training (HCI).

Local service user 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 more proactive with regard to the challenges faced in providing safe, high quality care for mothers, babies and their young patients.

Reported incidents, complaints and positive feedback (origin of data: Q-Pulse)	2015	2016	2017	2018
General Incidents	163	286	541	711
Medication Incidents	16	8	8	9
Total Incidents	**179**	**294**	**549**	**720**
Complaints	17	30	18	13
Postive Feedback	8	52	368	390

Note: Incidents include hazards and other non-clinical incidents.

Reported Clinical Incidents by speciality 2018 (origin of data: Q-Pulse)	
Obstetrics	480
Gynaecology	20
Paediatrics	14

Most frequently reported perinatal events 2018 (origin of data: Q-Pulse)	
Admission to SCBU	103
Post partum haemorrhage	90
Antepartum haemorrhage	10
Manual removal of placenta	7
Readmission	27
Third degree tears	17

Practice Development

Ms Deirdre Naughton and Ms Carmel Cronnolly

Goal of 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 2018 we supported thirty-five 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. This year our students were allocated to an additional new clinical placement in Portiuncula, our midwifery-led supportive care antenatal clinic. There they gained valuable experience in providing antenatal care to low risk women. Students themselves evaluated this new placement very positively.
- In addition, we supported twelve undergraduate General Nursing students and three Public Health Nurse Students during their maternity placement in PUH.

NMBI National Student Midwife Competence Assessment Tool

- In 2017 a working group with representation from all key stakeholders including student representation was established by NMBI. This group, which included our CPC, was tasked with the development of a standardised competence assessment tool (CAT) to assess clinical practice during the four-year midwifery education programme. This new CAT was developed, refined and finalised in 2018 and reflects the standards and requirements for the Midwife Registration programme NMBI (2016). The national competence assessment tool will contribute to more consistent assessment of practice for students and promote safe midwifery practice
- On-going education on the new competence assessment tool for year 1 of the programme is provided to all staff midwives in PUH. Implementation of the year 1 CAT is planned for first year student midwives clinical placement in March 2019.

Return to Midwifery Programme

- In 2017 we provided clinical placement for 2 midwives undertaking the Return to Midwifery Practice Programme in Portiuncula. We are delighted that one of these midwives has chosen to continue to work with us in the maternity setting.

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 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.
- Portiuncula hosted a very successful Midwifery symposium in November. With support from CNME and NMPDU the theme focused on striving for Quality Midwifery Practice through Innovation, Research and Strategy. In total 79 attendee's for full day and 9 "drop ins" to attend from all five Saolta maternity partners and the Coombe Women and Children's hospital. The day was exceptionally well evaluated with many expressing a renewed passion and pride for midwifery developments. The twitter handle #PUHmidiwfery symposium 2018 attracted 167, 710 impressions
- 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.

Sligo University Hospital

Ms Juliana Henry and Ms Madeleine Munnelly

Sligo University Hospital is committed to the delivery of a high quality, patient centred service in a safe, equitable and efficient manner.

We recognise and value the contribution of each staff member and endeavour to support them in their on-going development'

The Obstetrics and Gynaecology 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.

Sligo University Hospital is a 281 bedded hospital with a catchment area of Sligo, Leitrim, South Donegal, West Cavan and Roscommon. The mainstream acute services provided by Sligo University Hospital include the following:

Emergency Medicine, Surgery, ENT, Ophthalmology, Orthopaedics, Paediatrics, Obstetrics/Gynaecology, Medicine, Cardiology, Diabetology, Dermatology, Gastroenterology, Geriatrics, Respiratory Medicine (including Adult CF Patients), Rheumatology, Nephrology (Consultant sessions from Letterkenny General Hospital), Neurology, Oncology, Palliative Medicine, Haematology, Microbiology, Oral and Maxillofacial Surgery, Orthodontics, Pathology, Anaesthesia, Intensive Care Medicine, Pain Service and Radiology. In addition, Services in Immunology and Radiation Oncology are provided from University College Hospital, Galway.

A regional Rheumatology service is based at Our Lady's Hospital, Manorhamilton (OLHM).

A full range of clinical and non-clinical support services are provided, including Theatres, CSSD, Pharmacy, Laboratory, Clerical / Administrative, Social Work and Therapies.

Services are provided on a regional basis at Sligo University Hospital in respect of ENT, Ophthalmology (including service to Longford), Neurology, Orthodontic, Paediatric Insulin and Pump Service, Rheumatology and Dermatology Services.

A number of specialities provide Outpatient clinics at Community Hospitals in our catchment area.

The Maternity Unit is Co-located within the General Hospital and provides a range of general and specialist services designed to meet the needs of women with normal, medium and high risk pregnancies.

SUH Maternity Team

- 4 WTE Consultant Obstetrician / Gynaecologist
- 1 WTE Director of Midwifery
- 1 WTE Assistant Director of Midwifery / Nursing (vacant post)
- 1 WTE Clinical Midwife Manager 3
- 3 WTE Clinical Midwife Manager 2
- 4 WTE Clinical Midwife Manager 2 / Shift Leader
- 1 WTE Antenatal Education CMM2 / Lactation Consultant
- 4 WTE Clinical Midwife Specialist Sonographer (1 on long-term sick leave)
- 1 Radiographer Clinical Specialist - Sonographer
- 1 WTE Clinical Midwife Specialist Bereavement
- 0.5 WTE Maternity Clinical Placement Coordinator
- 1 WTE Advanced Midwife Practitioner
- 49.76 WTE Midwife
- 13 WTE NCHD
- 6 WTE Health Care Assistant
- 3 WTE Ward Clerk
- 3 WTE Medical Secretary
- A link Social Worker
- A Physiotherapist for maternity services (shared)
- A Psychiatric Liaison Officer (shared)

The Maternity Service in SUH is a multi-sited service provided over four floors from the multi-storey building since 1992. The site is accredited for General Practice training, Higher Specialist Training in General Paediatrics, and by the Irish Committee on Higher Medical Training for General Medicine training. It is a clinical placement site for pre-registration midwifery and nursing students, student public health nurses and for the Return to Midwifery Practice programme.

There were 1,357 births in 2018. The inpatient combined antenatal / postnatal ward on Level 4 works within a complement of 28 beds, a similar number of cots and a 2-bedded induction room. 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, antenatal 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 and Early Pregnancy Assessment Unit (EPAU) provide care Monday to Friday. The neonatal unit has 10 cots for babies >32 weeks' gestation. There is one community midwifery antenatal service.

SUH provides excellence in the care of women and babies through a range of maternity services:

- Early Pregnancy Assessment Unit
- Maternal and Fetal Assessment Unit
- Antenatal clinics in SUH (obstetric and midwifery)
- Outreach antenatal clinics (obstetric and midwifery)
- Antenatal education classes
- Antenatal breastfeeding education
- Breastfeeding drop in Clinic
- Antenatal care
- Intrapartum care
- Postnatal care
- Gynaecology outpatient clinic
- Gynaecology inpatient
- Gynaecology theatre
- Colposcopy services
- Postnatal breastfeeding clinics
- Maternity bereavement service

The two models of care in SUH are:

1. Medical-led team care: Care in this pathway is led by consultant Obstetricians within a Multidisciplinary Framework antenatal care based in the acute hospital outpatient facility three

times a week. There are weekly outreach antenatal clinics in Manorhamilton, Carrick-on-Shannon and Ballyshannon. Clinics are held in community hospital outpatient facilities, and are attended by medical and midwifery staff from SUH.

2. The midwifery-led model of care is led by an Advanced Midwife Practitioner and run alongside the consultant-led clinics, which facilitates a bi-directional flow. These clinics facilitate women who are on the supported or assisted pathways of care. There is also one weekly, midwifery-managed, antenatal review clinic for low-risk women in SUH, which has been established for many years.

Antenatal Clinics

There are three antenatal Consultant led Clinics per week and three consultant led clinics outreach clinics. There are 4 midwifery clinics per week in SUH and 1 outreach Midwifery Clinic (New service). The Schedule of antenatal clinics is detailed below.

The service is accessed via GP referral to Obstetrics and Gynaecology Central Booking department irrespective for choice of clinic. Women who request to attend a particular outreach clinic will be facilitated or offered an outreach clinic based on home address. All referrals for Antenatal services in SUH are divided equally amongst the consultant obstetricians. A letter advising women of their booking appointment details will be sent to the woman's contact address in advance of the appointment date.

Midwives Clinic

This clinic operates on a 'share of care' principle in that care is shared between the mother's GP & midwives. Mothers are booked under a consultant initially and then attend the midwives clinic for subsequent antenatal visits.

Monday

- AM Antenatal Clinic - Medical Led
- AM - Midwives Clinic (led by Advanced Midwife Practitioner combined supported and assisted clinic)
- PM Midwives Clinic (Supportive Pathway)

Tuesday

- AM Antenatal Clinic- Medical Led
- AM – Midwives Clinic (led by Advanced Midwife Practitioner, combined supported and assisted clinic)

Thursday

- AM Antenatal Clinic- Medical Led
- AM – Midwives Clinic (led by Advanced Midwife Practitioner, combined supported and assisted clinic)
- PM- Booking clinic for private patients. And for women attending outreach antenatal Clinic in St Patricks Hospital Carrick on Shannon, Co Leitrim.

Outreach Antenatal Clinics

- Ballyshannon – Shiel Hospital Thursday PM- Medical Led
- Manorhamilton- Our Lady's Hospital Wednesday- Medical Led
- Carrick on Shannon- St. Patrick's Hospital Thursday AM- Medical Led

Delivery Suite

3 delivery suites, a 2 bedded pre labour area and one admission/assessment room.

Access: Self referral/ Referral after telephone liaison/ Obstetric Referral/ GP referral

All women attending in suspected labour or out of hours can self refer are to the Delivery suite. Following admission, midwives work in partnership with the woman and the obstetric team (if not low risk) to provide evidence based care. All women in labour receive 1:1 midwifery care based on best available evidence and informed consent of the woman.

Out of hours and weekends, From 18 weeks of pregnancy, women with pregnancy related concerns can self-refer to the delivery suite, be referred by their GP, or referral after telephone liaison to the delivery suite.

Regardless of the reason for presentation, all women will have a full maternal and Fetal assessment performed. This may include interventions such as blood tests, CTG monitoring and ultrasound scanning. They are then referred to the most appropriate health care professional (HCP). A plan of care will be made in collaboration with the woman and the HCP's. All activities are documented in the woman's notes and communicated to the relevant Health care team. Women who are less then 32 weeks gestation, whose delivery is considered a risk of preterm delivery, may be, based on individual circumstances be transferred to a tertiary centre.

Maternity Ward

The maternity ward is a 28 bedded unit which provides care to both antenatal & postnatal mothers & babies and a 2 bedded induction room. The ward comprises of a six bedded ante natal ward, a two bedded induction of labour room, 22 postnatal beds & cots & 1 Breastfeeding room. Holistic care is provided to women from early pregnancy up to and following the birth of their baby.

Mothers undergoing induction of labour and caesarean sections are also cared for on the ward. There is a multidisciplinary approach to care and the maternity staff work in close liaison with: obstetricians, paediatric staff, medical physicians, physiotherapists, social workers, dieticians, clinical nurse specialists, radiology, General practitioners and public health nurses.

Bereavement Service

A bereavement Service is provided to women and their families following pregnancy and perinatal loss. The service is co-ordinated by the Bereavement Support Midwife in collaboration with the Multidisciplinary team to bereaved parents and their families. Anticipatory bereavement support is also provided for families whose baby is diagnosed with Fatal Fetal Abnormalities. The service is accessed via referral by midwife/clinician or self referral.

Key Achievements across the Service for 2018

- Winner of the Irish National Healthcare award in Quality and Safety for Safe Site Check List.
- Nominated for Midwifery Led Project of the year in Irish National Healthcare awards Sligo University Hospital – "Implementing the National Maternity Strategy"
- "Bereavement Care in Maternity Services SUH" nominated in End of Life Care at Irish National Healthcare awards
- Replacement of maternity beds to Electric beds on Maternity ward
- Purchase of Five Cardiac Monitors for High Dependency Monitoring
- Collaboration with the CNME for Breastfeeding Training
- NRP coordinator provided NRP training at Antenatal Classes
- Provision of Legal Study day for Maternity Services
- Midwife Peer Vaccinator on Flu Vaccine Campaign
- Installation of new White Board with ISBAR handover
- CTG training workshop
- Funding, Planning and design commenced to reconfigure a room on the maternity ward to a Bereavement Suite.
- Second cool cot donation from Feilicain
- Funding secured to reconfigure a room on the Delivery Suite to a 'Home from Home' Suite for low risk women.

