# Contents

<table>
<thead>
<tr>
<th>Corporate Governance</th>
<th>Medical and Midwifery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deputy Chairman’s Report</td>
<td>Neonatology</td>
</tr>
<tr>
<td>Master’s Report</td>
<td>Advanced Neonatal Nurse Practitioner</td>
</tr>
<tr>
<td>Executive Committee Report</td>
<td>Breastfeeding Support Services</td>
</tr>
<tr>
<td>Finance Committee Report</td>
<td>Community Midwifery Service</td>
</tr>
<tr>
<td>Secretary/General Manager’s Report</td>
<td>Early Transfer Home</td>
</tr>
<tr>
<td>Director of Midwifery and Nursing’s Report</td>
<td>Clinical Governance</td>
</tr>
<tr>
<td>Ethics Research Committee</td>
<td>Neonatal Liaison Service</td>
</tr>
<tr>
<td>Board of Governors</td>
<td>Neonatal Resuscitation</td>
</tr>
<tr>
<td>Governors Ex-Officio</td>
<td>Bereavement</td>
</tr>
<tr>
<td>Nominated by the Minister for Health &amp; Children</td>
<td>Urodynamics</td>
</tr>
<tr>
<td>Nominated by Dublin City Council</td>
<td>Diabetes</td>
</tr>
<tr>
<td>Governors Elected</td>
<td>Infection Prevention and Control</td>
</tr>
<tr>
<td>Executive Committee Members</td>
<td>Fetal Medicine Unit</td>
</tr>
<tr>
<td>House Committee</td>
<td>Gynaecological Services</td>
</tr>
<tr>
<td>Finance Committee</td>
<td>Antenatal Education</td>
</tr>
<tr>
<td>Ethics Committee</td>
<td>Pregnancy Yoga Classes</td>
</tr>
<tr>
<td>Professional Advisors</td>
<td>Clinical Nutrition and Dietetics</td>
</tr>
<tr>
<td>Resident and Visiting Medical Staff</td>
<td>Clinical Engineering</td>
</tr>
<tr>
<td>Honorary Consulting Staff</td>
<td>Senior Administration Staff</td>
</tr>
<tr>
<td>Senior Midwifery and Nursing Staff</td>
<td>Allied Health Professionals</td>
</tr>
<tr>
<td>Allied Health Professionals</td>
<td>Executive Committee Members</td>
</tr>
<tr>
<td>Senior Administration Staff</td>
<td>House Committee</td>
</tr>
<tr>
<td>Medical and Midwifery</td>
<td>Ethics Research Committee</td>
</tr>
<tr>
<td>Clinical Support Services</td>
<td>Board of Governors</td>
</tr>
<tr>
<td>Clinical Governance</td>
<td>Governors Ex-Officio</td>
</tr>
<tr>
<td>Governors Elected</td>
<td>Deputy Chairman’s Report</td>
</tr>
<tr>
<td>Executive Committee Report</td>
<td>Master’s Report</td>
</tr>
<tr>
<td>Finance Committee Report</td>
<td>Secretary/General Manager’s Report</td>
</tr>
</tbody>
</table>

### Corporate Governance

- Deputy Chairman’s Report
- Master’s Report
- Executive Committee Report
- Finance Committee Report
- Secretary/General Manager’s Report
- Director of Midwifery and Nursing’s Report
- Ethics Research Committee
- Board of Governors
- Governors Ex-Officio
- Nominated by the Minister for Health & Children
- Nominated by Dublin City Council
- Governors Elected
- Executive Committee Members
- House Committee
- Finance Committee
- Ethics Committee
- Professional Advisors
- Resident and Visiting Medical Staff
- Honorary Consulting Staff
- Senior Midwifery and Nursing Staff
- Allied Health Professionals
- Senior Administration Staff

### Medical and Midwifery

- Neonatology
- Advanced Neonatal Nurse Practitioner
- Breastfeeding Support Services
- Community Midwifery Service
- Early Transfer Home
- Clinical Governance
- Neonatal Liaison Service
- Neonatal Resuscitation
- Bereavement
- Urodynamics
- Diabetes
- Infection Prevention and Control
- Fetal Medicine Unit
- Gynaecological Services

### Clinical Support Services

- Antenatal Education
- Pregnancy Yoga Classes
- Clinical Nutrition and Dietetics
- Clinical Engineering
<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Occupational Health</td>
<td>39</td>
</tr>
<tr>
<td>Pathology and Laboratory Medicine</td>
<td>40</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>41</td>
</tr>
<tr>
<td>Decontamination</td>
<td>42</td>
</tr>
<tr>
<td>Quality</td>
<td>42</td>
</tr>
<tr>
<td>Physiotherapy</td>
<td>43</td>
</tr>
<tr>
<td>Radiology</td>
<td>44</td>
</tr>
<tr>
<td>Social Work</td>
<td>45</td>
</tr>
<tr>
<td>Chaplaincy</td>
<td>46</td>
</tr>
<tr>
<td>Theatre Development</td>
<td>47</td>
</tr>
<tr>
<td>Facilities Engineering</td>
<td>51</td>
</tr>
<tr>
<td>Engineering</td>
<td>52</td>
</tr>
<tr>
<td>Environmental</td>
<td>52</td>
</tr>
<tr>
<td>General Services</td>
<td>53</td>
</tr>
<tr>
<td>Catering</td>
<td>56</td>
</tr>
<tr>
<td>Human Resources</td>
<td>57</td>
</tr>
<tr>
<td>Information Management</td>
<td>58</td>
</tr>
<tr>
<td>Information Technology System Status</td>
<td>59</td>
</tr>
<tr>
<td>Patient Services</td>
<td>59</td>
</tr>
<tr>
<td>Medical Records</td>
<td>60</td>
</tr>
<tr>
<td>Purchasing and Supplies</td>
<td>60</td>
</tr>
<tr>
<td>Partnership</td>
<td>61</td>
</tr>
<tr>
<td>Patient Service User Forum</td>
<td>63</td>
</tr>
<tr>
<td>Education</td>
<td>48</td>
</tr>
<tr>
<td>University College Dublin</td>
<td>48</td>
</tr>
<tr>
<td>Royal College of Surgeons in Ireland</td>
<td>48</td>
</tr>
<tr>
<td>Education and Practice Development</td>
<td>48</td>
</tr>
<tr>
<td>General Support Services</td>
<td>50</td>
</tr>
<tr>
<td>Backcare and Ergonomics Programme</td>
<td>50</td>
</tr>
<tr>
<td>Casemix/HiPE Programme</td>
<td>50</td>
</tr>
</tbody>
</table>

**Financial Statements and Activity**

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial Statements</td>
<td>62</td>
</tr>
<tr>
<td>Activity Analysis</td>
<td>64</td>
</tr>
</tbody>
</table>
Deputy Chairman’s Report

I have great pleasure in presenting the Annual Report of the Hospital for 2011.

The report outlines the main activities of the Hospital during the year in which activity, in terms of mothers delivered, reduced slightly. During the year 9,250 women gave birth to 9,459 infants which is a decrease of 5.2% over 2010.

The hospital’s financial performance is set out in detail in the report of the Finance Committee.

In looking forward to 2012, while overall activity remains relatively static there is an ongoing shift by mothers presenting away from private/semi private into public facilities. This is putting a strain on certain resources and effectively reduces the finances available to the Hospital. In addition the deficit remains a primary focus for the Executive team with the stated need for a major investment on the site whilst simultaneously pursing our longer term goals of a major development elsewhere. These needs are widely recognised not only here at the Hospital but also within the HSE and despite these financially challenging times we will continue to pursue these goals. In order to be prepared to meet these challenges, a review of governance arrangements was initiated by the Executive Committee in Autumn 2011.

In October 2011 Mr J. Brian Davy resigned as a member of the Hospital’s Executive Committee. Brian had been a member of the Hospital’s Executive Committee for over 30 years, having held various positions up to and including Deputy Chairman. The Davy family have a long association with the Hospital with Brian’s father, James, becoming a Governor and joining the Executive in 1932 and remained on the Committee for almost 50 years and was Deputy Chairman for his last 8 years until his resignation from the Committee in 1981. I wish to thank Brian and the Davy family for their commitment to the Hospital over all those years.

The continued success of the Hospital in meeting patients’ needs within the current infrastructure combined with the financial constraints, is solely down to the determination and commitment of all the Hospital staff.

In spite of the financial constraints the Hospital has managed to continue to support important ongoing education programs. With the support of the Medical Fund a scholarship system was set up this year to support Nurses and Midwives who wished to pursue further third level education.

This was the final year of Dr Michael Robson’s seven year term as Master. During his term as Master, Mike has very adeptly guided the Hospital through challenging times and was instrumental in ensuring that the new theatre development became a reality. Dr Robson’s primary focus was always for the welfare of the patient and during his Mastership he worked tirelessly to improve the services for all patients attending the NMH. For his leadership and counsel over these seven years I thank Mike on behalf of the staff and the Executive. It was a pleasure to work with him and we wish him all the best for the future.

With Dr Robson’s term coming to an end the Governors elected his successor during May 2011. Following a rigorous process involving presentations and interview of a number of candidates Dr Rhona Mahony was elected by the Governors. Dr Mahony will commence her term on 1st January 2012 and I wish her every success.

Next I would like to thank Mary Brosnan, Director of Midwifery and Nursing. Mary has an extremely challenging job managing the staffing resources and balancing these with the activity levels. However with the support of her team everything runs smoothly and everyone is kept happy. Mary has the thanks and the support of the Executive and I.

I would like to thank Mrs Pat O’Boyle and Mr Ronan Gavin our Secretary/General Managers during the year. Pat left us in May of this year and will be greatly missed. Both Pat and Ronan have dealt with many problematic issues during the year, including the precarious issue of funding, and once again we finish the year in a relatively sound financial position.

Mr Tommy Hayden, Acting Financial Controller, took over the financial reigns at short notice and has, despite the additional financial pressures of cutbacks and income fall-offs, managed to keep not only the executive satisfied but also the HSE and for this deserves much thanks.

I also want to express my gratitude to my fellow Executive members for their time and commitment. Their life experience and knowledge is an invaluable support to the Hospital.

And finally a special thanks to all of the staff in the Hospital. Despite the infrastructural issues, staffing issues with
In 2011, 9250 women delivered 9459 babies. This was a 5.1% decrease on 2010 and the first year that there had been a decrease since 2005 when a cap on the number of deliveries had been introduced. However although this decrease was welcome it presented new problems as there was also a drop in fee paying patients which constitute a significant part of the hospital’s income. This meant more patients accessing the public care facilities with no additional resources in either space or staff. Inevitably this will put more pressure on those services and it is therefore crucial that the hospital develops its community antenatal and postnatal care for the majority of women for whom it is suitable. Ultimately the hospital needs to develop models of care in the future that satisfy both patients’ requirements and also have a sound economical footing.

The clinical outcomes in 2011 remained of a high standard. Of the 9459 babies who weighed more than 500g 66 were either stillborn or died during the first 7 days of life. The uncorrected perinatal mortality rate for the hospital was therefore 7.0 per thousand and the corrected perinatal mortality 4.0 per thousand. There were 2 maternal deaths. Our caesarean section rate for 2011 was 21.4% which was an increase on 2010 but remains low by national and international standards. Of particular importance though is that despite being a tertiary referral hospital our caesarean section rate in low risk women remains the lowest anywhere both nationally and internationally irrespective of what type of unit you look at.

There were 23880 attendances in FAU and 1451 babies were admitted to the neonatal unit 47 of which were referred in after delivery elsewhere.

Gynaecology services in this hospital again remain an aspect of women’s health which continues to suffer because of the ever increasing number of babies being born. Strategies to redress this balance are continually being looked at and with the completion of the new theatre hopefully there will be an opportunity to ease the pressure on the operating capacity which is needed to develop gynaecology. Our Colposcopy services though continue to improve with reduced waiting times and an improved service.

At the same time as the large clinical workload the Hospital continues to enhance its international reputation in research with publications both in scientific laboratory work and clinical practice.

This is my last annual report and it has been a privilege to serve this hospital as Master. In particular I would like to acknowledge the support and trust that I received from all the staff of the hospital and the board during the last 7 years. Without this it would have been impossible.

Finally it remains for me to wish Rhona Mahony my successor as Master the very best for the future and hope that she finds the experience as rewarding as I did.