Staffing Achievements

- Appointment of Ms Caroline Carney as Shift Leader in Labour Ward.
- Appointment of Ms Ita Morahan to CMM2 in Antenatal Clinic
- Appointment of Ms Louise O'Malley to CMM3 position
- Ms Roisin Lennon RAMP published in British Journal of Midwifery "Pain Management in labour and childbirth: Going back to basics"
- Ms Roisin Lennon RAMP presented at Irish Association of Advanced Nurse Midwife Practitioners in Farmleigh "The experience of being a registered nurse prescriber within an acute service setting"
- Ms Roisin Lennon RAMP presented poster at National Nurse Midwife Prescribing Conference Dublin Castle "The experience of being a registered nurse prescriber within an acute service setting"

Education and Training

- Ms Colette Kivlehan Shift Leader undertook a Quality & Healthcare Management Module in St Angela's College Sligo.
- Ms Mairead Beirne Ethical Practice & Quality & Health Care Mgt Modules and commenced a Masters in Perinatal Mental Health at University of Limerick.
- Ms Michelle Moriarty commenced a MSc Quality & Safety in Healthcare
- Ms Ita Morahan, completed a BSc Nursing Management in the RSCI Dublin.
- Ms Siobhan O'Dowd Staff Midwife completed Masters in Education
- Ms Marla Kennedy CMM2 Ms Marita Keenan Staff Midwife and Ms Roisin Lennon AMP completed Lactation Consultant training
- Ms Leona Mulvey commenced a Module on Ethical Practice & Quality & Health Care Mgt Modules in in St Angela's College Sligo.
- Ms Sheila Mulderrig Ms Niamh McGarvey Ms Rita Reilly attended BMUS & UCD Scanning day
- 2 Consultant Anaesthetists undertook the Train the Trainer Training for Prompt training.
- 3 CMM's attended First time managers training
- Ms Roisin Lennon and Dr Heather Langan presented at Grand Rounds on Sepsis PET and VTE
- Ms Louise O Malley and Ms Roisin Lennon facilitated CTG workshop with Ms Deirdre Naughton Midwifery Practice Development Coordinator Portiuncula Hospital

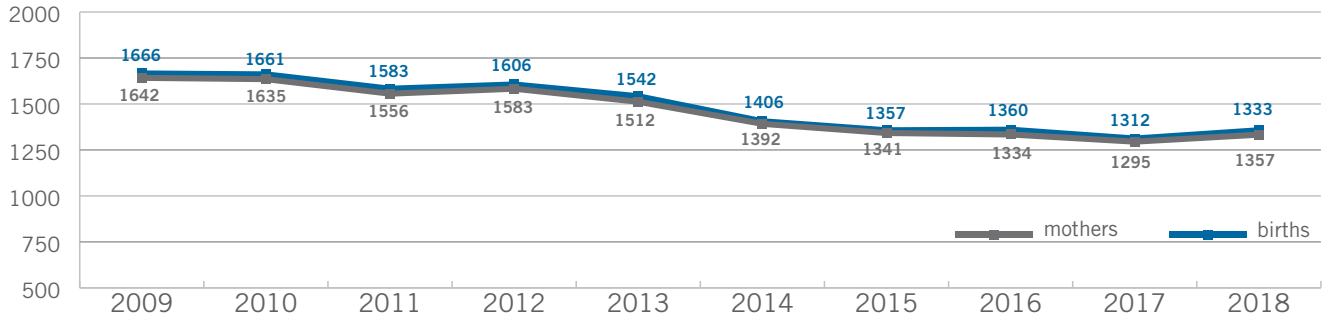
Statistical Summary

Ms Juliana Henry, Ms Madeleine Munnelly and Ms Louise O'Malley

	Primigravida	Multigravida	Total
Total Number of Mothers	478	855	**1333**
Total Number of Babies	487	870	**1357**
>24 weeks or >/= 500g			

	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Number of Mothers	1642	1635	1556	1583	1512	1392	1341	1334	1295	1333
Number of Babies	1666	1661	1583	1606	1542	1406	1357	1360	1312	1357

Number of Mothers & Babies over the last 10 years



Obstetric Outcomes (Mothers)	Primigravida	%	Multigravida	%	Total	%
Spontaneous Onset	231	48.3%	502	58.7%		0.0%
Induction of Labour	183	38.3%	167	19.5%	350	26.3%
Epidural Rate		0.0%		0.0%	480	36.0%
Episiotomy	151	31.6%	50	5.8%	201	15.1%
Caesarean Section	199	41.6%	294	34.4%	493	37.0%
Spontaneous Vaginal Delivery	162	33.9%	523	61.2%	685	51.4%
Forceps Delivery	24	5.0%	5	0.6%	29	2.2%
Ventouse Delivery	92	19.2%	31	3.6%	123	9.2%
Breech Delivery	1	0.2%	2	0.2%	3	0.2%

Obstetric Outcomes (Babies)	Primigravida	%	Multigravida	%	Total	%
Spontaneous Vaginal Delivery	163	33.5%	528	60.7%	691	50.9%
Forceps Delivery	24	4.9%	5	0.6%	29	2.1%
Ventouse Delivery	92	18.9%	31	3.6%	123	9.1%
Breech Delivery (Singleton)	1	0.2%	2	0.2%	3	0.2%
Breech Delivery (1st Twin)	0	0.0%	0	0.0%	0	0.0%
Breech Delivery (2nd Twin)	0	0.0%	1	0.1%	1	0.1%
Caesarean Section (Babies)	207	42.5%	303	34.8%	510	37.6%
Total	**487**	**100.0%**	**870**	**100.0%**	**1357**	**100.0%**

Multiple Pregnancies	Primigravida	%	Multigravida	%	Total
Twins	10	2.1%	15	1.8%	24
Triplets	0	0.0%	0	0.0%	0

Multiple Pregnancies by year	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Twins	23	24	25	23	26	13	16	27	17	24
Triplets	0	0	0	0	0	1	0	0	0	0
Total	**23**	**24**	**25**	**23**	**26**	**14**	**16**	**27**	**17**	**24**

Perinatal Deaths	Primigravida	Multigravida	Total	%
Stillbirths	2	1	4	0.29%
Early Neonatal Deaths	0	0	0	0.00%

Perinatal Mortality Rate	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Stillbirth rate (per 1,000)	3.6	5.4	3.2	3.7	1.3	3.6	3.7	6.6	3.8	3.0
Neonatal Death rate (per 1,000)	1.2	0.6	2.5	3.7	2.6	2.8	3.7	0.7	0.8	0.0
Overall PMR per 1,000 births	4.8	6.0	5.7	7.5	3.9	6.4	7.4	7.4	4.6	2.2

Parity	Number	%
Para 0	390	29.3%
Para 1	400	30.0%
Para 2	245	18.4%
Para 3	152	11.4%
Para 4	75	5.6%
Para 5	36	2.7%
Para 6	15	1.1%
Para 7	9	0.7%
Para 8	5	0.4%
Para 9	3	0.2%
Para 10	3	0.2%
Total	**1333**	**100.0%**

Parity by year	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
0	31.4%	29.5%	31.0%	28.7%	29.3%	26.6%	29.1%	29.3%	36.0%	29.3%
1,2,3	59.6%	61.0%	59.0%	60.1%	59.2%	61.0%	59.6%	59.1%	51.7%	48.2%
4+	9.0%	9.5%	10.0%	11.2%	11.5%	12.4%	11.3%	11.6%	12.4%	22.5%

Age @ Booking	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
<15 years	0.0%	0.2%	0.1%	0.0%	0.0%	0.0%	0.1%	0.0%	0.0%	0.0%
15-19 years	3.4%	2.7%	3.3%	2.4%	1.9%	2.8%	1.9%	2.1%	2.4%	1.7%
20-24 years	11.5%	10.9%	9.7%	10.2%	9.7%	8.3%	7.8%	9.0%	10.0%	7.7%
25-29 years	24.7%	23.9%	23.5%	22.7%	21.8%	19.2%	21.9%	18.5%	18.9%	19.1%
30-34 years	34.8%	33.7%	37.8%	35.2%	37.4%	36.4%	35.2%	35.3%	34.0%	36.6%
35-39 years	21.3%	23.7%	21.9%	24.4%	23.9%	27.7%	26.5%	29.0%	28.7%	29.0%
>40 years	4.2%	4.9%	3.7%	5.1%	5.3%	5.6%	6.5%	6.0%	6.0%	6.0%

County of Origin	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Sligo	58.1%	55.3%	56.5%	56.7%	55.4%	55.2%	55.2%	55.0%	54.40%	55.80%
Donegal	10.5%	11.5%	10.2%	10.6%	9.5%	10.8%	10.4%	11.8%	10.90%	11.70%
Leitrim	20.8%	19.5%	21.2%	19.5%	21.0%	19.6%	21.7%	20.5%	20.20%	20.40%
Mayo	1.6%	1.9%	2.4%	1.8%	2.7%	1.9%	2.1%	1.9%	2.50%	1.30%
Roscommon	8.3%	10.6%	8.4%	10.5%	10.6%	11.6%	10.0%	9.6%	11.10%	9.70%
Cavan	0.3%	0.5%	0.8%	0.5%	0.5%	0.6%	0.4%	0.9%	0.50%	0.60%
Galway	0.0%	0.0%	0.1%	0.1%	0.0%	0.0%	0.1%	0.0%	0.00%	0.00%
Longford	0.2%	0.2%	0.0%	0.2%	0.1%	0.2%	0.0%	0.0%	0.20%	0.10%
Dublin	0.1%	0.0%	0.1%	0.0%	0.1%	0.1%	0.0%	0.1%	0.00%	0.00%
Others	0.0%	0.5%	0.3%	0.2%	0.2%	0.0%	0.1%	0.1%	0.20%	0.30%

Non-national Births	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Number	114	72	62	66	82	72	79	109	97	103
%	6.9%	4.4%	3.9%	4.1%	5.4%	5.0%	5.8%	8.0%	7.4%	7.7%

Gestation at Delivery	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
<24 weeks	0	6	8	3	3	2	2	1	1	0
24-27 weeks	5	5	2	3	1	5	6	2	1	2
28-31 weeks	6	5	4	3	4	5	2	4	3	4
32-35 weeks	38	39	25	31	37	36	53	64	65	75
36-39 weeks	684	681	668	716	674	646	646	629	602	665
40-41 weeks	833	869	832	810	796	685	611	606	603	556
>42 weeks	100	58	45	42	29	27	21	28	20	31
Total	**1666**	**1663**	**1584**	**1608**	**1544**	**1406**	**1341**	**1334**	**1295**	**1333**

Birth Weights by year	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
<2500g	53	74	45	46	71	50	54	71	56	62
2500 - 2999g	201	189	182	191	175	143	153	158	166	176
3000 - 3499g	516	547	470	535	484	470	467	464	387	426
3500 - 3999g	616	552	608	571	533	512	482	442	482	480
4000 - 4499g	229	251	238	219	231	206	160	194	187	180
>4500g	51	50	41	46	50	25	41	31	34	33
Total Number of Babies	**1666**	**1663**	**1584**	**1608**	**1544**	**1406**	**1357**	**1360**	**1312**	**1357**

Induction of Labour	Primigravida	%	Multigravida	%	Total	%
2009	164	26.0%	207	20.5%	371	22.6%
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%

Perineal Trauma	Primigravida	%	Multigravida	%	Total	%
Number of vaginal deliveries	279		561		840	
Intact		0.0%		0.0%	157	18.7%
Episiotomy	151	54.1%	50	8.9%	201	23.9%
2nd Degree Tear		0.0%		0.0%	271	32.3%
1st Degree Tear		0.0%		0.0%	97	11.5%
3rd Degree Tear	7	2.5%	4	0.7%	11	1.3%
Other Laceration		0.0%		0.0%	103	12.3%
Total		**0.0%**		**0.0%**		**0.0%**

Incidence of Episiotomy	Primigravida	%	Multigravida	%	Total	%
2009	199	39.1%	85	10.2%	284	21.2%
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%

B.B.A.	Primigravida	%	Multigravida	%	Total	%
2009	0	0.0%	3	0.3%	3	0.2%
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	0.8%
2018	0	0.0%	2	0.2%	2	0.1%

3rd Stage Problems	Primigravida	%	Multigravida	%	Total	%
Primary PPH (1000ml)	49	10.3%	47	5.5%	90	6.8%
Manual Removal of Placenta	2	0.4%	7	0.8%	9	0.7%

	Primigravida	%	Multigravida	%	Total	%
Shoulder Dystocia	5	1.0%	2	0.2%	7	0.5%

Robson Groups	n-CS	n-Women	%
Group 1 - nullip singleton cephalic term spont labour	56	233	24.0%
Group 2 - nullip singleton cephalic term induced or pre-labour CS	112	211	53.1%
Group 3 - multip singleton cephalic term spont labour	12	369	3.3%
Group 4 - multip singleton cephalic term induced or pre-labour CS	32	178	18.0%
Group 5 - previous CS singleton cephalic term	195	234	83.3%
Group 6 - all nulliparous breeches	15	16	93.8%
Group 7- all multiparous breeches	23	24	95.8%
Group 8 - all multiple pregnancies	18	24	75.0%
Group 9 - all abnormal lies	8	8	100.0%
Group 10 - all preterm singleton cephalic	22	36	61.1%
TOTAL	**493**	**1333**	

Total No. of Mothers who had 1 Previous Caesarean Section	199
Number of women who had VBAC after 1 previous Caesarean Section	40

Gynaecology

Ms Juliana Henry

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.