Master’s Report

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Dr. Michael Robson
Master

Mr. Ronan Gavin, Secretary/General Manager, Dr. Rhona Mahony, incoming Master with Mr. Niall Doyle, Deputy Chairman

Niall Doyle
Deputy Chairman
Executive Committee Report

Executive Committee

At the Annual General Meeting the outgoing members of the Executive Committee, with the exception of Mrs C Hederman and Mrs R Lynch who both resigned, were proposed and seconded and were elected as ordinary members of the Executive Committee for the coming year.

Mr Brian Davy resigned from the Committee in October 2011.

New Governors

The following new Governors were elected during the year:
Mr Barry Dixon, Ms Paula Reid, Ms Suzanne O’Brien, Ms Margaret McCourt, Prof. Bill Powderly, Ms Bernie Spillane, Ms Teresa Murphy, Ms Eugenée Mulhern and Ms Fiona Davy.

Charter Day

We had a very good attendance at Charter Day which was held on the 27th January 2011 and was hosted by Dr Michael Robson to whom we are most grateful.

Staff Appointments

New appointments during the year included Mr Ronan Gavin Secretary/General Manager and Mr Tommy Hayden, Acting Financial Controller. Mr Cathal Keegan was appointed Acting IT Manager, Ms Marie Therese Joy was appointed CMM2 and Ms Mary Coffey was appointed Advanced Midwife Practitioner.

Staff Retirements

The following staff members retired during the year after many years of service.

Kathleen Curley, Catering Manager, Rita Dunne, Catering Assistant and Eddie Power, Porter.

We thank them all for the many years of service and wish them a happy retirement.

Hospital Awards & Certificates

Awards for the year 2011 were as follows: The John F. Cunningham Medal was awarded to Dr Siobhan Neville. The Kieran O’Driscoll prize was awarded to Mr David Brennan. The Royal College of Surgeons/NMH medal was awarded to Mr Scott Chicotka. The A. Edward Smith Medal was awarded to Ms Olwen Murphy.

Medals were also presented to student midwives for the BSc in Midwifery Course as follows: The Hospital Gold Medal was presented to Ms Judith Engelhardt and the Elizabeth O’Farrell Medal was presented to Ms Jennifer Candy. The Director of Midwifery’s Award was presented to Ms Deirdre O’Neill in recognition on becoming a nurse Colposcopist.

The Neonatal Intensive Care Nursing Medal, which was donated by Dr Niall O’Brien, was awarded to Ms Mariola Buczowska.
Hospital Finances

As can be seen from the report of the Finance & General Purposes Committee an accumulated deficit of €1,582,481 was carried forward at year-end. Gross expenditure for the year was €65.4 million which was a decrease of 2.1% over 2010. This decrease occurred despite activity remaining at consistently high levels and arose from reductions in public sector pay and overheads.

Maternity Hospitals Joint Standing Committee

The Committee, under the Chairmanship of Dr Miriam Hederman O’Brien, continued to meet on a monthly basis during the year. Issues of common interest were discussed which included the increasing numbers of births, infrastructure deficits, moratorium on staff, developments in relation to the KPMG report, laboratory tests, pharmacy services, procurement, strategic IT projects, patient surveys and value for money initiatives.

The JSC met with the HSE Chief Executive, Mr Cathal Magee in January 2011 and discussed the position of maternity, gynaecology and neonatology in the Irish national health services.

The hospital would like to acknowledge the commitment of Dr Miriam Hederman O’Brien to the Joint Standing Committee and thank her for her immense contribution.

Conclusion

The Executive Committee has great pleasure in acknowledging the work and co-operation they received from all categories of staff; medical, paramedical, midwifery & nursing, administration, maintenance, catering, portering and household.

Mr Gabriel Hogan
Honorary Secretary
Finance and General Purposes Committee Report

Hospital gross expenditure for 2011 was €65.4 million which was 2.1% lower than in 2010. The hospital incurred a financial deficit of €967,698 or 1.5% of expenditure for 2011. The accumulated deficit was €1,582,481 at 31 December 2011.

The Hospital continued to experience funding and cost pressures in 2011. The Health Services Executive (HSE) allocation was €44.5 million, a decrease of 7.35% from the allocation of the previous year. The income of the hospital for 2011 was €19.9 million which was an increase of 7.7% from the previous year and was equivalent to 30.5% of gross hospital expenditure.

Payroll costs (including the end of year HSE voluntary redundancy and early retirement programmes) remained substantially the largest area of expenditure accounting for 79% of gross expenditure with non-pay costs accounting for the remaining 21%. Unfunded pension and lump sums accounted for over 10% of the pay bill. Overall the pay bill fell by 0.75%. There was a shift in the year of 1% away from pay towards non pay costs. Non pay expenditure decreased by 6.9%.

The Finance and General Purposes Committee continued to monitor and evaluate the use of the Hospital’s resources, meeting every month through the year. This is essential to ensure that the Hospital meets its financial, staff number and service level targets, as agreed with the HSE. The approval and monitoring of staffing levels was a major focus for the committee, as was the approval and control of all major expenditures.

Once again there was sustained pressure on staff, mainly due to continuing pressure from the HSE for the Hospital to maintain staff numbers within an ‘approved ceiling’ in spite of continued high activity levels.

Attention was also focused on working capital management during 2011. Further improvements in processing procedures for health insurance claims resulted in amounts due from the various health insurers at 31 December falling from €2.96 million at the end of 2010 to €2.66 million at the end of 2011 and well within HSE expectations.

During the year capital funding of €2,265,148 was received from the HSE. €2,010,000 was spent on the new operating theatre and €105,148 was spent on medical equipment. A further €150,000 was allocated towards the emergency refurbishment of the neonatal ward although this grant only covered only about 50% of the expenditure and the balance had to be found within the already overstretched maintenance budget. The hospital premises is very old and needs significant maintenance each year to keep functioning, but the HSE maintenance allocation is completely inadequate to cope with routine maintenance let alone the inevitable emergencies that arise in a building of this vintage which is being operated at an intensity well beyond its capacity.

The hospital faces considerable financial challenges again in 2012 as a result of continuing high activity levels, competition for private income and the government and the HSE’s difficult funding position.

Catherine Ghose
Honorary Treasurer
### Pay Costs

<table>
<thead>
<tr>
<th>Category</th>
<th>2011</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultants and NCHDs</td>
<td>€10,021</td>
<td>€10,357</td>
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<tr>
<td>Paramedical</td>
<td>€3,661</td>
<td>€3,735</td>
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<tr>
<td>Administration</td>
<td>€5,569</td>
<td>€5,868</td>
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<tr>
<td>Midwifery and Nursing</td>
<td>€22,888</td>
<td>€22,284</td>
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<tr>
<td>Support Services</td>
<td>€4,201</td>
<td>€4,837</td>
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<td>Pensions and Lump Sums</td>
<td>€5,408</td>
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<tr>
<td><strong>Total</strong></td>
<td>€51,784</td>
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</table>

### Non Pay Costs

<table>
<thead>
<tr>
<th>Category</th>
<th>2011</th>
<th>2010</th>
</tr>
</thead>
<tbody>
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<td>Medical</td>
<td>€7,557</td>
<td>€8,248</td>
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<tr>
<td>Maintenance and Furnishings</td>
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<td>Finance</td>
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<td>Computer Expenses</td>
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<td>€587</td>
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<td>Utilities</td>
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<tr>
<td>Training and Assoc. Costs</td>
<td>€404</td>
<td>€567</td>
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<tr>
<td>Office Expenses</td>
<td>€566</td>
<td>€739</td>
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<tr>
<td>Miscellaneous</td>
<td>€1,283</td>
<td>€1,305</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>€13,592</td>
<td>€14,601</td>
</tr>
</tbody>
</table>
2011 has been another year of intensive activity for the Hospital. Though the number of births reduced slightly the Hospital remained extremely busy in every Department. The areas of Fetal Assessment, Neonatology and Colposcopy all experienced continued growth in activity. Once again this activity should be considered in the context of the contracting public finances. The hospital allocation was reduced from previous years and thus we continued the constant striving for efficiencies and cost reductions while maintaining quality care for patients. These difficulties were further exacerbated by the number of staff who left in December 2010 under the first ‘exit scheme’ and who were not replaced. Staff and management recognised these resource issues and worked in a spirit of collaboration to identify and implement appropriate solutions while maintaining service for patients. This included a number of initiatives and changes that were jointly introduced under the ‘Croke Park Agreement’. The quality of our clinical outcomes, especially in the context of our staffing, financial and infrastructural resources, is a testament to the dedication of all of the staff working at the Hospital.

2011 was an important year as it was the final year of Dr Michael Robson’s Mastership which also meant that it was the year in which a new Master would be elected. Following an arduous interview and presentation process Dr Rhona Mahony was elected by the governors in May 2011. Dr Mahony’s 7 year term commences on 1 January 2012 and I wish her the best and look forward to working with her. I greatly enjoyed working with Dr Robson both in my roles as Financial Controller and Secretary/Manager over the past years and I wish Dr Robson the very best for the future here in the NMH post Mastership.

The Hospitals infrastructural deficits continue to be a major concern. With the support of the HSE funding and approval was secured for additional theatre space. The development of the new Theatre onsite in close proximity to the existing Theatre and other Departments presented many challenges. Staff directly involved with the project and staff throughout the Hospital are to be congratulated for the manner in which we overcame these challenges and clearly demonstrated the unity of entire Hospital in our determination and commitment to the Theatre project and the primary objective of improved patient care.

This determination and spirit was also in evidence when we had to relocate NICU for a number of weeks to undertake remedial works in the area. The refurbished NICU represents an improvement on the previous facility but is still inadequate in terms of the volumes and type of activity that is undertaken.

The infrastructural deficits of the current buildings are widely recognised by the Board and the management team. Whilst the new theatre suite has addressed a major issue this was the first item on a long list which is inevitable with a building that was mostly constructed in the 1930’s. In terms of clinical need and patient safety some of the immediate concerns are NICU, Out of Hours/Casualty, FAU and HSSD. It is imperative that these priority areas are addressed in the short term and this will be a primary focus in the next 12 months. All of these deficits are also recognised by the Health Services Executive and the Department of Health. We continue to engage with the HSE to secure a commitment for very substantial infrastructural funding to resolve both the immediate and longer term issues.

During the year a number of staff retired or left for pastures new. We wish them all well for the future. However with the ongoing moratorium on replacements and with the impact of the initial exit scheme (December 2010) and the impending impact of the second exit scheme (Feb 2012) this only serves to highlight the importance of our staff. Practically every area has felt, or will feel, the impact of reduced staffing levels.

Another challenge for us all is maintaining income levels in these times of financial austerity. While a substantial proportion of our budget is allocated from the HSE a significant element (>20%) has historically come from private and semi private patients. This past 18 months has seen these figures eroding and this is expected to be a serious challenge over the coming 12 months.

The hospital continues to maintain accreditation to the environmental standard ISO 14001 and which is a credit to our Engineering Department and also to all staff in the Hospital who help to make this possible. In addition the microbiology laboratory was granted accreditation to ISO 15189. Both Anatomical Pathology and Blood Transfusion maintain their ISO 15189 accreditation previously awarded and all are to be congratulated for achieving and maintaining these very high standards.
In September Dr Eoghan Mooney, Consultant Histopathologist, was invited by the RCPI to present the Sean Boyle Memorial Lecture on “Adverse Neonatal Neurological Outcome: Does the Placenta Hold the Answer?”. Dr Mooney was awarded the Sean Boyle Memorial Medal by Dr Michael O’Dowd at the annual dinner that evening.

In October 2011 Mr Brian Davy resigned as a member of the Hospital’s Executive Committee. Brian had been a member of the Hospital’s Executive Committee since May 1981 and was Honorary Treasurer for almost ten years and Deputy Chairman for over ten years during this period. I wish to thank Brian for all his help and support to the Hospital over the many years.

I would like to thank Ms Pat O’Boyle, my predecessor, who left us at the end of April 2011, for her support during the few years she was with us. I would also like to thank Dr Michael Robson, Master, Ms Mary Brosnan, Director of Midwifery and Nursing and Dr Peter Boylan, Clinical Director for their welcome support during my first year as Secretary/Manager. My thanks also to Mr Tommy Hayden who stepped into my previous role of Financial Controller at short notice and who has been a great support. Similarly I want to express my appreciation to Clare Gray and Angela Bissette who welcomed me into the role of Secretary/Manager and ably steered me through my first year. I also want to express my gratitude to members of the Finance Committee and the Executive Committee for their advice and support throughout the year. I wish Dr Robson the very best for the future here in the NMH post Mastership.

The Hospital remains a very busy and vibrant environment. Despite difficulties with funding and infrastructure the staff always focus on the patient. Any Hospital’s primary resource is its staff and while we may sometimes feel we are deficient in numbers we are certainly not deficient in terms of quality, dedication and commitment. I would like to thank all of the staff for their support and commitment throughout the year.

Ronan Gavin,
Secretary/General Manager

Dr Eoghan Mooney, Consultant Histopathologist, with Dr Michael O’Dowd, Chairman of the Institute of Obstetricians and Gynaecologists, RCPI at the Institute’s Annual Dinner in September 2011. Dr Mooney was an invited speaker at the Institute’s Study Day and Annual General Meeting. He presented the Sean Boyle Memorial Lecture on “Adverse Neonatal Neurological Outcome: Does the Placenta Hold the Answer?”. Dr Mooney was awarded the Sean Boyle Memorial Medal by Dr Michael O’Dowd at the annual dinner that evening.
Director of Midwifery and Nursing

During 2011 the midwifery and nursing staff continued to provide an exceptional service to the women and babies in our care. Despite all the ongoing challenges of activity when the workload sometimes seems relentless, I am so impressed that the staff always ensure that patients receive such excellent care with compassion and kindness and I am grateful to all my colleagues for their commitment to our service. We continue to experience accommodation problems as our infrastructure does not always meet the demands of our patient numbers. The ward areas in particular are very cramped and regularly overcrowded and require upgrading. The operating theatre development project began during the summer and is expected to be completed in spring 2012; this will bring much needed modernisation to our busy theatre suite. The disruption and noise generated during the building works has been tolerated incredibly well by the patients and particularly the staff who had to work through it and provide a safe and efficient service throughout the construction.

Education of midwives, general nurses, public health nurses and other students has always been a priority for us and I am very proud of the success rates achieved by our midwifery graduates in both the undergraduate and post registration programmes. Graduation ceremonies were held in the hospital on in December 2011 prior to the UCD conferring ceremony. I wish to congratulate all of our graduates on their achievement. Many staff in midwifery, neonatal, gynaecology and theatre areas also undertook additional courses throughout the year and I would like to thank them and offer my congratulations to them on their success.

This year we are delighted that the first midwifery and nursing Masters scholarship programme within the hospital was supported by the Medical Fund. Thirteen midwives and nurses applied for funding to undertake Masters degrees and five were successful. This scholarship scheme is intended to foster midwives involvement in research, which will enhance and develop our profession.

The hospital continues to be committed to supporting the nurse/midwife prescribing programme. The number of nurse/midwives who are now registered nurse prescribers amounts to 32 and a further 6 are currently undertaking the nurse prescribing programme (RNP). We continue to increase this cohort to facilitate the availability of prescribing by midwives or nurses on every shift in core areas. I am extremely grateful to the medical mentors who have contributed so much of their time to make this possible, in particular Dr Michael Robson, Master and Dr Declan Keane, Consultant Obstetrician and Gynaecologist. I am also very indebted to Ms. Nicola Clarke who is co-ordinating the prescribing initiative.

The moratorium on public service staff recruitment has now been in place since March 2009. This has placed a very difficult burden on existing staff who are providing a safe high quality service to our patients. The midwifery and nursing staff are always innovative in finding new ways to make our care more effective. The midwifery and administration staff in the antenatal outpatient department (OPD) have developed outreach booking clinics in Pearse Street Primary Care Centre. This has been a very successful initiative facilitating new links with our community partners. The consulting rooms at the rear entrance of the hospital are now being renovated as hospital clinic space with various clinics including OPD, gynaecology, physiotherapy, bereavement services all availing of this clinical space. The Colposcopy clinic continues to develop, supported by funding from the National Cervical Screening Service and we are delighted to have nurses undertaking further training in colposcopy, once again with thanks to Dr Grainne Flannelly and medical colleagues who are mentoring these nurses.

Finally I would like to thank all my colleagues for their continuous commitment to patient care. The current fiscal climate is challenging but in the usual spirit of our hospital, we work together and try to make each person's journey through our service individual and special.

Mary Brosnan
Director of Midwifery and Nursing
Ethics Research Committee

The Ethics Research Committee is approved to receive and approve application proposals nationally. The Ethics Committee has been established since 2005.

We hold monthly meetings except there is no meeting in the month of August. There is one quarter lay attendance and quorum at each meeting. The Committee had one member resign during 2011 due to work commitments.

Generally, the applications are approved at each meeting; if not approved the Chairman will request clarification on a particular issue.

In 2011 the Ethics Research Committee received 50 research application proposals. There was one clinical trial application submitted during this period. There were two research proposals rejected.

The National Maternity Hospital has been involved with the RESCAF (Standard REC form) Group in developing the Standard REC form and we now have adopted the Standard Application Form which is used nationally by research ethics committees.

Dr. John Murphy
Consultant Paediatrician
Chairman, Ethics Research Committee

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Governors Ex-Officio
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Councillor Andrew Montague, (Lord Mayor – Vice Chairman)
Dr Michael Robson, (Master)
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Very Rev. John McDonagh, (Parish Priest of the Parish of Sandymount)
Very Rev. John Gilligan, (Administrator of the Parish of St. Andrew, Westland Row)

Nominated by the Minister for Health and Children
Ms Patricia O’Shea
Ms Pamela Fay

Nominated by Dublin Corporation
Councillor Pat Crimmins
Councillor Edie Wynne

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1957  * Mrs Sheila Geoghegan
1958  Dr Deirdre Pepper
1959  * Professor Sheamus Dundon
1959  * Professor Eamon O’Dwyer
1962  * Mr Alex J Spain (RIP, Jan 2012)
1964  * Mr Patrick J Spain
1967  * Mrs Katriona Maguire (Resigned May)
1969  * Dr Alan O’Grady
1970  * Mrs Emer Meagher
1971  * Mrs Alice Finlay
1974  * Dr Joseph Alvey
1974  * Mr S. Patrick Boland
1975  * Mrs Mary Ensor
1975  * Mr Donal S. McAleese
1976  * Professor Enda Hession
1976  * Dr Declan Meagher
1976  * Mrs Rosaleen Lynch
1977  * Mrs Laura MacDonald

Martina Cronin, CMM2 Delivery Ward with Dr. Michael Robson, who completes his Mastership at the end of the year
1978 * Mrs Una Crowley *(RIP, Oct)
1980 * Dr John R McCarthy
1980 * Dr Niall O’Brien
1981 * Mr J. Brian Davy
1983 * Mrs Maureen Spain
1983 * Mr Neil V McCann *(RIP, July)
1983 * Mrs Judith Meagher
1983 * Professor Sean Blake
1984 * Dr Dermot MacDonald
1984 * Mrs Stephanie Stronge
1985 * Dr Jack T. Gallagher
1985 * Dr. Reginald Jackson
1985 * Mr Edward Bourke
1986 * Mrs Maeve Hayes
1986 * Mr Gabriel Hogan *(Honorary Secretary)*
1986 * Mrs Monica Owens
1986 * Dr Joseph Stanley
1987 * Professor Paddy Masterson
1989 * Mrs Anne Davy
1990 * Mrs Carmencita Hederman
1990 * Mrs Margaret Anderson
1990 * Mrs Kathleen O’Grady
1991 * Dr John F. Murphy, Obs/Gynae
1992 * Dr Frances Meagher
1992 * Mr Kevin Mays
1995 * Mr Peter Sutherland
1995 Dr Declan O’Keeffe
1995 * Professor Colm O’Herlihy
1996 * Mr William Johnston
1997 * Dr Peter Boylan
1998 * Mrs Joanne Keane
1998 * Mrs Anne Murphy
1998 * Mr Frank Downey
1998 * Mr Anthony Garry
2000 * Mr John Spain
2000 * Dr Freda Gorman
2001 * Mrs Helen Moe
2001 * Ms Yvonne McEvoy
2001 * Mrs Jane Collins
2001 * Ms Alexandra Spain
2001 * Mrs Margo McParland
2001 * Mrs Catherine Altman
2001 Dr John Murphy, Paeds.
2003 Mr Niall Doyle *(Deputy Chairman)*
2003 * Ms Lydia Ensor
2002 Ms Sara Appleby
2005 Ms Caroline Hayes (Simons)
2005 Dr Peter Lenehan
2005 Dr Orla Sheil
2005 Dr Peter McParland
2005 Ms Sheena Carton
2005 Ms Elaine Doyle
2005 Dr Declan Keane
2005 Ms Maeve Dwyer
2007 * Dr Kevin McKeating
2007 Mrs Mary Donohoe
2008 Ms Catherine Ghose *(Honorary Treasurer)*
2011 Mr Barry Dixon
2011 Ms Paula Reid
2011 Ms Suzanne O’Brien
2011 Ms Margaret McCourt
2011 Professor Bill Powderly
2011 Ms Bernie Spillane
2011 Ms Teresa Murphy
2011 Ms Eugenée Mulhern
2011 Ms Fiona Davy

*Denotes life member

**Committee Members**

**Executive Committee**

Mrs Catherine Altman
Dr. Peter Boylan
Cllr. Pat Crimmons
Mr Brian Davy *(Resigned, Oct)*
Mr Frank Downey
Mr Niall Doyle *(Deputy Chairman)*
Ms Lydia Ensor
Ms Pamela Fay
Ms Catherine Ghose *(Honorary Treasurer)*
Very Rev. John Gilligan
Ms Carmencita Hederman *(Resigned, May)*
Mr Gabriel Hogan *(Honorary Secretary)*
Mr William Johnston
Dr Declan Keane
Lord Mayor of Dublin, Cllr Andrew Montague *(Vice Chairman)*
Ms Rosaleen Lynch *(Resigned, May)*
Dr. Diarmuid Martin *(Archbishop of Dublin, Chairman)*
Mr Kevin Mays
Dr John Murphy
Dr Kevin McKeating
Dr Peter McParland
Mrs Kathleen O’Grady
Prof. Colm O’Herlihy
Mrs Patricia O’Shea  
Dr Michael Robson (Master)  
Cllr. Edie Wynne  
Ms Eugenée Mulhern (from Oct)

House Committee  
Dr. Michael Robson, Master  
Mrs Elaine Doyle, Chairperson  
Mrs Kathleen O’Grady  
Mrs Judith Meagher  
Mrs Rosaleen Lynch (Resigned, Sept)  
Mrs Helen Moe  
Mrs Margo McParland  
Mrs Catherine Altman  
Mrs Jane Collins  
Mrs Mary Donohoe  
Ms Suzanne O’Brien (from June)  
Ms Sheena Carton (from Dec)  
Ms Teresa Murphy (from Dec)  
Ms Sara Appleby (from Dec)  
Ms Bernie Spillane (from Dec)  
Ms Fiona Davy (from Dec)

Finance Committee  
Mr Niall Doyle, Deputy Chairman  
Dr Michael Robson, Master  
Ms Catherine Ghose, Honorary Treasurer  
Mr Gabriel Hogan, Honorary Secretary  
Mrs Kathleen O’Grady  
Mr William Johnston  
Mrs Pat O’Boyle, Secretary/General Manager (Jan-May)  
Mr Ronan Gavin, Secretary/General Manager (from May)  
Ms Mary Brosnan, Director of Midwifery & Nursing  
Mr Tommy Hayden, A/Financial Controller (from May)

Ethics Research Committee  
Dr. John Murphy, Consultant Paediatrician, Chairman  
Dr. Michael Robson, Master  
Mrs Pat O’Boyle, Secretary/General Manager (Jan-May)  
Mr Ronan Gavin, Secretary/General Manager (from May)  
Ms. Mary Brosnan, Director of Midwifery & Nursing  
Dr. Edgar Mocanu  
Ms. Dorothy McCormack  
Dr. Susan Knowles

Mr. Padraig Ingoldsby  
Ms. Ann Rath  
Ms. Fionnuala Watkins  
Ms. Valerie Kinsella  
Ms. Denise O’Brien  
Mr. Eoin McHugh  
Ms. Angela Gargan  
Ms Claire Callanan  
Ms Gemma Cody

Professional Advisors  
Law Advisors  
Beauchamps Solicitors  
Riverside Two  
Sir John Rogerson’s Quay  
Dublin 2  
Bankers  
The Bank of Ireland  
2 College Green  
Dublin 2  
Auditors  
Price Waterhouse Coopers  
Chartered Accountants  
One Spencer Dock  
North Wall Quay  
Dublin 1
Resident and Visiting Medical Staff