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.

We have designated, where possible, an emergency gynaecology bed to be 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. The prompted a change in the referral pathway to the service and other quality improvement initiatives to ensure a safe and quality emergency Gynae Service.

We continue to provide an early pregnancy assessment service, with the addition of a designated senior registrar being onsite for all our EPAU sessions. As a result of a quality improvement plan to address the high number of presentations out to Gynae services out of hours we extended our EPAU opening hours and now facilitate direct GP referral with CMS triage to the EPAU service.

We continue to provide 7 day patient services sessions on a monthly basis, in our dedicated day services unit.

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It has been a challenging year for Colposcopy services in the aftermath of the Cervical service review. Despite the challenges within the service we continue to offer 16 clinic sessions on a monthly basis and nurse smear clinics.

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.

In 2018, 1011 new gynaecology out patient referrals attended; with 3276 patients attending the service for review overall. There were a total of 1397 gynaecology ward attenders.

Gynaecological Surgery Report

Ms Madeleine Munnelly

LSCS	493
Balloon Ablation Uterine	1
Biopsy Cervix	3
Biopsy of endometrium	16
Cervix Cautery/Diathermy	2
Colposcopy	4
Cystectomy	1
Cystoscopy	3
D&C	268
Diagnostic Laparoscopy	11
ERPC	84
EUA Gynae	73
Excision of Cyst	3
Fentons Procedure	3
Hysterectomy +/- BSO	4
Hysterectomy subtotal	1
Hysterectomy TAH	8
Hysterectomy TAH + BSO	28
Hysterectomy Vaginal	5
Hysterectomy Vaginal + Pelvic Floor Repair	7
Hysteroscopy	284
I&D, Abscess	1
Insertion of Mirena Coil	97
Insertion of Ring Pessary	1
Labial Resection	1
Laparoscopy	18
Laparoscopy & Dye	9
Laparoscopy Tubal Ligation	2
Laparoscopy+/- Laparatomy	1
Laparotomy ?Salpingectomy	1
LLETZ	24
Marsup of Bartholins Gland	4
Omentectomy	1
Ovarian Cystectomy	4
Oophorectomy	1
Open endometrial ablation	2
Pelvic Floor Repair +/- Hysterectomy	2
Perineal body re-fashioning	1
Polypectomy Cervical	12
Polypectomy Uterine	4
Removal of Mirena	25
Removal of Vaginal Pessary	1
Repair Ant	2
Repair Ant & Post	2
Repair of Episiotomy	1
Repair Pelvic Floor Prolapse	
2	
Repair Posterior	2
Repair Vaginal Anterior	6
Shirodkar Suture	3
Smear	12
Sterilisation Laparoscopic	2
Vulval Biospy	14
Polypectomy Cervical	13
Polypectomy Uterine via Hysteroscopy	4
I&D Abcess	1
Aspiration of Ovarian Cyst	1
Biopsy Cervix	3
Vulval Biopsy	14
Insertion of IUCD	1
Labial Resection	1
Excision Vaginal Cyst	3
Ectopic Pregnancy Sapingectomy	2
Salpingectomy Bilateral	1
Salpingectomy	2
Salpingectomy, Laparoscopic	1
Salpingo-oophorectomy	5

Obstetrics and Gynaecology Anaesthesia Report

Dr. Seamus Crowley and Ms Madeleine Munnelly

In 2018, there were a total of 1598 gynaecology procedures performed. This included 493 caesarean sections, of which 260 were elective and 233 emergency. A total of 42 general anaesthetics were administered for Caesarean Sections, 21 of which were conversions from regional anaesthesia to facilitate surgery. Labour ward activity included 1357 deliveries to 1333 mothers in this period. There were 350 (26.3%) inductions of labour and 480 (36.0%) epidurals performed during 2018. There were 123 ventouse deliveries, of which 71.5% had an epidural, and 29 forceps deliveries, of which 72.4% had an epidural.

Developments in 2018

PROMPT training continued with a total of 36 multidisciplinary staff trained.

Pre-assessment Anaesthesia Clinic

119 women were assessed in the high-risk Anaesthetic Clinic in 2018.

Post-Dural Puncture Headaches

1 patient required blood patch for PDPH.

	Caesarean Sections	Percentage
Total	493	100
Elective	260	52.7
Emergency	216	47.3
Spinal	364	73.8
Epidural top-up	87	17.6
General Anaesthesia	*42	*8.5

*21 of 42 were conversions from Regional anaesthesia to facilitate Caesarian Section surgery.

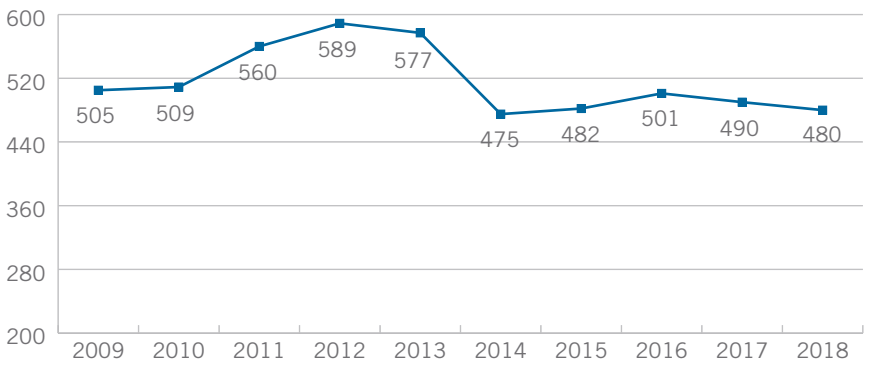
ICU HDU and CCU admissions 2018

There were 24 maternity admissions to Intensive Care (including High Dependency Care) in 2018.
Level 1 care 10
Level 2 care 12
Level 3 care 2

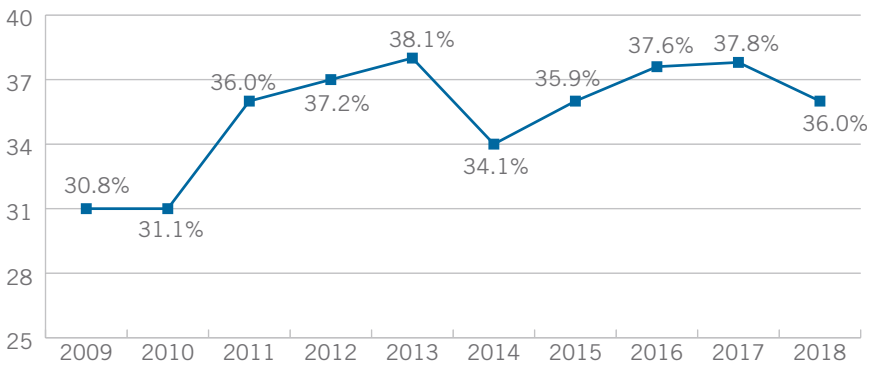
These are classified as:
- 6 Pre-Eclampsia
- 1 Pre-Eclampsia and PPH post Em CS
- 1 HELLP
- 1 Raised LFT's and worsening pruritis
- 2 Sepsis
- 1 Postnatal Group A strep infection
- 1 Laparatomy day 40 post Em CS for division of adhesions
- 1 Post op Em CS for Fibroid and Bicornuate uterus
- 1 Post op Em CS unbooked with Cardiac history
- 1 Post op Em CS and Bladder injury
- 1 Anaesthetic incident
- 1 PPH post op EL CS for Placenta Praevia
- 4 PPH's post SVD's
- 1 PPH post op El CS
- 1PPH post Failed Ventouse - NBFD

Admissions, once clinically well, were discharged to Maternity Ward.

Number of Women who had Epidurals in Labour 2009 - 2018



Percentage of Women who had Epidurals in Labour 2009 - 2018



Paediatric Report

Ms Bernie Biesty

Introduction

The following report includes clinical activity on the Paediatric Ward (in patient) and Paediatric Day Unit for the period January 1st to December 31st 2018. Data is also included for paediatric admissions from the Emergency Department (ED), paediatric admissions to Intensive Care Unit (ICU) and admissions to paediatric ward by specialty. The provision of Paediatric Services in SUH is multi disciplinary and interdepartmental. Many have included contributions to this report. On behalf of the Paediatric Specialty, I would like to thank all of our staff for their ongoing support, hard work and commitment to the service in 2018. Staff face many challenges in their daily work but the child and family remain their focus.

Overview of Paediatric Ward Activity 2018

There were a total of 3704 children treated between the inpatient and day unit attendances. There were a total of 1958 admissions to the paediatric ward (1,923 in 2017). There was 101.26 % bed occupancy, an increase of 4.92% from last year, with over 100% occupancy for 7 months of the year. The average length of stay was 3.19days (similar to 2107). There were 1016 surgical admission (251 of those day cases), 620 of those elective. The elective surgical admissions by specialty included ENT 82%, General Surgical 2%, Ophthalmology 9% and Orthopaedics 6.5 %. There were 1,387 children admitted via the ED. There were a total of 32 transfers out to other hospitals and 7 transfers in from other hospitals.

Paediatric Day Unit

There were 1495 Day Unit Attendances (ward attenders and day cases). (Please note this figure is displayed on graph as 1746, 251 of these patients were day cases treated on the inpatient unit and should not be recorded in Day Unit Activity). One of the major challenges we face in managing our day unit is the recording and capturing of data. Data is recorded manually and sometimes retrospectively. So, for comparative purposes we need to be mindful of this. A Quality Improvement Plan is in place to respond to this , 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.

ICU Admissions

There were 5 children admitted to ICU SUH during 2018 (compared to 15 in 2017). Diagnoses include Respiratory Arrest (1), DKA (1), Acute Exacerbation Asthma (2) and Post Cleft Palate Surgery Haemorrhage (1). Of these 5 ICU admissions, 2 were transferred to PICU, 1 to Temple Street transferred by IPATS and 1 to Royal Victoria, Belfast transferred by ICU team, SUH . Both children were intubated and ventilated. The remaining 3 patients who were not transferred out spent between 9-15 hours in ICU for monitoring purposes before transferring back to the paediatric ward for further management. Caring for the critically ill child and transfer of these patients from SUH remains an ongoing challenge, which we are addressing through ongoing training and education and the establishment of the Paediatric Transfer Working Group (Nursing). However, I would like to thank the entire medical, nursing and support staff associated with ICU for their ongoing commitment and support in 2018. (Information was obtained from the ICU Clinical Information System with the support of Mr. Karl Milnes, Clinical Informatics Coordinator).