Master
Dr Michael Robson, FRCS, MRCOG, FRCP

Department of Obstetrics and Gynaecology
Dr Peter Boylan, MB, MAO, FRCP, FRCOG
Dr Stephen Carroll, MB, BCH, BAO (UCD), MRCOG, MRCP, MD (UCD)
Dr Grainne Flannelly, MB, BCH, BAO, MRCOG, MRCP, MD (Aberdeen)
Prof Michael Foley, MB, MAO, FRCP, FRCOG
Dr Declan Keane, MD, FRCP, FRCOG
Dr Peter Lenehan, MB, FRCP, FRCPI, MRCOG
Dr Orla Sheil, MD, FRCP, FRCPI
Dr Mary Wingfield, MD, MRCOG
Dr Shane Higgins, MRCOG, FRANZCOG, MPH (Melb)
Dr Rhona Mahony, MD, MRCOG
Dr Cathy Allen, MB, MRCOG, MRCP, DCH (Locum)
Dr Jens Knudsen, MRCOG, DipGum, DFFP, Dip Adv Obs (Locum)
Dr Olga Vikhareva Osser, MD, PhD (Locum)
Dr Louise Fay, MB, MRCOG, MRCP, DipGUM, DipForMed (Locum)
Dr Marie Christine de Tavernier, MRCOG (Locum)

Department of Obstetrics and Gynaecology, University College Dublin
Prof Colm O’Herlihy, MD, FRCP, FRCOG, FRACOG
Prof Fionnuala McAuiliffe, MD, MRCOG, MRCP, DCH

Department of Obstetrics and Gynaecology, Royal College of Surgeons
Prof Dermot MacDonald, MD, MAO, FRCP, FRCPI, FACOG (Hon)

Department of Pathology and Laboratory Medicine
Director: Dr Eoghan Mooney, MB, MRCP, FRCP, FFPathRCPI
Dr Susan Knowles, MD, MRCP, DCH (Microbiology)
Dr David Gibbons, MB, FCAP
Dr Karen Murphy, MB, MRCP, MRCP (Haematology)
Dr Paul Downey, MB, MRCP, FRCP, FFPathRCPI
Orla Maguire FRCP, EurClinChem
José Espinoza Pineda, MD (Locum Haematology)

Department of Paediatrics and Neonatology
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Dr Colm O’Donnell, MB, BCH, BAO, MRCPO, DCH, MRCPCH, FRACP, PhD
Dr Anne Twomey, MD, MRCP, FAAP
Prof Eleanor Molloy, MB, BCH, BAO, PhD, FRCP, MRCP, MRCPCH
Dr Carlos Blanco, MD, PhD (Locum)

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Director: Dr Kevin T McKeating, MB, BCH, FFARCSI
Dr Breda O’Kelly, MB, BCH, BAO (UCD), MD (UCD), DObs (RSPI), FFARCSI, AEA, SESS (Paris VII)
Dr Ingrid Browne, MB, BCH, MRCP, FFARCSI, AEA, SESS (Paris VII)
Dr Ola Peter Roseag, MB, FRCP
Dr Roger McMorrow, MB, BCH, BAO, FCARCSI, Dip Med Man, Dip Mtn Med
Dr Larry Crowley, MB, MRCP, FCARCSI

Respiratory Physician
Dr Walter McNicholas, MD, FRCP, FRCP (C), FCCP

Cardiovascular Medicine
Dr Alice Stanton

Psychiatrist
Dr Anthony McCarthy, MB, BAO, BCH, MRCP, MRCPsych

Diabetic Physician/Endocrinologist
Dr Claire Gavin, MB, BCH, BAO, MRCP, FRCP

Ophthalmologist
Dr Michael O’Keeffe, MB, FRCS

Physician in Chemotherapeutic Medicine
Dr David Fennelly, MB, BCH, BAO, LRCSI, MRCP

Department of Radiology
Dr Brigid V Donoghue, MB, DMRD (London), FCRR
Prof Risteard O’Laoide, BA, MB, BCH, BAO, FCRR
Dr Eoghan Laffan, FFR, RCPI

Renal/Metabolic Physician
Prof Alan Watson, MD, FRCP, FACP, FRCP
Honorary Consulting Staff

Surgeons
Mr Enda McDermott, MCh, FRCSI
Prof Martin Corbally, MB, BCh, BAO, MCh, FRCSI, FRCS (Paed Surg)
Mr Feargal Quinn, MB, FRCSI

Oto-Rhino-Laryngologist (ENT Surgeon)
Mr Alex Blayney, MCh, FRCS, FRCSI

Urological Surgeons
Mr David Mulvin, MCh, FRCSI
Mr David Quinlan, FRCSI
Mr Gerry Lennon, NCH, FRCSI

Consultant in Genitourinary Medicine
Prof Fiona Mulcahy, MD, FRCPI

Gastroenterologist
Dr John Crowe, MB, PhD, FRCPI

Orthopaedic Surgeon
Mr Damian McCormack, BSc, MCh, Orth

Dermatologist
Dr Aoife Lally, MB MRCPI

Paediatric Cardiologists
Dr Paul Osiliok, MB, FRCP, DCH
Dr David Coleman, MB, BCh, DCH, FRACP
Dr Colin McMahon, MB, BAO, BCh, DCH, MRCPI, MRCP (UK), FAAP

General and Colorectal
Prof P Ronan O’Connell, MD, FRCSI

Paediatric Neurologists
Dr Bryan Lynch, MB, BCh, BAO, FAAP
Dr David Webb, MB, BAO, BCh, MRCPI, MD, FRCPCH

Neurologists
Dr Conor O’Brien, MB, MSc, PhD, CSCN (Emg), FRCP
Dr Janice Redmond, MT, MD, FRCPI, FACP, DAB Psych Neuro, DAB Elec-Diag Med

Paediatric Infectious Diseases
Prof Karina Butler, MB, FRCPI

Infectious Diseases
Prof Colm Bergin, MB, FRCPI, MRCP (UK)

Clinical Geneticist
Dr William Reardon, MD, MRCPI, DCh, FRCPCH, FRCP (London)

Radiologists
Dr Suzanne Shine, MB, BCh, BAO (Hons), AFRCPI, FFR RCS, MSc Rad Sci
Dr Stephanie Ryan, MB BCh U Dubl FFR RCSI FRCSI

Palliative Medicine
Dr Marie Twomey, MB, MRCPI

Hepatology
Professor Aiden McCormick, MD, FRCPI, FRCP, FEBG

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Dr Stephanie Ryan, MB BCh U Dubl FFR RCSI FRCSI

Palliative Medicine
Dr Marie Twomey, MB, MRCPI

Hepatology
Professor Aiden McCormick, MD, FRCPI, FRCP, FEBG
Senior Midwifery & Nursing Staff

**Director of Midwifery & Nursing**
Mary Brosnan, MSc, RGN, RM

**Assistant Directors of Midwifery & Nursing – Day Duty**
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Nicola Clarke, MSc, RSCN, RGN, RM, IBCLC, Dip HSP, FFNM (RCSI)
Geraldine Duffy, BSc (Hons), RGN, RM, RNC, ANNP (UKCC)
Mary F. Moore, RGN, RM Dip Mgmt, HDip, HC Risk Mgmt

**Assistant Directors of Midwifery & Nursing – Night Duty**
Josephine Reilly-Griffin, RGN, RM, Dip Mgmt
Martina Carden, RGN, RM, Dip Mgmt
Bernadette O’Brien, RGN, RM, BMS (Hons), RNP

**Assistant Director of Midwifery & Nursing – Clinical Practice Development Co-Ordinator**
Maureen Kington, BSc (Hons) Midwifery Studies, RGN, RM, Dip Mgmt

**Advanced Midwife / Nurse Practitioners**
Mary Jacob, MSc, BSc (Hons), RGN, RCN RM, FFNM (RCSI), RNP ANP (Women’s Health)
Helen Walsh, MSc, BSc Nursing, FFNM RCSI, ANP, RNP, RGN (Neonatology)
Mary Coffey, MSc, RGN, RM, HDipRNP (Diabetes)

**Clinical Midwife / Nurse Managers 3**
Valerie Kinsella, MSc Healthcare Ethics & Law, RGN, RM, HDDI
Ann Rath, RGN, RM BSc Nursing Mgmt (Hons)
Margaret Hanahoe, RGN, RM, RNP
Hilda Wall, RGN, RM, Dip Healthcare Management
Mary Byrne, RGN, RM Dip Mgmt
Karen Sherlock, RGN, RM, BNS

**Clinical Midwife / Nurse Managers 2**
Caroline Brophy, RGN, RM, BNS (Hons) Outpatients Clinic
Jennifer Fitzgerald, BMS, RGN, HDip RM Gynaecological Clinic
Aileen Fox, RGN, RM Early Transfer Home Team
Margaret Fanagan, RGN, RM, Dip HA Antenatal Education
Kathleen O’Sullivan, RGN, RM, BMS (Hons) Antenatal Education
Ann Calnan, RGN, RM BSc Nursing Mgmt (Hons) Unit 3
Tina Murphy, RGN, RM, BNS (Hons), RNP Delivery Ward

Brid Shannon, RGN, RM, RNP Delivery Ward
Helen McHale, RGN, RM, RNP Delivery Ward
Martina Cronin, RGN, RM, BSc Nursing Mgmt (Hons) Delivery Ward
Laurence Rousseill, RGN, RM, BSc Midwifery (Hons) Delivery Unit
Gillian Santry, RGN, RNP, BSc Nursing Mgmt (Hons), RNP Delivery Ward
Breid O’Dea, RGN, RM, Outpatients Clinic
Maggie Bree, RGN, RM, Theatre
Dana Hardy, RGN, RM, BNS, Theatre
Breda Corinella, RGN, RM Unit 8
Phyllis Doughty, RSCN RGN, RM Unit 8
Rachel Irwin, BSc NMgt RGN, RM Unit 8
Sara Duff Rock, RGN, RM Unit 8
Fidelma Martin, RGN, DipHe(RSCN), BNS (Hons), Unit 8
Fionnie Fee, RGN, RM Unit 8
Maria O’Connell, RGN, RM Gynae Outpatients Clinic
Joan Ward, RGN, RM Unit 4
Marie Therese Joy, RGN, RM Unit 9/10
Marion O’Leary, RSCN, RGN, RM, BSc Nursing, Unit 5
Elizabeth Butler, RGN, RM, IBCLC Unit 7
Catherine Callinan, RGN, RM Merrion Wing
Clare O’Dwyer, RGN, RM, H Dip HC Risk Mgt, BSc (Hons)

**Clinical Midwife/Nurse Specialists**
Cecilia Mulcahy RGN, RM, MSc Diag Imaging (CMS - Sonography)
Imelda Keane, RGN, BNS, Dip Shww (CMS - Occupational Health)
Bridget O’Brien, RGN, RM, HDip Neonatal Studies (CMS - Neonatal Resuscitation Officer)
Caroline McCafferty, RGN, RCN, BSc Nursing Management (CMS - Neonatal)
Ciara Murphy, RN, ENB 405, RCH (Dip HE), BNS (Hons) (CMS - Neonatal)
Lorraine O’Hagan, BSc Midwifery (Hons) RGN, RM, Dip in Social Studies IBCLC, RNP (CMS - Lactation)
Catherine McCann, RGN, RM, RCN, BSc Midwifery, IBCLC (CMS - Lactation)
Denise McGuinness, RGN, RM, DipNAdmin, BMS, IBCLC (CMS – Lactation)
Sheila Power, MSc, RGN, RM PHN, BNS (CMS – Bereavement)
Margaret Reynolds, RCN, RGN, RM (CMS – Bereavement)
Community Midwives
Kate Casey, RGN, RM
Niamh Cummins, RGN, RM, BSc Midwifery (Hons)
Julie Higgins, RGN, RM, BSc Midwifery (Hons)
Clodagh Manning, RGN, RM
Roisin McCormack, RGN, RM BSc Midwifery (Hons)
Teresa McCreery, RGN, RM, RSCN
Niamh Morrissey, RGN, RM
Bernie O’Callaghan, RGN, RM
Fiona Roarty, RGN, RM, PHN
Annmarie Slíne, RGN, RM, BSc Midwifery (Hons)
Sinead Thompson, RGN, RM, Dip HE, BSc Midwifery
Katie Hearty, RGN, RM, BSc Midwifery (Hons)
Sharon Croke, RGN, RM, RNP (Hons), BSc Management (Hons)

Haemovigilance Officer
Bridget Carew, RGN, RM, H Dip Healthcare Risk Mgt, HDip Quality in Healthcare

Clinical Skills Facilitator
Lucille Sheehy, BMS, RGN, HDip RM
Niamh Dougan, RGN, RM

Neonatal Clinical Skills Facilitator
Thankamma Mathew, RGN

Cancer Nurse Co-ordinator
Helen Frances Craig, RGN, HDip Onc

Education Co-ordinator
Patricia Feeney, BSc, MSc, RN, RM, RNT

Post Registration Midwifery Programme Co-ordinator
Ann Marie Dunne, MSc (Edu), NICU, Grad Dip, RGN, RM

Clinical Placement Co-ordinators
Orla Gavigan, BMS (Hons), RGN, RM, DipMgmt
Theresa Barry, RGN, RM, BSc Nursing Mgmt (Hons)
Elaine Creedon, RGN, RM, BNS, BSc Midwifery Nursing Mgmt

Allocations Liaison Officer
Catriona Cullen, RGN, RM, BSc Midwifery
Allied Health Professionals

Medical Social Workers
Loretto Reilly, Head Medical Social Worker, BScSc, CQSW
Ciara McKenna, Senior Medical Social Worker, BScSc, NQSW
Laura Harrington, Medical Social Worker, BA, HDip Sp, MSoc Sc, NQSW
Aoife Shannon, Medical Social Worker, BA, HDip Sp, MSoc Sc, NQSW
Erin Fisher, Medical Social Worker, BA Social Work, NQSW

Radiographers
Mary Corkery, DCR
Bernadette Ryan, DCR
Clara Nolan, BSc (Hons) Rad, MBS
Angela O’Sullivan, DCR, DIP MS, PG DIP MUS

Physiotherapists
Judith Nalty, Physiotherapy Manager, BSc (Physio), MISC
Lesley-Anne Ross, MSc (Physio), MISC
Jo Egan, BSc (Physio), MISC
Leah Bryans, BSc (Physio), MISC
Ciara Ryan, BSc (Physio), MISC (locum)

Laboratory Manager
Marie Culliton, MSc, MBA, FAMLS

Chief Medical Scientist
Maggie Walsh, FAMLS

Specialist Medical Scientist
Joseph Byrne, FAMLS

Surveillance Scientist
Meriel Matheson, MAMLS

Senior Medical Scientists
Mary Anderson, MAMLS
Anya Curry, MSc, FAMLS
Deirdre Fagan, MSc, FAMLS
Catherine Doughty, MSc, FAMLS
Frances Hogan, MAMLS
Mary Hunter, MSc, FAMLS
G Kelleher, MSc, FAMLS

Luke MacKeogh, MBA, FAMLS
Padraig McGarry, MSc, FAMLS
Mary Moriarty, BSc, MAMLS
Padmaja Naik, MSc, FAMLS

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Christina Lynham, BSc Pharm, MPSI
Aine Toher, BSc Pharm, MPSI
Eimear Curran, BSc Pharm, MPSI (locum)

Pharmacy Technician
Linda Simpson

Clinical Pharmacist
Noreen O’Callaghan, BSc Pharm, MPSI

Psychosexual Counsellor
Meg Fitzgerald, BScSc, MSW, NQSW, Dip PST

Dietician
Roberta McCarthy, BSc/DipHumNut&Diet, MINDI
Sinead Curran, BSc/DipHumNut&Diet, MINDI

Clinical Risk Manager
Angela Gargan, BSc Nursing, RGN, Dip Health & Safety Welfare at Work, H. Dip Quality & Healthcare Risk Mgt.
Clare O’Dwyer, RGN, RM, H Dip HC Risk Mgt, BSc (Hons) Nursing Mgmt

Clinical Engineering
Karl Bergin, PCET, Dip. App. Sc., BSc(Hons), MEng, CPhys, MinstP
Eoghan Hayden, mSc, BSc (CompSc)

Clinical Psychologist
Marie Sleven, MA

Haemovigilance Officer
Bridget Carew, RGN, RM, H Dip Healthcare Risk Mgt, HDip Quality in Healthcare
Senior Administration Staff

Secretary/General Manager
Pat O’Boyle, MA (until May)
Ronan Gavin, BBS (Hons), ACA (from May)

Financial Controller
Ronan Gavin, BBS (Hons), ACA (until May)
Tommy Hayden, AIPA (from May)

IT Manager
Karl Bergin, PCET, Dip. App. Sc., BSc(Hons), MEng, CPhys, MinstP (Acting)
Cathal Keegan, BSc (Mgt), P. Grad Dip. (IT)

Human Resources Manager
Lauri Cryan, MSc, MCIPD

General Services Manager
Tony Thompson, DipHSM, Dip SCM

Purchasing and Supplies Manager
Damian McKeown, MBA

Facilities Engineering (Acting)
Frederick Byrne

Patient Services Manager
Alan McNamara

Information Officer
Fionnuala Byrne, MSc, BA (ICT), P. Grad (Stat)

Quality/Accreditation Manager
Geraldine McGuire, RGN, RM, Dip Nursing Mgmt

Health & Safety Officer/Project Manager
Martin Creagh, DipHSWW, BSc, IOSH

Some delivery ward staff
Neonatology

2011 was a busy year for the Neonatal Intensive Care Unit (NICU). The Department serves both a local and a national role. It cares for the almost 10,000 babies booked for delivery at the hospital and for many other cases transferred either antenatally or after birth from other hospitals throughout the country.

In 2011 there were 2500 admissions to the NICU. Among these admissions were 131 infants with birthweight <1500g. There were 47 infants with birthweight <1000g; 20 of these infants were transferred from other hospitals. This large number of infant admissions requiring care reflects the high birth rate nationally. There are 75,000 births annually. The Irish birth rate is 18 per 1,000 population. This is the highest in Europe. The Rate in the UK and France is 13 per 1000, with Italy and Germany reporting a rate of 9 per 1000.

The Unit was actively involved in World Prematurity Day, 17th November 2011. This a movement to promote awareness of the medical challenges posed by prematurity. The Day was marked by an international meeting held at the Royal College of Physicians. The European Foundation for the Care of Newborn Infants (EFCNI) produced an EU benchmarking report. All EU countries including Ireland contributed to the Report. The prematurity rate in Ireland is 6%, which is the second lowest rate in Europe. The rate in the UK is 8.3%. The reason for the low rate in Ireland is unexplained. The costs of caring for preterm infants was calculated- €79,000 for extremely low birth weight infants, €35,000 for very low birth weight, €19,000 for low birth weight infants.

A new booklet for parents ‘Newborn Infants & the Special Care Baby Unit’ was produced by Unit 8 in November 2011. The publication which is 81 pages long was written by the doctors, nurses and allied health care professionals. The booklet provides parents with a written and photographic account of the sick newborn infant’s journey through neonatal intensive care. The booklet was officially launched by Dr. James Reilly, Minister for Health on 17th November 2011.

The Neonatal Unit strives to provide care of the highest standards. It remains a constant challenge to provide and implement the rapidly increasing numbers of new techniques and treatments. An exciting and very promising new treatment for birth damaged infants has been introduced to the Unit. This treatment called ‘Therapeutic Cooling’ has potential to prevent the neurological consequences in some cases of birth asphyxia. During the year 10 infants received this treatment and it is likely that numbers will increase further in 2012. In addition to our infants, infants are transferred from other hospitals for this treatment.

There is an active research programme being undertaken by the Unit. The areas under research include Newborn Resuscitation (Lisa McCarthy), Neonatal Brain Injury (Deidre Sweetman), Preterm Infant Heart Study (Katie Armstrong), Central Catheter Sepsis (Emily Kieran), Vitamin D Immunomodulation (Cheke), Counselling Interventions in Newborn Care (Aoife Twohig). The projects have generated a number of important clinical findings which have been presented to national and international audiences. In the Unit there are 4 doctors enrolled for an MD thesis and 2 doctors enrolled for a PhD thesis. They are under the supervision of Eleanor Molloy and Colm O’Donnell.

The Unit collects and analyses clinical details on all infants admitted to the Unit. Data on all infants BW<1500g is submitted to the Vermont Oxford Collaborative.

I was appointed as National Clinical Lead in Neonatology in June 2011. Hilda Wall was appointed as Neonatal Nurse lead. The overarching aim of the programme is to provide high quality care to all 75,000 infants born in the country each year. The objective is to provide high quality medical and surgical care to all ill newborns. There needs to be seamless transfer from Level 1 to Level 2 through to Level 3 neonatal intensive care. All infants should have equal rapid access to neonatal care irrespective of geographical location. ‘Postcode’ disadvantage must be eliminated.

Plans for the extension of the National Neonatal Transport Programme (NNTP) to a 24 hour 7 day service are at an advanced stage. Our Unit, in collaboration with the
Advanced Neonatal Nurse Practitioner, Neonatology

Neonatal intensive care provides care for both premature and sick infants. The staff continues to be challenged in providing care which can meet the requirements of the neonatal population. This year has again involved working in improving and updating neonatal guidelines and protocols which now incorporates clinical care guidelines. This is a continuous process in partnership with the multidisciplinary neonatal guidelines group.

Education

In collaboration with Dr. John Murphy, Consultant Neonatologist, the first Advanced Nurse Practitioner (ANP) Neonatology study day took place in the NMH. The day involved talks from ANPs from Dublin and the UK. It was very well supported and was found to be informative, diverse and educational and it is hoped that we will continue facilitating this study day on a yearly basis. The first neonatal palliative care study day in Ireland took place in November. This day was extremely well attended and well received and it is hoped that with funding we can run this study day on alternate years.

Research

There is an ongoing audit of the management of pneumothoraces in the NICU. The development of an evidenced-based protocol for the insertion and management of pigtail catheters will be a project in 2012. The audit which we carried out on all infants from 2009 to 2011 has been submitted for conference presentation as well as an abstract for publication. Audits this year included newborn SaO2 checks prior to discharge in maternity hospitals in Ireland and the reporting process to the Coroner regarding neonatal deaths in Ireland.

Objectives

The development of the first ANP (Neonatology) training programme in Ireland will commence in January 2012. This has been achieved with the commitment of the RCSI, the Faculty of Paediatrics of the Royal College of Physicians of Ireland, Consultant Neonatologists, ANPs and the Dublin Maternity Hospitals. The committee of the Council of International Neonatal Nurses are a worldwide organisation and the 8th International Neonatal Nurses conference will be held in Belfast in 2013. The committee comprises of members from the USA, Australia, the UK and Ireland. It is a great achievement to have this conference take place in Ireland and will be work in progress until September 2013.

Helen Walsh

Advanced Neonatal Nurse Practitioner, Neonatology

Coombe and Rotunda, will be providing the service. The NNTP provides a rapid retrieval facility for ill newborns needing transfer to a specialist centre. Currently the NNTP undertakes 300 transports annually and this will rise to over 400 when programme goes to 24/7.

An Advanced Neonatal Nurse Practitioner (ANNP) course has been set up by the RCSI. This is the first time that training as an ANNP is being undertaken in Ireland. Shirley Moore has enrolled in the course which starts on Jan 2012.

During the year the Unit was refurbished. It was a large exercise and it involved rewiring, new lights, new floors, new sinks and wall re-plastering.

In summary the Unit continues to provide a large and busy service. Despite the current cutbacks and constraints it strives to be innovative and to implement new treatments.

Dr. JF Murphy

Consultant Neonatologist
Breastfeeding Support Services

The aim of Breastfeeding Support within the National Maternity Hospital is to promote, support and protect breastfeeding. The breastfeeding initiation rate for 2011 was 69.7%, (national average 52%). This represents an increase of 1.1% on last year’s rate. As seen in the table below, the rates have consistently increased yearly. However, we recognise that increasing breastfeeding rates is only part of our goal. More importantly, it is to ensure that mothers who choose to breastfeed are made aware of best practices in order to optimise their mothering and feeding experience.

Breastfeeding Initiation Rates

<table>
<thead>
<tr>
<th>Year</th>
<th>Initiation</th>
<th>Discharge Excl/partial</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>69.7%</td>
<td>67.5%</td>
</tr>
<tr>
<td>2010</td>
<td>68.5%</td>
<td>66.8%</td>
</tr>
<tr>
<td>2009</td>
<td>68.8%</td>
<td>64.4%</td>
</tr>
<tr>
<td>2008</td>
<td>66.6%</td>
<td>63.8%</td>
</tr>
<tr>
<td>2007</td>
<td>63.70%</td>
<td>61.73%</td>
</tr>
<tr>
<td>2006</td>
<td>61.8%</td>
<td>58.6%</td>
</tr>
<tr>
<td>2005</td>
<td>58.9%</td>
<td>55.6%</td>
</tr>
</tbody>
</table>

Clinical Service

The breastfeeding support service continues to develop with 2,352 patient contacts in the year, reviewing mother baby dyads on the postnatal wards, neonatal unit and for follow ups at the breastfeeding clinic. We attend the five postnatal wards daily to assist mothers with breastfeeding difficulties, and support staff in teaching mothers to breastfeed.