Quality achievements in Paediatrics 2018

- Establishment of Paediatric Transfer Working Group (Nursing)
- Nursing Metrics
- PEWS
- Safety Pause & Clinical Handover Project
- SAFE collaboration
- Healthy Eating Menus for Children
- Pop up Eating Disorder Team

Paediatric Transfer Working Group (Nursing)

Currently, critically ill infants and children are cared for and transferred by various staff and departments from SUH (Paediatrics/ICU/ED). In August 2018, the Paediatric Transfer Working Group (Nursing) was established to ensure the safe and timely transfer of critically ill infants and children by SUH by the most appropriate staff and to provide guidelines to improve the quality of care of critically ill infants & children in SUH. The purpose of the group is to agree, prioritise and develop Quality Improvement Plans to support safe transfers of children as part of comprehensive system wide strategy to aid safe transfers of critically ill children and contribute to improved patient safety. This includes developing a SOP to guide nursing staff for the safe transfer of critically ill infants/ children, to provide education, training and up skilling of staff, to ensure that all staff caring for critically ill children in SUH are compliant with training and education provided (PLS/APLS/ STABLE/TRANSPORT) and to ensure that infants/children are transferred by the most appropriate staff. To date the group has reviewed current processes including role clarity from a nursing perspective for paediatric transfers and is making recommendations for the safe and timely transfers including the development of an algorithm to identify/support nursing staff as to who is most appropriate person to transfer the infant/child. This collaborative working group consists of DOM, DOM , CNM'S Paediatric, ICU and NICU, Clinical Skills Facilitator ICU and ADON ICU/ED.

Nursing Metrics

The Paediatric Ward, SUH continue to participate in Nursing Metrics. 2018 saw the introduction of a new suite of metrics. Results show ongoing commitment to providing high standards of evidence based care with the development and implementation of action plans supporting areas of non compliance to standards. CNM2, Bernie Clancy, ACNM2 Orla McDonagh and S/N Michelle McTigue led the nursing metrics in 2018. Support provided from Ms Maeve Lee, NMPDU, SUH.

HSE Childrens

All Group - All Locations	Jan 2018	Feb 2018	Apr 2018	May 2018	June 2018	July 2018	Aug 2018	Oct 2018
Medication Storage and Custody	→ 100%	→ 100%	→ 100%	→ 100%	→ 100%	↓ 92%	↑ 100%	→ 100%
MDA Drugs	→ 100%	→ 100%	→ 100%	→ 100%	→ 100%	→ 100%	→ 100%	→ 100%
Medication Administration	→ 100%	→ 100%	→ 100%	→ 100%	→ 100%	↓ 93%	↑ 100%	↓ 93%
Medication Prescription	→ 93%	↑ 100%	→ 100%	→ 100%	↓ 97%	↑ 100%	↓ 97%	→ 97%
Nursing Care Plan: Personal Details	→ 94%	↑ 100%	→ 100%	→ 100%	→ 100%	↓ 89%	→ 89%	↓ 76%
Nursing Care Plan	→ 100%	→ 100%	↓ 92%	↑ 100%	→ 100%	→ 100%	→ 100%	→ 100%
Nursing Care Plan: NMBI Guidance	→ 100%	→ 100%	→ 100%	→ 100%	→ 100%	→ 100%	↓ 94%	↑ 100%
Vital Signs	→ 100%	→ 100%	↓ 95%	↑ 100%	→ 100%	→ 100%	↓ 95%	→ 95%
Invasive Medical Devices	→ 100%	→ 100%	→ 100%	↓ 50%	↑ 75%	↓ 50%	↓ 0%	→ 0%
Discharge Planning	→ 100%	↓ 75%	↑ 100%	↓ 89%	↓ 78%	↑ 89%	↓ 44%	↑ 100%
Total	→ 98%	↑ 99%	→ 99%	→ 99%	↓ 97%	↓ 95%	↓ 93%	↑ 94%

PEWS 2018

The PEWS has been successfully integrated into clinical practice since October 2016. Monthly audits are carried out on the paediatric unit to ensure PEWS is being used in accordance with national guidelines. The audit determines if

- The correct age specific charts are being used for each child
- Is the document being completed correctly in each parameter
- Is the escalation guide and variance being correctly used by all staff including appropriate interventions required for the total PEWS score?

Overall compliance for the year 2018 is at 92-95%, with the aim for 100% compliance this year. A QIP has been implemented to improve compliance, the introduction of the safety pause has highlighted the deteriorating child and increasing PEWS scores, and education and support regarding use of the PEWS document is ongoing at clinical level. It would be useful to carry out further research to determine if the PEWS has reduced the number of children requiring transfer to high dependency/PICU centres. I would like to acknowledge S/N Nicola Waters for leading out on the PEWS audits.

Safety Pause & Clinical Handover Project

The National Standards for Safer Better Healthcare (HIQA, 2012) advocate 'Sharing of necessary information to facilitate the safe transfer or sharing of care in a timely and appropriate manner and in line with relevant data protection legislation' (2.3.3, Page 46) as a required standard for the provision of safe, quality care. Recent adverse incidents (Keogh, 2013, HIQA, 2013, Francis, 2013 & NCEC, 2013) have highlighted the impact of poor commmunication in the provision of care and have informed the development of a national guideline governing clinical handover in the acute hospital (NCEC 2014). The paediatric ward in meeting standards and requirements governing effective communication agreed to undertake the shift handover project in June 2018 in collaboration with Nurse Practice Development.

An observation of handover practice in the Paediatric completed in June 2018 concluded a custom and practice process for handover whereby handover was conducted at the nurses station away from the patient. A key recommendation of this audit was the introduction of a standardised process governing handover in accordance with National Guidance governing Clinical Handover (National Clinical Guideline No.11, NCEC 2014). The Shift Handover Project was implemented in the Paediatric ward in July 2018 and aimed to:

- Introduce a standardised process/ tool (ISBAR) in the communication of information at handover in accordance with national guidance.
- Include a safety briefing in the handover process
- Provide evidence of transfer of accountability and responsibility at handover

- Provide opportunity for patient / families to participate in care thus inproving patient experience
- Reduce incidence of never events eg medication prescription errors
- Improve compliance in risk assessment completion
- Improve staff satisfaction regarding patient handover

Following review of national guidance and staff engagement, the following handover practice was agreed and implemented.

Step One: The Safety Pause

The safety pause aims to enhance communication, prioritise patient safety and experience and embed quality improvement in daily practice. The Safety Pause which is held at the Patient Status at a glance Whiteboard is attended by all staff on duty and serves to answer the following question 'what patient safety issues do we need to be aware of today?' . While this process serves to enhance communication governing patient safety issues, immediate actions may also be discussed and agreeed at this time.

Step Two: ISBAR Framework And Bedside Handover

On completion of the safety pause, staff migrate to their allocated teams and complete handover at the bedside. The ISBAR mnemonic serves to prompt staff in the delivery of information, thus ensuring consistency in information shared and reducing potential for omission. While delivering handover at the bedside, staff use this opportunity to meet and greet the patient, check the patient identification wristband, check intravenous infusions/ treatments, accuracy in signage at the bedside and documentation in the bedside folder. Discussion regarding patient care at the bedside allows for staff to review medical management and nursing care and also provides opportunity for the patient to participate in the discussion regarding their care. Checking documentation to include EWS Chart, DPAR and risk assessments stored at the bedside provides opportunity for staff discussion regarding patient management and identification of omissions that may lead to potential errors. Any omissions may be addressed at this time thus promoting patient safety and continuity of care.

Step Three: The Handover Signature Sheet

The final critical step in the process involves documented evidence that handover has taken place. Staff were in agreement to document detials of handover received in accordance which ISBAR in the nursing progress notes on commencement of each shift.

A PDSA cyclical approach was adopted in the introduction of a change in practice and included the following steps.

1. Develop Project Charter, GANT Chart and complete SMART tool.
2. Observation of practice
3. Engagement with staff with view to introduction of new practice
4. Observation of practice following introduction of change
5. Engage with and support staff during the initial weeks of implementation to embed the new practice and address any challenges

Evaluation of the process with staff has concluded the following.

Staff have reported increased satisfaction with the new approach to include

- timely communication of safety issues
- the opportunity to meet the patient and commence prioritising care
- reduced time in delivery of handover
- reduced incidence of never events eg medication prescription errors
- improved compliance in risk assessment completion
- documented evidence that handover has take place.

I would like to acknowledge the work and support of Ms Eileen Carolan & staff NMPDU and Ms Orla McDonagh, ACNM2 Paediatrics who led the Clinical Handover project. (information submitted by Ms Eileen Carolan, NMPDU).

SAFE Collaboration

Situation Awareness for Everyone (SAFE) is a quality improvement initiative which aimed to improve situation awareness in clinical teams in order to detect potential deterioration and other potential risks to children in hospital. This programme, facilitated by the RCPI invited teams from Paediatric Units across the country to participate. The team from Paediatrics, SUH consists of Dr Ghia Harrison, Consultant Paediatrician, Ms Bernie Biesty, CNM2, Dr Elana Nichete, Paediatric Registrar. The key intervention of the SAFE programme is the 'huddle", a structured case management discussion which is central to facilitating situation awareness. In this process, a range of prospective indicators of risk or deterioration, including clinical indicators (High PEWS), staff concern (opportunity for staff to identify their concerns about patients who may not trigger concern with PEWS or where they have a "gut feeling" that something "isn't right" with a patient) and parental concern are considered. The core tasks of the huddle are to identify risks to patients, the development of a shared team understanding of patients who are at risk of deterioration and the making of plans to mitigate such risks. The huddle, when incorporated with other tools such as PEWS and ISBAR leads to improvements in the quality of information shared amongst the MDT and ultimately enhances patient safety. Here, in SUH, we have piloted and evaluated our Huddle. There are many challenges to implementing and sustaining this change including time, attendance, buy in from all members of the MDT. We are working collaboratively with our MDT colleges to improve consistency and attendance at the Huddle in an effort to embed the Huddle in our daily work.

Paediatric Menus

Over the past year a Paediatric Subgroup of the Oral Nutrition Steering Group, SUH was established to develop and implement a "Healthly Eating" initiative on the Paediatric Ward. Traditionally chips were served daily at lunchtime on the ward despite multiple attempts to remove them from the daily menu over the years. This year it was finally achieved. At present children are offered a choice of pasta with / without a sauce and grated cheese / chicken goujons or fish fingers, soup, variety of sandwiches, fruit and yogurts daily at lunchtime. Parents and staff have reported satisfaction with this change.

It was also decided to trial the introduction of a 'Grab and Go' option for parents who are unable to leave the ward at mealtimes. This involves parents paying €5 to catering staff who will deliver a pre-packed lunch – including a brown bread sandwich, fruit and bottle of water to the parent on the ward.

Paediatric Pop up Eating Disorder Team

Traditionally the admission of an eating disorder patient to the paediatric ward was very challenging for everyone as the medical team and ward staff did not have CAMHS support or any clear guidelines. These patients by virtue of the nature of their illness can be very challenging in the hospital environment.

Our colleagues looking after adults with acute eating disorders, as a result of similar experiences had established a Pop up Eating Disorder Multidisciplinary Team a few years ago. They supported the implementation of the internationally approved MARSIPAN (Management of Really Sick Patients with Anorexia Nervosa) guidelines locally and have been very successful in treating some very challenging acute adult anorexia nervosa patients. They had very kindly supported the paediatric team with some complex patients in recent years. Based on the experience of working with the adult team, it was identified that a similar paediatric team could be very effective. This team would work to implement the Junior MARSIPAN Guidelines locally. With the support of Dr Clare Veitch, Consultant Child and Adult Mental Health, Consultant Paediatricians, Dieticians and ward nursing staff a MDT Guideline for the Management of Acute Eating Disorder patients was developed and implemented. Currently the established practice is that a multidisciplinary team meeting is called as soon as practicable post admission a patient with anorexia nervosa and weekly thereafter. At this meeting a strict management plan is agreed for the following week. Generally parents / carers with be invited to speak with the team at the end of the meeting if any particular concerns need to be addressed. Adaptations to the management plan between meetings are resisted.

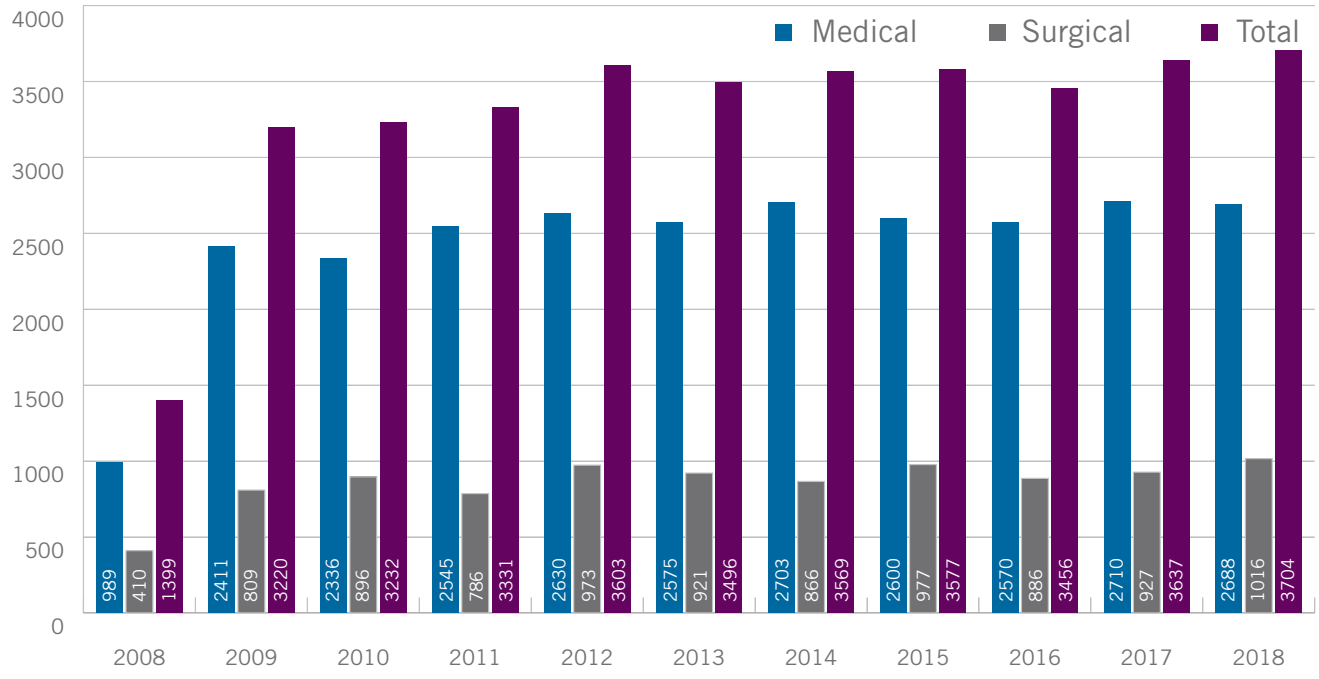
While this patient group remains challenging for healthcare professional in the acuter setting, our overall experience to date is that patients are achieving safer weights and staff are feeling more supported. Post discharge from hospitals patients remain under the care of the CAMHs service.

Clinical Nurse Specialist – Paediatric Liaison

The role of the Clinical Nurse Specialist – Paediatric Liaison (CNS PL) was developed in Sligo University Hospital in 2001 and has evolved over the years to meet the challenges and changes in healthcare delivery to children and their families. The CNS PL (Ms. Mary Connor) supports the Paediatric Specialty (in patients, day ward , out-patients and NICU) working as a link between infants & children with acute and chronic conditions and their families, nursing staff, the Consultant Paediatricians, other hospitals and the wider multidisciplinary team in SUH.

The CNS PL role encompasses a large component of patient care across the acute and community setting. This role includes patient assessment working closely with the Consultant Paediatricians and the wider multidisciplinary team, patient / family education, counselling and support and interdisciplinary and multidisciplinary communication including strong liaison with primary care providers. The CNS PL role is a critical one in the advancement of quality care delivery through guideline development and knowledge sharing at local, regional and national levels. The CNS PL role is also crucial to the forging of strong links between the patient and their care providers.

Admissions to Paediatric Ward by Medical or Surgical 2008-2018



On a day to day basis, the CNS PL role involves liaison with the multidisciplinary team both in hospital and in the community, discharge planning in consultation with professionals and parents and the provision of short-term support and monitoring for the child and family in the home. The CNS PL also performs procedures such as, phlebotomy and dressings in the home or as a ward attender whichever is appropriate, care of central lines including Broviac, Hickmann and T.I.V.A.D's, coordination of the RSV prophylaxis programme for infants, provision of support for enteral feeding to children, families /carers including training and education, liaising with PHN's regarding supplies and follow up and monitoring of enteral feeding tubes. The CNS PL provides education to families and school/crèche staff on anaphylaxis management and prolonged seizure management

As part of our shared care programme with the Oncology/Haematology Service, Our Lady's Children's Hospital Crumlin, the CNS PL supports parents and children undergoing chemotherapy, provides central line management including dressings and blood sampling and liaising with OLCHC regarding treatments and follow up. The CNS PL also has a pivotal role in the coordination of administration of chemotherapy to children locally in conjunction with adult services in SUH.

The role of the CNS PL is invaluable in its ability to enable children and their parents to participate in decision making about their health needs, articulate and represent children's interests in collaboration with the multidisciplinary team, implement changes in healthcare in response to patient needs and service demands and the provision of specialist information, training and education to children, their families/carers and healthcare professional both in the acute and community setting.

Cardiac Investigation Department support for Paediatric Specialty

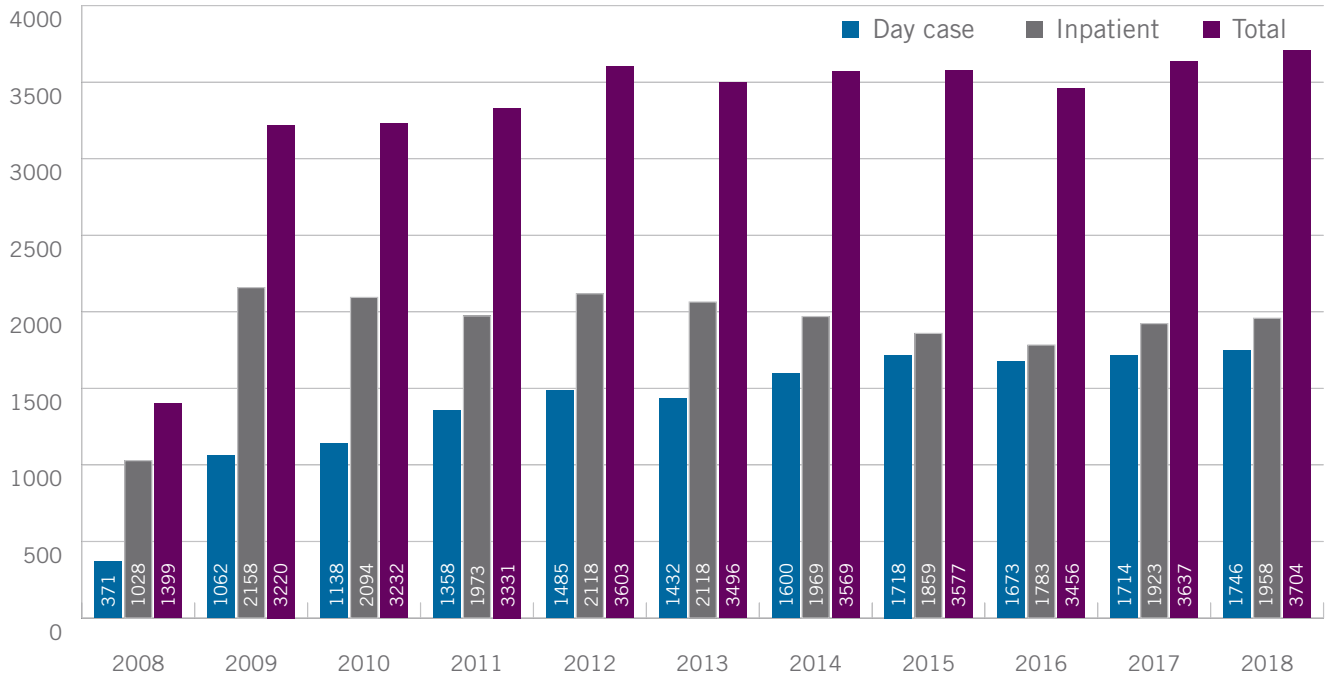
The Cardiac Investigation Department supports the Paediatric and Neonatal specialities with a wide range of routine diagnostic procedures in the evaluation and screening of Congenital Heart Disease in this region and beyond. Referrals are accepted from Paediatricians both here at Sligo University Hospital (SUH) and Letterkenny University Hospital (LUH). This is a regional service for patients of the North West of Ireland with clinical governance and support from Dr Adam James, Consultant Cardiologist at the tertiary referral site of Our Lady's Children's Hospital Children, Crumlin.

Staffing of the Cardiac Investigations department is provided by Cardiac Physiologists with a special interest in Paediatric Cardiology.

Routine Paediatric 15 Lead Electrocardiograms (ECG) is performed to determine the heart rate and cardiac rhythm as well as determination of chamber size by voltage criteria. In 2018, a total of 198 paediatric ECG's were performed for in-patients. Routine arrhythmia detection using 24/48/72 hour Holter Monitors and five day Cardiac Event monitors as well as 24 hour ambulatory Blood Pressure monitors are also provided in our department. Support is also provided to ante-natal clinics and the foetal assessment unit for rapid access to both ambulatory blood pressure monitoring and Holter monitoring.

Cardiac Ultrasound (Echocardiography or Echo) is a valuable diagnostic tool in the assessment of Neonates and small children for congenital heart disease. Echo allows two dimensional imaging of cardiac structures and with the assistance of colour flow mapping and

Admissions to Paediatric Ward by Day Case / Inpatient 2008-2018



spectral Doppler aids in the detection of cardiac defects both intra-cardiac and extra-cardiac.

Both the ECG and Echo provide valuable diagnostic information to the referring Consultant paediatrician to assist in the management of these patients and in decision making regarding referral to a specialist centre for the expert opinion of a Paediatric Cardiologist. In 2018, 446 patients have been referred to us within the North West region for evaluation of children with suspected congenital heart disease.

Quality assurance meetings are held locally in house and are overseen by the Chief Cardiac Physiologist who has over 30 years' experience in Paediatric Echocardiography having worked in Paediatric specialist centres in Ireland and the UK. Continued professional education is an essential requirement and staffs have attended courses in Birmingham and Southampton as well as participated in the accreditation process of the European Society of Cardiology in Echocardiography.

It is hoped that a new initiative in the coming year would see the visiting Consultant Paediatric Cardiologist, Dr Adam James, who currently attends clinics twice a year here in Sligo and three times a year in Letterkenny (LUH) increase the frequency of these visits and devote an addition half day to oversee and report on Echocardiograms which have been performed here in SUH as is best practice for clinical governance. It is hoped an additional one hour can be devoted to teaching especially in the area of ECG interpretation for all staff.

Pharmacy services to Paediatric Unit SUH

The Paediatric services SUH receive 0.25WTE Clinical Pharmacist services. This role includes:

- review of inpatient medication (twice weekly)to monitor prescriptions, prevent prescribing errors and avoid adverse drug reactions
- answering medication relation queries including dosing, administration, monitoring, supply and side effects
- liaison with Community Pharmacy regarding supply of difficult to source medication upon discharge
- maintaining medication administration instruction sheets for children on multiple and complex medication regimens
- sourcing and compounding of medicines that are not commercially available in acceptable dosage forms for children
- advice regarding administration of medicines via enteral feeding tubes
- advice to GPs and Community Pharmacies on drug dosing and supply in children and in pregnancy
- checking prescriptions for parenteral nutrition for neonates
- membership of Paediatric SMT
- review and advice on PPPGs relating to medication and membership of SUH paediatric ppg group.
- promotion of medication safety on the ward and on discharge

The above activities which are highly valued by the specialty are restricted due to the time allocated. They underline the potential that would be achieved for all paediatric in-patients with suitably resourced Clinical Pharmacist time. At present some patients do not get a daily review by a Clinical Pharmacist despite the significant risks associated with this patient cohort. This situation is due to the limitation on time available for provision and development of these patient safety services.