Breastfeeding clinics are held Monday, Wednesday and Friday where mothers and babies are assessed with breastfeeding concerns. 600 mother baby dyads visits were facilitated at the clinic, however the time involved was eroding time that could be spent on the postnatal wards. As a pilot study we have introduced a group session once a week where all mothers with breastfeeding issues are seen as a group. This will be audited towards the end of this year, however we still continue to meet with mothers on an individual basis in the clinic, if necessary.

Classes

We continue to facilitate three breastfeeding workshops per month where attendance has grown annually, averaging 30-40 mothers per class. These sessions aim to empower parents and make them aware of support systems available to them postnatal.

A class with parents of premature babies in the NICU takes place weekly. We meet every Tuesday at 2 pm in the library and discuss any concern they have with regards to breastfeeding and expressing milk. Parents at this group can offer a unique support to each other.

Neonatal Intensive Care Unit Support

Mothers of babies born before 34 weeks are seen as soon as possible after delivery to initiate lactation and discuss best practice in order to maintain supply following discharge from hospital. We reviewed 135 mothers of premature babies on day 1-2 this year. In 2011, all babies weighing less than one kilo received breast milk as their first feed, representing an increase of 2% on last year.

Education

Education of staff continues with collaborative education between the NMH, Rotunda and Coombe Hospitals. We facilitated two twenty hour breastfeeding courses and two one day refresher courses. We also held a one day course specifically for the staff of the Neonatal Unit whose needs are different and unique.

Biological nurturing is being practiced within the hospital as a means of initiating breastfeeding for those mothers who wish to use it. During 2011 a series of information sessions took place revealing the technique and the research involved and was attended by a large number of staff.
National Breastfeeding Week (Oct 1st - 7th)

Each year we devise a programme to highlight and to reflect on breastfeeding practices, in line with National Theme. In 2011 the theme was “Raising the Bar”. During this week we encouraged all mothers to have skin to skin contact with their babies and to initiate breastfeeding in the “laid back position”.

Plans

Our action plans for the Baby Friendly Hospital Initiative (BFHI) this year was to achieve Step 3 which is “That pregnant women attending the hospital will be informed of the benefits and management of breastfeeding”. We continue to work closely with antenatal clinic staff however this step remains a challenge due partly to high activity levels.

Second plan for 2011 was that ‘Babies who are breastfeeding receive no other supplementation unless clinically indicated’ to ascertain practice within the hospital, supplementation audits were carried out monthly from September onwards. Further actions will be determined by the results of the audits.

Research

Biological Nurturing continues to be used as a method of initiating breast feeding. Refining of the breast care leaflet for mothers who have been bereaved is ongoing.

Audits

Regular audits of the service continued in 2011. Focusing in Step 3 (antenatal education) and supplementation issues. Practices are audited, reviewed and action plans developed to support the audits.

Other Activities

We continue to work closely with our peer groups, who have representation on the BFHI committee and attend talks and workshops within the hospital. Supporting, promoting and protecting breastfeeding underpins the work of the Lactation Team. We continue to work to achieve BFHI Status and to empower mothers to enjoy their unique breastfeeding journey.

Catherine McCann

CMS Lactation
Community Midwifery Service

The community midwifery service in Dublin has been in place for 12 years. We have now delivered 374 homebirths. The feedback from the mothers and families availing of the service has been very positive.

The complete service now has 17 midwives including the midwives providing the Early Transfer Home service. The aims of the Community Midwifery Service is to provide continuity of care and choice to low risk women throughout pregnancy, labour and the postnatal period. We provide 24-hour midwifery care for all women booked with the scheme. We aim to have a community midwife providing care in labour and to have a community midwife known to the woman conducting her care; to provide continuity of information in pregnancy, labour and postnatal period, and to provide early discharge without affecting postnatal care.

Antenatal Care

The antenatal clinics take place in the Ballinteer Health Centre, Leopardstown Primary Care Unit, St. Michael’s Hospital in Dun Laoghaire, Bray Health Centre, and Greystones Health Centre. We encourage all women to have combined care with their GP’s. If an obstetric opinion is requested, women are reviewed by Dr. Declan Keane in the outpatient clinic. If a woman needs an urgent medical opinion the registrars or assistant master on duty will review the woman as requested by the community midwife.

Antenatal classes have continued successfully in two separate locations, Dublin and Wicklow, with most women attending with their birthing partners, irrespective of their choice of place of birth. In cases of women where complications arose, the care was carried out by the community midwives in conjunction with our medical colleagues. It should be noted that the figures presented in this report include all women irrespective of pregnancy complications or outcomes.

Bookings

There were a total of 776 women booking with the scheme. Women are required to book with the community midwives before 8 weeks gestation to secure a place. We were unable to take 125 women who remained on our waiting list. 196 women left the scheme. 107 (9 homebirths) women had an early miscarriage. The Fetal Medicine Unit let us know if one of the mothers booked to the community midwives has a poor outcome at the scan and the midwife who booked the woman, where possible, will make a follow-up phone call. 12 women moved to another hospital, 36 moved to another clinic. 8 had sets of twins, 3 went to an independent midwife, 1 went to the diabetic clinic, 3 had assisted fertility, 4 had a previous caesarean section, 4 had a raised BMI, 9 were not suitable when they booked e.g. essential hypertension, Hep C. 3 women had cardiac history, 2 women had a placenta praevia diagnosed early in pregnancy. 2 women had fetus incompatible with life and we had 2 women with a mid-trimester loss.

<table>
<thead>
<tr>
<th>Total Deliveries</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal delivery</td>
<td>493</td>
</tr>
<tr>
<td>Caesarean section</td>
<td>38</td>
</tr>
<tr>
<td>Instrumental</td>
<td>48</td>
</tr>
</tbody>
</table>

Homebirths

The rate of homebirth has remained relatively unchanged over the past number of years.

The women in our care understand and sign two consent forms for Homebirth. This includes the reasons for transfer, expected date of delivery, date of post dates scan, some of the main complications of homebirth. The women feel confident in the knowledge that transfer means they become ‘domino’ and are looked after by the same team of midwives whom they know.

<table>
<thead>
<tr>
<th>Booked for homebirth</th>
<th>Delivered at home</th>
<th>Transfer rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nulliparous</td>
<td>15</td>
<td>6</td>
</tr>
<tr>
<td>Multiparous</td>
<td>56</td>
<td>43</td>
</tr>
<tr>
<td>Total Homebirths</td>
<td>71</td>
<td>49</td>
</tr>
</tbody>
</table>

‘DOMINO’: Continuity of Midwifery care from booking, antenatal, intrapartum and postnatal period.

An increased number of women requested domino/homebirths in 2011 but we were unable to accommodate them all.
midwifery led care in all clinics in Wicklow. This will be the first ‘mixed risk’ clinic facilitated by a midwifery team. The consultants will continue to come to the clinics to see higher risk women once every two weeks for the initial period and one a month thereafter.

We call this ‘Community Maternity Care’ as the midwife, GP, Public Health Nurses, Consultants and hospital staff are involved with the woman’s care. She will be looked after by the most appropriate professional, in the most appropriate and convenient place for the woman. All of the maternity care team feel this is the way forward for maternity care in Ireland. This is an opportunity for women with complicated previous history’s or complicated pregnancies to have the support of a midwife and the expertise of the medical team.

Margaret Hanahoe
CMM3, Community Midwifery Service

Early Transfer Home

The Early Transfer Home Programme (ETHP) has completed its ninth year in operation and 2011 has been our busiest year to date. The number of clients who have availed of the postnatal service has increased from 1,306 in 2010 to 1,467 in 2011; an increase of 11%. The team carried out a total of 3999 visits over the year which indicates that each client received an average of 2.7 visits by the ETHP community midwives. Similarly, the satellite antenatal clinic attendances in Dun Laoghaire have shown a slight increase from 363 in 2010 to 483 in 2011. Factors such as the heightened hospital activity levels and greater awareness of the programme may be responsible for the increase in both antenatal and postnatal services.

Following a review of the service provided, it shows that almost equal amounts of both nulliparous and multiparous availed of the scheme. The majority of the clients had a spontaneous vaginal delivery (69.5%) and went home on day 2 (55.3%). The breast feeding rates for 2011 were 55%. Our staffing levels amount to 3 WTE comprising of both part and full time members.

The service was expanded in 2011 to incorporate Dublin 6 West. Further development of the ETHP remains work in progress. Cross hospital transfer between the three Dublin maternity hospitals offering ETH to all childbearing women will proceed at some point in the future.

### Domino Outcomes

<table>
<thead>
<tr>
<th></th>
<th>Nullip</th>
<th>Multips</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td>SVD</td>
<td>141 (67.8%)</td>
<td>303 (94.1%)</td>
<td>444 (76.7%)</td>
</tr>
<tr>
<td>Caesarean section</td>
<td>29 (13.9%)</td>
<td>9 (2.8%)</td>
<td>38 (6.6%)</td>
</tr>
<tr>
<td>Ventouse</td>
<td>26 (12.5%)</td>
<td>8 (2.5%)</td>
<td>34 (5.7%)</td>
</tr>
<tr>
<td>Forceps</td>
<td>12 (5.8%)</td>
<td>2 (0.6%)</td>
<td>14 (2.3%)</td>
</tr>
<tr>
<td>Epidural Rate</td>
<td>80 (37%)</td>
<td>44 (12%)</td>
<td>124 (20.7%)</td>
</tr>
<tr>
<td>Induction of labour</td>
<td>62 (30%)</td>
<td>47 (14%)</td>
<td>109 (18.1%)</td>
</tr>
</tbody>
</table>

### Discharge Feeding Method (Domino and Homebirths)

<table>
<thead>
<tr>
<th></th>
<th>Nullip</th>
<th>Multips</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breastfeeding</td>
<td>165 (77.1%)</td>
<td>279 (78.4%)</td>
<td>444 (76.7%)</td>
</tr>
<tr>
<td>Formula</td>
<td>21 (9.8%)</td>
<td>46 (12.6%)</td>
<td>67 (11.6%)</td>
</tr>
<tr>
<td>Combined breast and formula feeding</td>
<td>13 (6.1%)</td>
<td>8 (2.2%)</td>
<td>21 (3.6%)</td>
</tr>
<tr>
<td>Unrecorded</td>
<td>15 (7.0%)</td>
<td>32 (8.8%)</td>
<td>47 (8.1%)</td>
</tr>
<tr>
<td>Total</td>
<td>214</td>
<td>365</td>
<td>579</td>
</tr>
</tbody>
</table>

### Special Care Baby Unit

A total of 49 babies were admitted to the Special Care Baby Unit. We continue to offer these women support and assistance while their babies are in the unit and complete their postnatal care at home.

### Future

Women and their partners report being made feel part of the birthing process and fully informed and involved in all decision making. They felt empowered and in control of their pregnancy, labour and postnatal period. Due to maternity leave among the staff and the current economic climate, we are looking at ways of working smarter. Unfortunately, we ceased the postnatal support group. We have found that increasingly the three teams’ join together to share homevisits as there has been an increase in women availing of ETH in both Dublin and Wicklow.

Consultant Dr. Shane Higgins and Margaret Hanahoe have met with the Local Health Manager, GP’s and consumer group members. With the help of the Executive Management Team, our community partners and Dr. Rhona Mahony, all processes are now in place to commence
Clinical Governance

Clinical Governance is the framework through which the hospital is accountable for continuous improvements in services and quality creating an environment of clinical excellence. It is a patient-centred approach to care that is accountable in providing a safe, high quality service in an open and questioning environment.

The key components of Clinical Governance are:

- Clear lines of responsibility and accountability for the overall quality of clinical care
- A comprehensive programme of quality improvement activities
- Clear policies aimed at managing risk

A Clinical Governance Committee was formed in the hospital early in 2005. This committee was established to continuously monitor the quality of services and ensure high standards of care by developing a culture of excellence. The committee meets weekly and members include the Master, Director of Midwifery/Nursing, General/Secretary Manager, Clinical Risk Managers, Clinical Practice Co-ordinator and Quality Manager.

The committee met on 48 occasions during 2011. A total of 2,786 incidents were reported to the State Claims Agency. Of these, there were 2,622 clinical incidents and 164 non-clinical incidents. This number represents the enormous commitment by the staff of the National Maternity Hospital to continually monitor and improve care.

There were presentations from external speakers on different aspects of patient safety day held here in the hospital during the year.

The Quality, Risk, Health & Safety committee which meets on a monthly basis. The purpose of this committee is to operate an integrated process for the management of risk and the continuous update of the Risk Register.

The Risk Register is maintained at both organisational level and local level. The purpose of the Risk Register is to capture risk information from the ‘bottom up’ within each service area. The Risk Register will be a primary tool for risk tracking and analysis. This is to ensure that health, personal and social services are safe and of an acceptable quality.

The Committee will report through the Secretary/General Manager to the Executive Management Team and the Board of Governors with the appropriate reporting and linkages to the Clinical Governance Committee.

A report on Wound Care in WIN Magazine was published following a review in 2009. It highlighted that a minimalistic approach to wound care was optimum, and that further research was required to improve client care in regards to wound care.

- 1467 women went home with the Early Transfer Home (ETH) team in 2011. (increase of 150 women)
- 483 antenatal visits took place in the ETH midwives clinic in Dunlaoghaire.
- 3999 (ETH) + 2169(domino, homebirth) 6168 postnatal visits were carried out in the South Dublin area.
- 338 women availed of ETH in Wicklow. (increase of 6%)
- 2200 approx postnatal visits were carried out by the Wicklow midwives.
- There was a total of 8,368 postnatal visits at home.

Aileen Fox
ETHP Co-ordinator
Neonatal Liaison Service

Introduction

The Neonatal Clinical Nurse Specialists (CNS) continues to ensure effective community liaison and discharge planning of babies from the Neonatal Unit. The CNS improves overall discharge planning and ensures that it’s a seamless process in the Neonatal Unit therefore improving the care and education given to parents and their babies. The role also entails working with families whose infant will be discharged home requiring complex care involving home tube feeding, oxygen or suctioning and all the associated education required.

Caseload

The CNS caseload includes preterm infants < 1.5 kgs or < 32 weeks gestation, infants requiring palliative care and those infants with the following: long term illness, life limiting conditions, neurological problems, congenital anomalies and other cases.

Activity Levels

<table>
<thead>
<tr>
<th>Total Discharges</th>
<th>1510 (babies)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discharges CNS Involved in</td>
<td>191</td>
</tr>
<tr>
<td>Phone Contacts</td>
<td>322</td>
</tr>
<tr>
<td>Discharged Home on:</td>
<td></td>
</tr>
<tr>
<td>Tube Feeding</td>
<td>3</td>
</tr>
<tr>
<td>Suctioning</td>
<td>1</td>
</tr>
</tbody>
</table>

Training and education

Staff education continues to be provided to new and exiting staff throughout the year to improve discharge planning in the neonatal unit.

The CNS also contributed to the Neonatal Special Care booklet which is distributed to all parents in the Unit providing invaluable information for them.

The CNS is involved in teaching sessions with Midwifery/ Nursing staff, Midwifery and Public Health Nurse Students and Medical staff in the Neonatal Unit.

Research

The CNS is involved in a ‘MRI White Matter Volume Study’ to assess the white matter volume of the brain of premature babies. The CNS is responsible for the recruitment, collection of information and submission of forms to The MRI Department in The Children’s University Hospital Temple St. since March 2010.

Future Development

A parent satisfaction questionnaire will be devised as an audit tool and circulated to parents to evaluate the importance of the CNS role and the Parents experience.

A Poster presentation of The Role of The Neonatal CNS will be presented in 2012 at a National Conference.

The CNS will continue to host and chair meetings with the other CNS in Neonates (Discharge Planning) in the other maternity and children’s hospital in Dublin.

The CNS will organise information sessions for Public Health Nurses later in the year focusing on issues relating to premature/sick babies and common problems related to these babies.

The CNS will be meeting with the Road Safety Authority with regard to updating the Car Safety booklet to include more information regarding car safety for premature babies.

Caroline McCafferty
Ciara Murphy
CNS Neonatal

Neonatal Resuscitation

The role of the Clinical Midwife Specialist (CMS) in Neonatal Resuscitation ensures that the service of Neonatal Resuscitation continues to improve the quality of care for the Neonate and Parents. The Neonatal Resuscitation service continues to develop through education, research and communication, to provide a standardisation of care in Neonatal Resuscitation. The CMS continues to attend, liaise and co-ordinate high risk deliveries.

Audit of Activity

The Neonatal Resuscitation Providers Programme Course (NRP) 5th Edition continues to be provided on a monthly basis for the Midwifery, Nursing and Paediatric Staff. The 6th Edition NRP Textbook will be implemented in 2012.

Attendance for 2011
Midwifery/Nursing Staff: 77
Paediatric Staff: 13

Orientation and training sessions are provided for new paediatric staff during their initial phase of attending Neonatal Resuscitation in Delivery Unit and Theatre. Informal training sessions are provided for Midwifery/Nursing staff. The CMS has been involved in the planning process of the Neonatal Resuscitation area in the new Theatre.
Baby Cardio Resuscitation prior to discharge home from the Neonatal Unit continues to be taught to those parents of infants in Unit 8 and any parents with a history of Sudden Infant Death Syndrome or parental request.

For 2011 four mothers required delivery by Caesarean Section in St. Vincent’s Hospital, with safe outcomes for mothers and babies. The maternal indications were; 3 cases of Placenta Accreta and 1 case of Cardiac Disease. The CMS organised the logistical planning of delivery and transport of these four babies, through co-ordination and liaison between The National Maternity Hospital and St. Vincent’s Hospital. In 2011 the CMS prepared a policy and procedure document which was presented at the Neonatal Policy meeting and submitted to the Clinical Practice Development department for the amalgamation of policy and procedures between the two hospitals.

Research
The CMS recruited infants for a ‘MRI White Matter Volume Study’. This involved completing study information forms and submitting them to the MRI Department Children’s University Hospital, Temple Street.

The CMS continues to review published Neonatal care literature and developing protocols and guidelines and is a member of the National Neonatal Transport Programme (NNTP).

Bridget O’Brien
CMS Neonatal Resuscitation

Bereavement
The bereavement department cares for mothers and families as a result of miscarriage, stillbirth and neonatal deaths. Our activity level was high attending to the mothers on the wards but also facilitating the stillbirth and miscarriage clinics. Similarly there was increased demand for individual support and counselling sessions following a pregnancy loss.

The bereavement service receives considerable amount of phone calls every day and virtually all require advice, chart retrieval and follow up.

Stillbirth Clinic
73 mothers were counselled at this clinic in 2011. Parents who have experienced a stillbirth, late mid trimester miscarriage or neonatal death are seen at this clinic. The consultations are on average fifty minutes duration with an emphasis on explaining post mortem and laboratory results and planning for a future pregnancy. The clinic also provides an opportunity to ascertain how the parents are coping with the grief process and if individual support is required.

Miscarriage Clinic
In 2011, 67 women who had three consecutive miscarriages attended the miscarriage clinic as well as 42 women who had an early mid trimester miscarriage. Thrombophilia screening, cytogenetic testing and vaginal ultrasound are completed prior to attending the clinic.

Ward Visits
Almost all patients who present to the Gynaecology Ward for ERPCs meet the CMS in Bereavement. The duration of each visit and consultation depends on the needs of the patient. In 2011, 531 met the CMS Bereavement on the ward.

Counselling and Bereavement Support
Throughout the year there was a large demand for counselling and bereavement support with 264 hours of counselling support given to parents by appointment. Other parents were seen in the Fetal Medicine Unit or following diagnosis of a lethal fetal anomaly.

Funeral Services
The CMS Bereavement organises all hospital burials. In 2011 funerals were organised for 100 fetuses lost through early or mid trimester miscarriage.

Objectives
The CMS in Bereavement aim to continue to provide support, information and advocacy to patients attending the hospital who have experienced the death of a baby or a pregnancy loss. We will continue to collate information on mid trimester miscarriages and develop a database of these mothers. We are in the process of publishing two information booklets, one on postmortem and a general information booklet on the process of induction, birth and postnatal care following a perinatal loss. We plan to continue our educational input with staff and student midwives within the hospital and in UCD.

We offer a service that has parental support as our primary focus. Our plan is to continue to support and advise parents and their families who are facing or who have faced a pregnancy loss or the death of a baby. Support and advice is also extended to students and staff. We will continue to coordinate clinics and the issuing of certificates. Individual counselling is available to all parents of the hospital following bereavement and loss.

Sheila Power
Margaret Power
CMS Bereavement
Advanced Midwife Practitioner, Urodynamics

Introduction

The Urodynamic clinic provides urodynamic studies for women attending the National Maternity Hospital. As it is a tertiary referral centre, requests are received from consultant obstetricians and general practitioners in our catchment area and throughout Ireland. In addition, patients with voiding difficulties attend for Flow Studies and these patients constitute an important part of the urodynamics clinic. An important aspect of the urodynamics clinic is to see and follow up patients with postpartum urinary retention and postoperative urinary retention.

2011 saw the urogynaecology protocols for the service upgraded and incorporated into the Q Pulse document management system with a considerable amount of time being invested into the upgrade and revision of these protocols.

The unit is staffed by Ms. Maria O’Connell, clinical midwife manager and Ms. Mary Jacob, advanced midwife practitioner (AMP). The introduction of the AMP post has enhanced an established service and compliments the multi-disciplinary team approach to urinary incontinence and management.

Autonomy in Clinical Practice

The prescribing of medicinal products by the AMP has proved to be successful. The number of consultations and prescriptions written by the practitioner was fifty-five last year. These consultations are in addition to the patients seen at the clinic.

The waiting list for urogynaecology surgery is currently 4 – 6 months. One of the main advantages for seeing the AMP is that instead of the patient waiting for several months without assessment by the consultant, the patient’s diagnosis and treatment modalities will be commenced by the AMP for example, specialised physiotherapy, lifestyle changes and or medication management. Patients have the benefit of initiation of holistic, streamlined and integrated care, thereby improving service delivery. Urinary incontinence requires a holistic approach to the care of people with this condition.

Education

In 2011, the AMP has been facilitated with leave to represent the National Maternity Hospital (NMH) by presenting abstracts/posters at conferences and workshops both nationally and internationally which are relevant to urogynaecology practice. The AMP is actively involved with several organisations that focus on urinary incontinence, such as The International Continence Society, International Urogynaie Association, Association of Continence Advisors, Continence Federation of Ireland, Irish Continence Interest Group, Irish Urodynamics Nurses Association, Irish Association of Urology Nurses. Mary Jacob was appointed on the board of the Faculty of Nursing & Midwifery, RCSI from March 2010; It is wonderful that this specialist area of the hospital is represented at this level.

In addition, lectures given by the AMP have included transition year students, student midwives, medical students UCD and advanced nursing practice students in RCSI. Twelve lectures were delivered at the NMH staff mandatory study day. The AMP provided lectures for the Continence Promotion Unit, HSE on their bi-annual courses. The clinical midwife manager was facilitated to undertake this specialised course last year.

Research and Audit

Research and audit form an integral part of the AMP role in order to incorporate best evidence-based practice. An audit was conducted of the UDS clinic into the age profiles of patients attending, types of deliveries, clinic diagnoses, outcomes and treatment modalities which will be presented at a nursing conference. In addition, research was conducted into the management of acute urinary retention by intermittent self catheterisation versus supra-pubic catheterisation.

The Urodynamics Clinic aims to provide more services for 2012 in tandem with a complex changing environment including changing demographics and epidemiological profiles of the population.

Sincere thanks to the administrative staff for their help and assistance given to the Urodynamics Department throughout the year.

Mary Jacob
Advanced Midwife Practitioner, Urodynamics
Advanced Midwife Practitioner, Diabetes

Introduction

This service supports women with Type 1 diabetes, Type 2 diabetes, Gestational Diabetes, Diabetes Insipidus, Thyroid disease, Pituitary disease and Addison’s disease.

New Referrals

<table>
<thead>
<tr>
<th></th>
<th>Type 1 diabetes</th>
<th>Type 2 diabetes</th>
<th>Gestational diabetes</th>
<th>Impaired glucose tolerance</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>33</td>
<td>11</td>
<td>148</td>
<td>53</td>
</tr>
<tr>
<td>2011</td>
<td>50</td>
<td>25</td>
<td>170</td>
<td>113</td>
</tr>
</tbody>
</table>

**Pre-pregnancy planning service:** Folic acid 5 mgs is prescribed for all. Participants achieved HbA1c well within the target range and maintained excellent control in pregnancy.

**Initiation of insulin:** 45 women with Gestational Diabetes required insulin. Approximately one third were initiated as outpatients and the rest were admitted for 24 hrs to the antenatal ward.