Pharmacist (Paediatrics) Education 2018:

- Completion of HSE education programme on 'Parenteral Nutrition in Paediatrics & Neonatology', July 2018
- Attended OLCHC Paediatric Haematology & Oncology Shared Care Study Day, in SUH, May 2018
- Presented at Pharmacy Journal Club, 'The use of Melatonin in Paediatrics', November 2018

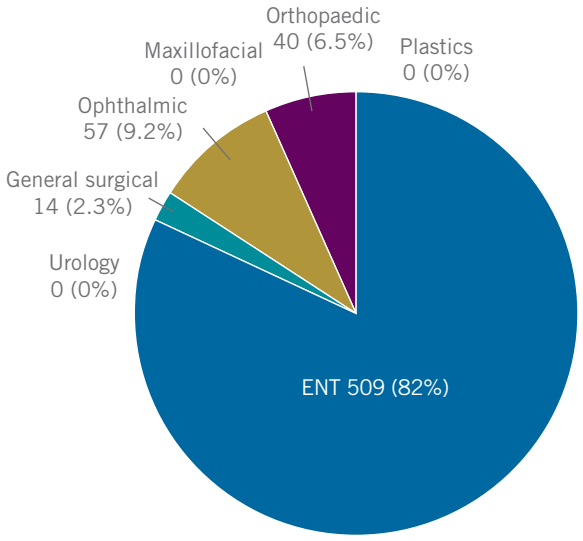
Pharmacy Technician 'top-up'

The Pharmacy Department also provide a stock 'top-up' service to the Paediatric ward. This involves ensuring that the ward has sufficient socks of an agreed list of medicines and that all medicines are in date.

Paediatric Acute Asthma IV medications guideline for Sligo University Hospital

In 2018 a guide on the use of intravenous medicines for acute asthma was launched. This was a project of the Paediatric Asthma Working Group and was developed to standardise the use of IV Magnesium Sulphate, IV Aminophylline and IV Salbutamol throughout the hospital. A multidisciplinary group involving Pharmacy, Paediatrics, ICU and ED collaborated to produce a single document with detailed dosing, monitoring and infusion tables for the three drugs. This has proved an invaluable resource to nursing and medical staff.

2018 Surgical admissions by specialty (elective admissions)



Paediatric services under shared care agreements – Aseptic production

Paediatrics SUH has a well developed shared care programme with Rheumatology, Gastroenterology , Metabolic and Haematology/Oncology Services, in collaboration with the tertiary referral centres. As part of their shared care, children receive Infliximab, Tocilizumab ,Vimizim and some chemotherapy in SUH. The Aseptic Compounding Unit (ACU) in the Pharmacy Department prepares these products as part of this agreement. All prescriptions are done in collaboration with the shared care team in OLCHC & CUH,Temple Street. The ACU pharmacy team have worked with the paediatric speciality to develop PPG's and SOPs surrounding this service. This service involves aseptic production only – no WTE has been allocated with regard to clinical pharmacy review of these patients, who attend on a day case basis.

Medical Social Work Service to Paediatrics, SUH.

The Medical Social Worker in SUH is available to support families through the emotional and practical challenges of a childhood illness which requires medical intervention and hospital admission. The Medical Social Worker's role is to assess what the family's needs might be and to address those needs within the service or to refer onto appropriate community based supports for follow up. Medical Social Work support is available to children and their families who attend the hospital on both an inpatient and outpatient basis. We recognise that a child's illness can be a stressful time for families. By providing practical and emotional support we aim to minimise these difficulties.

Childhood Illness

The Medical Social Worker recognises that a diagnosis of a long term condition or illness impacts on the whole family. We use our counselling skills to offer emotional support to children, parents and families who have a new diagnosis of illness or long term condition. We advocate and assist families to make contact with local services that may offer support on the child's discharge from hospital.

Bereavement

In the event of the death of a child we offer support to families at the time of bereavement and on a follow up basis. Offering parents one to one support and assistance on both an emotional and practical level. We support and advise parents in how to tell their other children and extended family.

Information and Guidance

The Medical Social Worker can provide support in relation to parenting and childcare issues and also with family life changes associated with illness and hospitalisation. We can also provide liaison, advocacy and support in relation to accessing various services and provision of information regarding social welfare entitlements, birth registration, housing etc.

Child Protection and Welfare

In some situations families may have difficulties caring for their children and meeting their children's needs. We offer support to families who have problems relating to family separation, addiction and mental health difficulties, disabilities, other health issues, financial and housing issues. The child's welfare is paramount and the Medical Social Worker works closely with parents, the multi-disciplinary team and Tusla - the Child and Family Agency where these issues arise and may cause concern. Medical Social Worker can be a support and a resource to mandated persons who have a responsibility to report Child Protection and Welfare concerns to Tusla, Child and Family Agency.

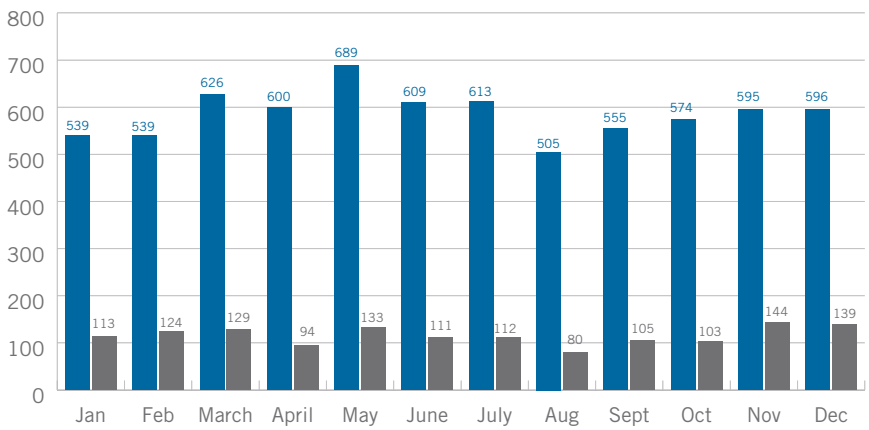
Resource Issue

One Senior Social Work Practitioner provides Social Work cover to the Paediatric and Neo Natal Units along with providing cover to another speciality area within Sligo University Hospital. Due to a lack of resources the Social Work Service does not have the capacity to provide a dedicated service to Children and Families attending Paediatric Services.

Retirements

The staff of the paediatric ward would like to send best wishes the following staff nurses who retired in 2018: Elizabeth Barrins, Ann Murray, Marie Walpole & Mary Doohan. We would like to thank them for their many years of hard work, dedication and commitment to the paediatric ward and wish them every health and happiness in their retirement.

2018 Paediatric ED Activity



Early Pregnancy Assessment Unit / Fetal Assessment/Fetal Ultrasound

Ms Niamh Mc Garvey

This unit was established in 2003 and comprises of 1 main assessment area with two couches and 3 scan rooms. It is situated on level 4 and operates on a Monday to Friday basis from 07:30 hours to 16:30 hours. The Early Pregnancy Unit (EPAU) provides assessment, support and advice is also provided for women who have possible problems in early pregnancy. It is led by Clinical Midwife Specialists in Sonographery, 2 Midwife (Sonographers) and supported by the multidisciplinary team. The EPAU runs from 07:30 -10:00 hours Monday to Friday. Women can access this service by GP or Obstetric Referral.

The Fetal Assessment Unit provides a service to antenatal women who require evaluation of both Fetal and maternal well-being. The Fetal Assessment Unit operates from 08:00 hours to 16:30hours and women access the service through self-referral, GP referral or referral from ANC from 18 weeks of pregnancy. Women who are planned for an Elective Caesarean Section are also pre assessed in the Fetal assessment Unit.

The Fetal Ultrasound Service was established in 1995. There are 4 CMS sonographers (1 on Longterm Sick leave) and 1 recently appointed Clinical Specialist Radiographer for Sonographery, whom perform all routine and emergency pregnancy USS within the speciality.

A total of 6,672 women attended the Fetal Assessment Unit/Early Pregnancy Unit in 2018, of whom 5,201 had scans performed

Neonatal Unit

Ms Carmel Durkin

Introduction

The Neonatal unit in Sligo University Hospital is a level one unit comprising of 2 intensive care cots, 4 high dependency cots and 4 special care cots. The service is lead by 5 paediatricians (1.0 WTE to community setting). The unit is staffed by a CNM2 and a mix of neonatal trained nurses, midwives and paediatric nurses, some with paediatric critical care training or experience.

The unit is supported by a multidisciplinary team which includes healthcare assistants, clerical officer, dietician, a paediatric physiotherapist with a special interest in developmental care, social worker, pharmacist, an experienced paediatric trained cardiac technician, lactation consultant, and a paediatric liaison nurse. A new appointment in 2018 of a CMS in Bereavement Support is an additional support to families and staff in the provision of palliative care and bereavement support.

Ophthalmology, ENT and Dermatology referral , review and follow up are available for infants attending Sligo University Hospital if required. There are also cardiac and cleft lip / palate satellite clinics periodically.

Neonatal Unit Activity 2018

There were 302 admissions to the neonatal unit in 2018 which included 17 day cases. There was a slight increase in admissions compared to 2017.The average total daily occupancy rate for 2018 was 47.62%. Looking at infant dependency as per BAPM (British Association of Perinatal Medicine) the average daily occupancy rate for intensive care was 0.68%, high dependency was 4.93% and special care was 113.42%. In 2018 31% of admissions were preterm i.e. < 37/40 gestation and 69% were term infants.

There were 41 transfers to and from tertiary neonatal and paediatric hospitals.

The NNTP facilitated 14 transfers (13 transfers out and 1 transfer in).

1 transfer in from a level 2 neonatal unit was facilitated by the referring unit due to nurse staffing shortages in our unit.

Nursing staff in Sligo University Hospital neonatal unit transferred a total of 26 infants. Of these 8 were emergency transfers out including 1 paediatric infant from Emergency Department. The remaining 18 infants were retro transfers for ongoing neonatal care. Infants were discharged to home, maternity ward, tertiary neonatal and paediatric hospitals, and 1 infant was transferred to paediatric ward for ongoing care.

Quality Initiatives in 2018

- Audit and site preparation for student midwife placement in NICU completed.
- Nursing staff attended 1st time preceptorship training as part of site preparation for student midwives.
- 2 paediatric nurses completed Neonatal Foundation Course and gained clinical experience in neonatal unit supported by preceptors.
- Nursing staff attended Maternity Bereavement study day.
- Nursing staff attended workshops on Open Disclosure and Complaints Management.
- Neonatal nursing staff achieved 100% certification for STABLE study day and NRP training.
- CNM2 attended 1st time manager's study days and People Management, Legal Framework.
- Standardisation of neonatal resuscitation trolleys throughout maternity services in Sligo University Hospital.
- Ongoing clinical skills training for venopuncture and phlebotomy for neonatal nursing staff.
- Commenced safety pause and clinical handover project.
- Introduced colostrum collection kits to support breastfeeding mothers with hand expression.
- Introduction of neonatal milestone cards.
- Name alert stickers were introduced for multiple births or infants with similar names

Conclusion

Continuing professional development continues to be supported to ensure safe, quality evidenced based practice. Challenges to the service include: unit design (not purpose built), storage facilities, lack of parent facilities, privacy, and recruitment and retention of neonatal nurses.

I would like to take this opportunity to thank all the staff in the neonatal unit for their dedication and commitment in caring for infants in the neonatal unit and for support provided to parents. Thanks also to the wider multidisciplinary team and senior midwifery management for their contributions and support.

Antenatal Clinics

Ms Ita Morahan

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.

In 2018 we booked 1416 under the care of four consultant obstetricians. 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 and Carrick on Shannon clinics. 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.

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. In 2018 we screened 692 women for gestational diabetes with 8% of those screened receiving a positive result. 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.

For 2019 we continue to provide a high standard of holistic care to women attending all of our antenatal clinics and look forward to future developments such as the appointments of a Mental Health Liaison midwife and a diabetic Midwife Specialist.

Antenatal Education

Ms Catriona Moriarty

Antenatal Education programmes are provided through a standardised multidisciplinary education package designed in collaboration with the maternity services, public health nursing physiotherapy and health promotion. The demand for Classes continued throughout 2018.The philosophy of the Antenatal Education team is to promote and support normal childbirth by empowering women and their partners to make evidence based informed choices. Students are welcome at all classes.

Classes which aim to support prospective parents in making informed choices consist of:

1. Classes for couples delivered in the local primary care centre.
2. Community classes throughout the region.
3. Young parent classes.
4. Refresher classes.
5. One to one classes
6. Breastfeeding preparation class.
7. Tour of the labour ward and maternity unit.

Referrals to antenatal education programme come from:

- Antenatal clinic
- Fetal assessment
- GPs/ practice nurses
- Public health nurses
- Physiotherapy department
- Social workers
- Health Promotion

Each programme is continually evaluated with assistance from Health Promotion staff and appropriate recommendations are implemented to meet the needs of prospective parents. The antenatal education committee which meet biannually with representation from Maternity, Physiotherapy, Social Care, Public Health Nursing, Health Promotion, General Practice Nursing and Consumers.

Breastfeeding

Ms Catriona Moriarty

Promoting, Supporting and Protecting breastfeeding is an integral part of care given to the pregnant woman, new mothers and their babies in Sligo University Hospital.

We continue to work towards fully implementing the 10 steps of the baby friendly hospital initiative (BFHI) recommended by WHO/UNICEF.

In 2018 our breastfeeding rates were 60.1% on initiation and 50.7% on discharge from hospital. We continue to strive to increase our rates by providing education for both parents and staff. In addition to our antenatal classes our breastfeeding preparation class is run in conjunction with public health nursing and supported by health promotion. The classes are held monthly both afternoon and evening to provide more choice for our parents. It is not only attended by first time mothers but also by mothers who did not breastfeed before or experienced challenges in establishing breastfeeding previously. In 2018 a total 215 mothers attended the classes many accompanied by partners or support persons.

A postnatal breastfeeding clinic for mothers is run by lactation consultant midwives and public health nursing. It is held once weekly by appointment. In 2018 91 mothers attended clinic by appointment. Some mothers had repeat clinic visits. Telephone support continued throughout 2018. Feedback to date has been very positive for this clinic.

The clinic is complimented by local breastfeeding support run by voluntary groups and health professionals.

On discharge from hospital all breastfeeding mothers are given contact details of support services within the hospital, community care area and breast feeding support groups within the area.

Sligo University Hospital is represented on the Breastfeeding Committee for Sligo /Leitrim with midwives public health nursing health promotion GP's neonatal staff and lactation consultants. This multidisciplinary team which also includes a consumer and voluntary groups meet quarterly and strives to increase the overall breastfeeding rates in our region.

National Breastfeeding Week 2018 Sligo University Hospital

Sligo University Hospital marked National Breastfeeding Awareness Week in 2018 with many events throughout the hospital and community. Information stands were placed in the main foyer of the hospital, antenatal clinics, classes and the maternity unit. The stands were very colourful and informative, with posters, leaflets and balloons printed with the message "Breast is Best" and were supported by midwives and lactation consultants. The stand in the main foyer of the hospital had baby vests with the benefits of breastfeeding printed on them. This generated great interest from the general public. Quizzes were held for mums on the maternity ward and at antenatal clinics both within the hospital and the outreach clinics in the community, with prizes for the winners.

Colourful badges were worn again this year by staff to promote breastfeeding with the logos "Breast is Best", "Breastfed is Best fed" and "Breastfeed it's Natural". Both the Labour ward and the Maternity Ward were decorated with arches of colourful pink balloons which were very well received by staff, parents and families.

In association with the Saolta Breastfeeding Forum and with support from Health Promotion, a workshop was held again this year for transition year students, both boys and girls, from local schools. This initiative, which is held jointly by acute hospitals in the Saolta Group receives very positive feedback each year and where better to promote breastfeeding as the "Natural Way" to feed babies..

Training continued throughout 2018. Twenty hospital and community staff attended six hour breast feeding updates and training. We also had an outside facilitator for 2 days who facilitated 14 hours of the Baby Friendly Hospital Initiative of which 18 staff from both hospital and community attended. Four midwives under took the Lactation Consultation exam in 2018 and were successful.

Colposcopy Service

Dr. Vimla Sharma and Ms Sinead Griffin

Team Members

Dr Vimla Sharma, Consultant Obstetrician Gynaecologist, Lead Colposcopist
Dr Heather Langan, Consultant Obstetrician Gynaecologist
Dr Nirmala Kondaveeti, Consultant Obstetrician Gynaecologist
Ms Sinead Griffin Clinical Nurse Manager
Ms Jennifer Curley, RGN
Triona Mc Intyre RGN
Ms Mary Kinirons, RGN
Ms Mary Delaney, RGN
Ms Patricia Murphy, Clerical Officer
Ms Davina Cox, Clerical Officer

The Colposcopy Service at Sligo University Hospital (SUH) continues to follow Cervical Check standards as set out in the Organisational & Clinical Guidance for Quality Assured Colposcopy Services.

Referral waiting times, biopsy rates and rates of attendance are all within the parameters set by Cervical Check. On average, four Consultants led colposcopy clinics are run per week and four nurse led smear clinics are run per month. Timely diagnosis and treatment are key priorities of the service.

The quality assurance criteria (KPIs) were satisfactory and within the parameters set by Cervical Check during the first half of 2018. The second half of 2018 was quite a challenging period for Cervical Check and so it was for all Colposcopy Units across the country including our unit. Some of biggest challenges were smear results backlog, delays in providing results to women, increase in clinical referrals to Colposcopy unit and referral waiting times.

In 2018 a total of 642 new patients (increase by 20% from 2017) attended the service and 953 (up by 5% over 2017) patients attended for follow up/review visits. There were 116 LLETZ treatments performed under local anaesthetic and 9 were performed under general anaesthetics. A total of 392 women attended nurse smear clinics. The appointment/cancellation rate & DNA rates were more or less the same over the last few years.

A total of three cases were diagnosed with cervical cancer. Squamous cell carcinoma was diagnosed in two cases and adenocarcinoma in one case. All of these cases were promptly referred to Gynae-Oncology centres in Dublin/Galway for further management.

Partnership Services

The service continued to work in partnership with Irisoft UK, which provides a patient management and audit software system known as Compuscope, and Medlab Pathology, Dublin, which provides cytology and high risk HPV testing services. Multidisciplinary team meetings were held at one to two monthly intervals and were facilitated by Dr Clive Kilgallen, Consultant Histopathologist, SUH, and Dr Eibhlis O Donovan, Consultant Histo & Cytopathologist, Medlab Pathology.

Reporting

Monthly, quarterly and annual reports of activity were generated and submitted to Cervical Check.

Summary

In summary, it was not only very busy (with 20% increase in referrals) but challenging year for the Colposcopy service at Sligo University Hospital. All the Consultants, nursing and administrative staff did go that extra length to provide quality care to all women who attended the service.

LLETZ histology results January December 2018
LA & GA LLETZ

	Total Number	Percentage
CIN I	19	15.2
CIN II	36	28.8
CIN III	61	48.8
CIN III + SMILE	4	3.2
SMILE	1	0.8
Squamous cell carcinoma	2	1.6
Adenocarcinoma	1	0.8
Negative	1	0.8
Total	**125**	**100**

Women's Health and Continence Physiotherapy Service

Ms Joanne Kilfeather

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 2018, 1,150 mothers were given postnatal Physiotherapy advice on the Maternity ward. This information related specifically to safe functional movements, chest 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 833 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 6 weeks post delivery. There were 13patients with 3rd degree tears treated in 2018, with an additional 13 women presenting with acute urinary incontinence issues

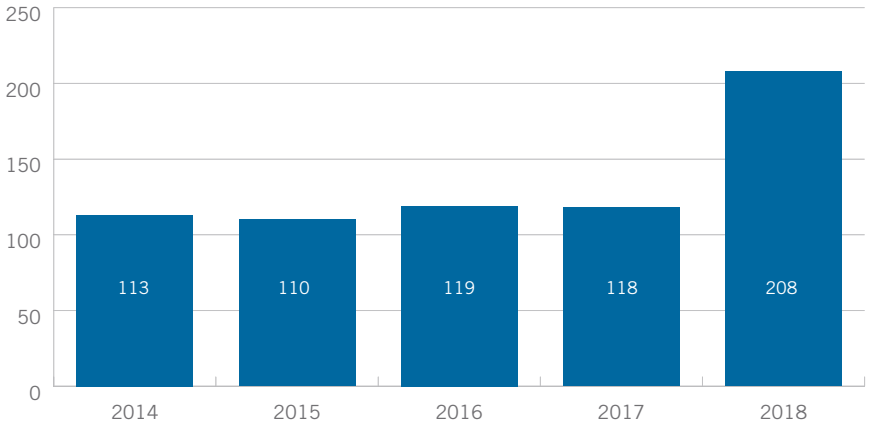
Our Outpatient Obstetric and Gynaecological Physiotherapy service treats patients with antenatal, post natal and gynaecological diagnoses, ranging from urinary issues, pelvic organ prolapse, pelvic pain and antenatal musculoskeletal pain. The outpatient service receives Consultant and GP referrals for both Obstetric and Gynaecological patients.

Antenatal Outpatients referrals account for 36% of the new patient referrals into the Women's' Health and Continence service. The vast majority of these referrals are concerned primarily with musculoskeletal pain.

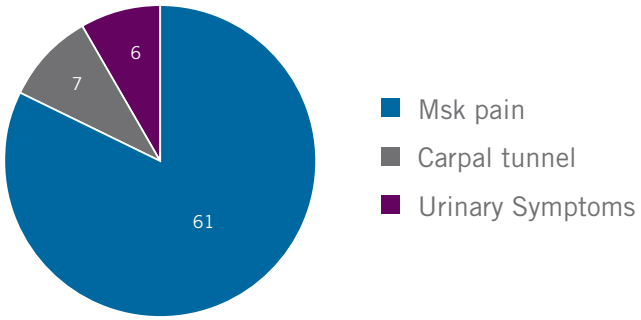
Antenatal Education

Physiotherapy provides two of the 5 five daytime classes and co-deliver the one night-time antenatal classes in every block of classes attended by an expectant mother. This service is run in conjunction with our midwifery colleagues.

New Outpatients Assessments



Antenatal Outpatient Referrals



Total No. Day Classes	Total No. Evening Classes
18	17

Limitations

Outpatient cancellations on the day of Physiotherapy appointments are particularly high in the area of Women's Health and Continence. In comparison to other Physiotherapy outpatient specialities the non attendance rate is almost double that of musculoskeletal outpatients. On further investigation, the highest rate of last minute non attendance is for mothers of young families due to reasons of either the mother or her children having an unexpected illness. This is an unfortunate and often unavoidable scenario which causes lengthened waiting times for other service users to attend this service.

Initiatives

Data from 2018 showed a rise in patient treatments due to the Women's Health Physiotherapist having returned from Maternity leave. We endeavour to put initiatives in place to try and address this problem.

In order to address the problem of late cancellations, a decision was made to make direct phone contact to a large majority of patients to discuss the appointment and confirm willingness to attend. This maximised the rate of attendance for new appointments. However, this alone cannot address the issue of unexpected malaise in a household and alternative initiatives are being explored with Physiotherapy and hospital management to improve attendance rates or to facilitate other means of patient engagement with the physiotherapy services.

Paediatrics and Neonatal Physiotherapy

Ms Sheila Kiely, Mr. Derek Wynne and Ms Joanne Kilfeather

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 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 year due to the loss of one member of staff to internal promotion. 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, neuro-developmental 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, 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, from the initial application of the harness and parent education, weekly harness reviews and drop in clinics for harness re-application on repeat scanning days. To date this increasing demand has been meet with existing resources but this situation is untenable into the future as the number of babies requiring harness treatment in the first five months of 2019 is already approaching the total number of babies who required the service in the whole of 2018. 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.

Figure 1-Number of Inpatient Paediatric Referrals

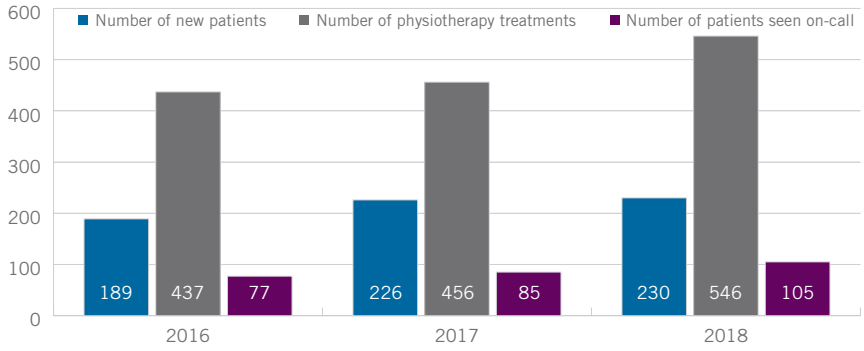
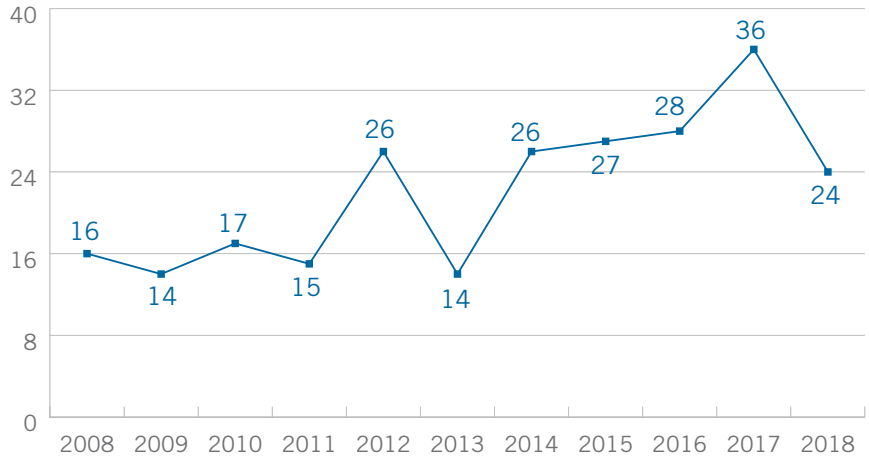


Figure 2- Number of Babies referred for Pavlik Harness Treatment 2008 - 2018



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 2018 the outpatient physiotherapy service was operating at a 50% capacity due to the promotion of a WTE clinical specialist in paediatrics 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 2018 (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).

	Number of New Patients	Number of Physiotherapy Treatments
Inpatient Paediatrics	230	546
Outpatient Paediatrics	93	741
Neonatal Intensive Care	11	21
Development Dysplasia of the Hip	36	360

North West Paediatric Insulin Pump Service

Ms Sinead Molloy and Ms Claire Maye

The NW paediatric pump service was established in 2015 at Sligo University Hospital, using a hub and spoke operational model with outreach to Letterkenny.

There were approx 110 patients using the service in 2018 attending Sligo University Hospital (SUH) and Letterkenny University Hospital (LUH). The service continues to display tangible benefits to the children of the North West with type 1 diabetes.

2018 was a busy year for the paediatric diabetes service in SUH. 16 children were placed successfully on insulin pump therapy under the care of Dr Raafat Ibrahim who attends service in Sligo. He also provides 1 outreach clinic to LUH every 6 weeks. Dr Raafat Ibrahim travels from Portiuncula University Hospital 4 days per month for clinical governance of the service as there is no paediatric endocrinologist at either centre. The aim of service is to place 2 children per month (alternating SUH/LUH) on insulin pumps by team in SUH under the care of Dr Ibrahim. During last quarter of 2018, Sligo had no paediatric diabetes dietician (on Maternity leave) therefore reduced numbers were assessed from LUH. In the absence of the paediatric diabetes dietician the CHOICE diabetes education programme was not completed with newly diagnosed patients in SUH.

Children attending LUH, attend SUH for pump assessment suitability and commencement and stay with paediatric diabetes service in SUH for 6 months post insulin pump start. Children on insulin pump have their data reviewed virtually and this is followed on with phone call to parents. All notes are kept electronically on prowellness software system allowing for data to be viewed in LUH by diabetes team ensuring continuity of care. These children and families would otherwise be obliged to travel a minimum of four times per annum to tertiary centres in Dublin to seek care. Children diagnosed less than 2 years of age are referred to hospitals when there is Paediatric endocrinologist resident for safety concerns.

Repatriation of established patients attending Dublin hospital has been done. Some families still choose to have shared care with Dublin (numbers are small) as they have access to psychology service in Dublin hospitals as part of their diabetes management. This service needs developing in SUH/LUH and Saolta group in 2019.Children with chronic illness internationally should have access to psychological care.

There continues to be a noted improvement in users' metabolic control year on year for those using insulin pump and children and families report better quality of life. Overall mean HbA1c of our insulin pump cohort has stayed at 55mmol/mol (7.2%) achieving the internationally recommended target of 7.5% (58mmols).This will be audited again in 2019 thus reflecting increased ability of the multidisciplinary team to support patients and their families in the daily management of a difficult burdensome chronic disease. Diabetes Technology has greatly enhanced service provided, allowing for virtual diabetes nurse clinics. The availability of flash glucose monitoring (libre) on long term illness for children under 21 years has been an asset in gaining an insight into daily glucose control over 24 hour period. Admissions to hospital of established children with Type 1 diabetes continues to be significantly reduced.

RAMP Midwifery Care

Ms Roisin Lennon

In 2018 a total of 226 women were cared for by the AMP with approximately 1315 antenatal reviews. This amounted to 17% of all women attending Sligo and Carrick on Shannon for their antenatal care. In 2017 there were 155 women cared for by the AMP with approximately 835 antenatal reviews.

Caseload

Around 50% 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 35% of women had a raised BMI, 2% 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 slight polyhydramnios at 39 weeks, 2 had slightly abnormal liver function tests but no cholestasis and the other 2 had rising blood pressures but normal bloods at term. Care was planned in collaboration with the consultant for these women.

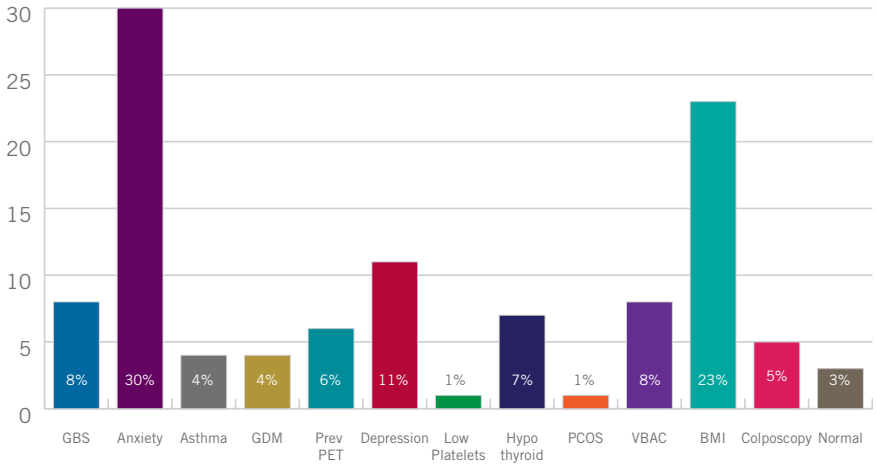
Transfer to consultant

Another 5% of women were referred back to the consultant team for various reasons including breech at 39 weeks, pre eclampsia, cholestasis and GDM on medication. Graph 3 shows the mode of birth for the three care pathways in SUH with the RAMP care pathway having the highest vaginal birth rate and lowest CS rate.

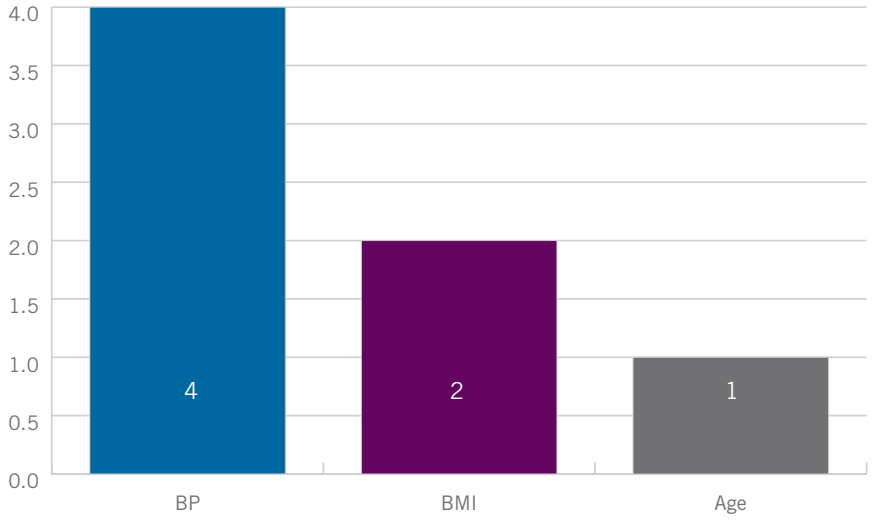
Onset of labour and IOL

Of the failed IOL, half were PROM and never in established labour with the other half having a CS at full dilatation for OP.

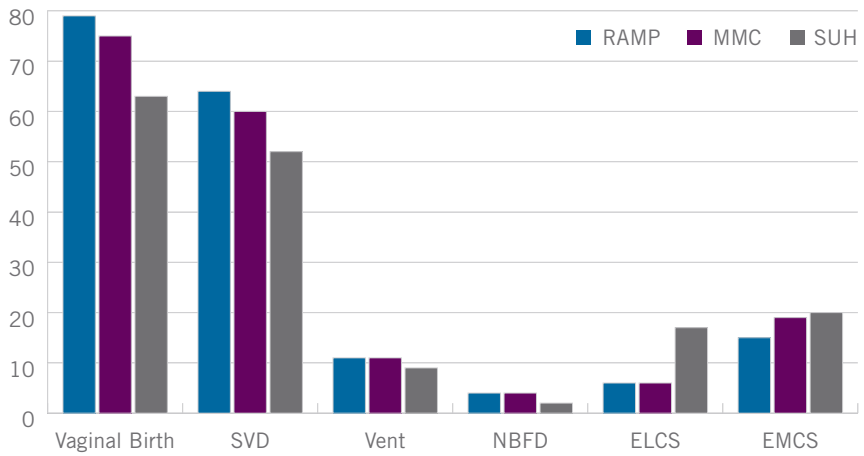
Graph 1 - Caseload 2018



Graph 2 - AMP/Consultant Shared Care 2018



Graph 3 - Births SUH 2018



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. A questionnaire was distributed to all post natal women from Sept to Dec 2018 who reported their experience of all their pregnancy care as being positive. Unfortunately despite questions to identify which care pathway the woman was on, it was impossible to ascertain accurately, which pathway of care the woman was on. It was felt that a questionnaire specific to each pathway may not be a true reflection of the woman's experience and it was decided to await the national patient survey for maternity services before attempting to introduce a new questionnaire to evaluate the service. Several cards, letters and emails of thanks and gratitude have been received by the RAMP from her caseload and these have been kept.

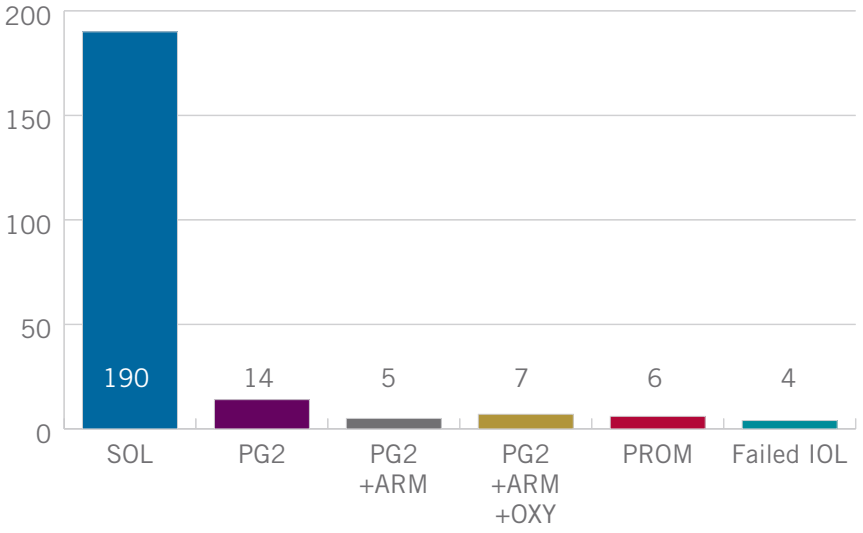
KPI 2 VBAC

14 ladies with one previous CS attended for AMP care in 2018. 3 ladies requested a repeat CS. 2 of these were never keen on VBAC and the other lady had a 4th degree tear at the birth of her first baby and an elective section for her second. Following several meetings, she decided to have an elective CS at 37 weeks. The 4th lady was unsuitable for IOL at 41 weeks and her only option was an elective CS.

2 ladies had an emergency CS. Both were for non reassuring CTG in the first stage of labour.

Overall, the RAMP service has continued to be a popular choice for the women using the maternity services of Sligo. There are plans to extend the service to other outreach areas once suitable premises are found.

Graph 4 - Onset of Labour RAMP 2018



Graph 5 - VBAC Mode of Birth RAMP 2018