**Insulin pump service:** Twelve patients required intensive education/support

**Mobile Phone service per month:**

Average calls made – 500

Average calls received – 10-30 daily

**Booking clinic:** Women with pre-existing diabetes were seen between 4 and 5 weeks for a booking visit, prescription of 5 mgs Folic acid and intensive diabetes assessment and update.

**Prescribing:** 186 prescriptions were written covering outpatient and inpatient services.

**Skills and Drills:** Over 70 staff midwives/nurses/student midwives attended.

**Staff screening for diabetes:** Over 140 attended for screening with some referrals for further investigations.

**Initiatives for 2011:** A Lifestyle education class was initiated in January for women with previous Gestational diabetes or newly diagnosed with gestational diabetes or impaired glucose. Over 300 women attended. There has been a reduced requirement for insulin therapy and a reduction in the rates of macrosomia since the intervention however this finding may be due to confounding variables.

A text reminder system for postnatal glucose tolerance test appointments has reduced the defaulter rate.

**Challenges**

- Maintaining level of service due to increased activity levels / increased patient population.
- Designated Clinical space: Many interventions are unpredictable e.g. initiation of insulin; starting on insulin pump
- Distance from work area: Education for staff / patients necessitates carrying equipment from place to place.

**Plans for 2012**

- Audit of outcomes for Lifestyle education class.
- Audit of insulin pump service.
- Initiate insulin as outpatients to free up beds and reduce ancillary costs

**Mary Coffey**

**Advanced Midwife Practitioner, Diabetes**

Infection Prevention and Control

The Infection Prevention and Control team reports to the multi-disciplinary Infection Control Committee (ICC) on a quarterly basis. The infection control programme and workplan, education, infectious disease surveillance, outbreak reports, audits, decontamination, occupational blood and body fluid exposures, new and revised policies, environmental monitoring and other infection control issues are discussed, investigated and monitored.

Education is the cornerstone of infection control. The team provides regular education at induction, in-service study days, locally in departments and as required. 625 staff and students received hand hygiene education in 2011. An option of online hand hygiene training was introduced in 2011. Guidelines, policies and procedures are produced and updated regularly and are available on Q-Pulse.
Surveillance

During 2011, there were no MRSA blood stream infections, no VRE infections, no Clostridium difficile infections, one community acquired norovirus infection, 11 community-acquired influenza infections and 2 non-pulmonary Mycobacterium tuberculosis infections. The incidence of caesarean section surgical site infection was 3.9% (Jan-July 2011). Local surveillance of blood stream infections, neonatal central vascular catheter associated blood stream infections, MRSA colonisation and other antibiotic resistant organisms is conducted with feedback of data provided to clinical staff and the infection control committee. There is mandatory reporting of all ‘Notifiable Diseases’ to the Director of Public Health and voluntary reporting of specific infections to the European Antimicrobial Resistance Surveillance Network (EARS-Net), the RCOG, the HPSC and the BPSU.

Audits

In 2011, audits were performed of hand hygiene, alcohol gel use, antibiotic consumption, antibiotic prescribing, catheter-associated urinary tract infections (gynaecology ward), peripheral vascular catheter care bundles, the clinical environment and the sterile services department. Overall hand hygiene compliance was 72.7% in Sept-Oct audit. This result was below the 75% recommended target set by the HSE. Hand hygiene compliance target for 2012 will be 85%. Hand hygiene audits will be performed at least twice per annum, with results notified to the HSE and will be publicly available. Cooperation of all staff will help to improve hand hygiene in the hospital. The total volume of alcohol hand gel (an indicator of hand hygiene practice) used was 546 Litres in Q1-2 2011 compared to full year data of 1124L in 2010, 1033L in 2009, 782L in 2008, 473L in 2007 and 207L in 2006. Alcohol gel consumption for Q1-2 2011 was 19.2L per 1000 bed days used. In 2012, the HSE will be recommending a consumption rate of 23L per 1000 bed days used. Antibiotic consumption for Q1-2 2011 was 22.1 defined daily doses per 100 bed-days used. This is the lowest antibiotic consumption for any hospital that contributed data nationally, including other specialist maternity hospitals.

We would like to thank all staff who practice excellent infection prevention and control standards for minimising the risk of transmission of any infection within the hospital.

Ms Shideh Kiafar
_Infection Control Midwife_

Ms Meriel Matheson
_Surveillance Scientist_

Dr Susan Knowles
_Consultant Microbiologist_
Fetal Medicine Unit

The National Maternity Hospital provides a comprehensive ultrasound and fetal medicine service to over 10,000 women who come through the service, in addition to being a busy tertiary referral unit accepting referrals from health professionals from all over the country. 2011 saw an increase in the number of high risk patients referred to our unit. Every maternity hospital in the country referred patients. The following services are provided: early pregnancy assessment, first trimester screening, detailed anomaly screening, monitoring of multiple pregnancy, assessment of fetal well being, amniocentesis, chorionic villus sampling, management of rhesus disease, fetal therapy including intrauterine transfusion, shunt placement and laser therapy, antenatal care for high risk pregnancies.

The Fetal Medicine Unit workload remained extremely busy with a total of 23,880 ultrasound scans performed and recorded on the Viewpoint System in 2011. This represents a 45% increase since 2002 (figure 1). This equates to an average of 90 - 100 scans every working day by an average of 4 midwife/radiographer ultrasonographers. It is not surprising that the unit is hard pressed to meet the increasing demands being put on it. In addition to performing numerous obstetric scans other duties of our ultrasonographers include performance of CTG’s, phlebotomy, preparation and attendance at invasive procedures, gynaecology scans, counselling and general antenatal care as well facilitating UCD and RCSI medical/midwifery students.

![Scans on Viewpoint](image1)

**Figure 1**

![Scans by Gestation](image2)

**Figure 2**
Figure 2 illustrates the number of scans by gestation and, once again, we can see that peak gestations for performing ultrasound occur in the first 13 weeks and again between 21 and 23 weeks when a routine anomaly scan is offered to all patients. A detailed information leaflet is given to all patients outlining the benefits and limitations of ultrasound. In patients where dates have been clarified in the first 12 weeks an anatomy scan will be booked for between 21 and 23 weeks to allow for better visualisation of the anatomy.

In an ideal situation all patients should be offered a first and second trimester scan in line with emerging European practice but unfortunately resources don’t allow for this development at present. Even if resources allow there is a chronic shortage of suitably trained personnel to fill these positions. Midwives who choose to specialise in this area are trained and supported to undertake the MSc in Diagnostic Imaging in UCD. Due to current HSE financial constraints, unfortunately recognition for this achievement does not seem a priority.

Anomalies are diagnosed using the RCOG / RCR classification and as in previous years the majority of these abnormalities are diagnosed by our own midwife/radiographer ultrasonographers and usually seen by a fetal medicine consultant within 24 hours. We continue to see an increase in the number of external referrals and if these are deemed urgent they can usually be seen by a consultant within 24 hours in one of the daily high risk clinics. Where appropriate, karyotype, surgical, neonatal and genetic counselling is arranged antenatally and the patient usually attends the Fetal Medicine Unit for the remainder of the pregnancy. The weekly perinatal meeting continues to be an excellent form for multi-disciplinary discussion of these complex cases. We also provide a fetal cardiology clinic in conjunction with a paediatric cardiologist and also a neurosurgical clinic where diagnosis is confirmed and management options are discussed.

The Fetal Medicine Unit continues to play an active role in teaching with both UCD and RSCI undergraduates in attendance. NCHDs are encouraged to attend for basic training by observing initially, followed by hands on experience. In view of the HSE implementation of Early Pregnancy guidelines, this has resulted in a further ultrasound course in UCD for all national units. Our unit is involved in the lectures and clinical teaching for this course. This has also led to an increase in the number of people attending the department to obtain experience.

The Early Pregnancy Assessment Unit continues to provide an excellent service to women experiencing complications in early pregnancy. As recommended by the ‘Ultrasound Diagnosis of Early Pregnancy Miscarriage’ clinical practice guideline that was published in December 2010, this service is available daily and audited regularly.

The workload of the unit remains extremely busy and stressful like other units in the hospital. The unit occupies an old ward and the individual scanning rooms are cramped and poorly ventilated. As the interim development plan has been shelved there is an urgent need to improve facilities and equipment for both patients and staff. The midwifery, radiography, medical and secretarial staff are to be commended for providing an excellent service in a less than perfect and often stressful environment.

Valerie Kinsella  
*CMM3 Fetal Medicine Unit*
Gynaecological Services

During 2011 gynaecology services at the National Maternity Hospital continued to deliver high standards of care despite another very busy year. A wide range of services are offered including specialist services in colposcopy, oncology, urogynaecology, reproductive medicine and adolescent services. In 2011 the gynaecology services continued to use successful implementation of text message reminder service which helped to reduce the number of non-attendees. The figures for the number of attendances at the outpatient clinic can be seen in the table below.

The perineal clinic continues to expand with large numbers of referrals from other units. The majority of these come from units in the midlands but also from the South East and Dublin. This has lead to the establishment of two-monthly Neuro Physiology clinics conducted by Dr Connor O’ Brien.

During the year, the gynae/colposcopy clinic continued to develop and expand. 2011 represented the third year of the Cervical Check Programme with continued increase for colposcopy services during the year. The multidisciplinary team worked hard during extended working hours to try and deliver timely access to a quality assured colposcopy service.

There was a noticeable increase of new patients attending the gynae/colposcopy services. To accommodate the increase in the number of patients, staffing and space issues were addressed. This year saw the successful accreditation of Deirdre O’Neill as a nurse colposcopist. This enables nurse led clinics which will facilitate a further increase in the number of patients. Additional space for the administration of colposcopy was obtained from the old post room/cash office. Dedicated clinical colposcopy sessions were increased to nine per week with a dedicated nursing and secretarial support team. The staff is highly motivated and innovative.

The clinic hours for colposcopy patients were extended to 8pm; this allowed the clinic to provide additional room by moving most of the follow up smears to evening clinics. But as patient numbers continue to grow, space is still an issue.

### Clinic Activity

<table>
<thead>
<tr>
<th>Clinic Activity</th>
<th>Attendances</th>
<th>Did Not Attend</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Return</td>
<td>New</td>
</tr>
<tr>
<td>Adolescent</td>
<td>365</td>
<td>210</td>
</tr>
<tr>
<td>Colposcopy</td>
<td>3946</td>
<td>2426</td>
</tr>
<tr>
<td>DES</td>
<td>38</td>
<td>2</td>
</tr>
<tr>
<td>Endocrine</td>
<td>24</td>
<td>7</td>
</tr>
<tr>
<td>Endometriosis</td>
<td>107</td>
<td>35</td>
</tr>
<tr>
<td>Gynae and Infertility</td>
<td>527</td>
<td>219</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>2402</td>
<td>1404</td>
</tr>
<tr>
<td>Miscarriage</td>
<td>82</td>
<td>2</td>
</tr>
<tr>
<td>Neuro Physiology</td>
<td>0</td>
<td>16</td>
</tr>
<tr>
<td>Perineal</td>
<td>99</td>
<td>342</td>
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<tr>
<td>Special Infertility</td>
<td>193</td>
<td>72</td>
</tr>
<tr>
<td>Stillbirth Counselling</td>
<td>70</td>
<td>0</td>
</tr>
<tr>
<td>Trophoblast</td>
<td>86</td>
<td>65</td>
</tr>
<tr>
<td>Unbooked Gynae*</td>
<td>20</td>
<td>464</td>
</tr>
<tr>
<td>Urodynamics</td>
<td>13</td>
<td>199</td>
</tr>
</tbody>
</table>

Unbooked Gynae are unbooked attendances within normal working hours to the Gynae Clinic.

Jennifer Fitzgerald
CMM2 Gynaecology Clinic
Clinical Support Services

Antenatal Education

Childbirth education has sought to give women a more active role in the birth experience, while at the same time helping women to understand the physiology of childbirth and the appropriate interventions that may be necessary during the process of labour and delivery. It promotes confidence in mothers and their partners to meet the challenge of childbirth and early parenting.

In the hospital courses of classes are run as a team effort with the specialized knowledge and skills of the midwife, physiotherapist and dietitian coming together to offer a comprehensive structured education to the mother and her partner.

There is a great demand for classes particularly couples classes and evening classes. It is difficult to meet the demand for evening classes, with a limited number of staff. There are thirteen courses running each week, eleven of which include partners with two classes in the evening at 5.30pm. In 2011, there was a total of 104 courses, with an attendance rate of 50%. The classes have been extremely busy with large numbers in each group.

The course of classes consists of five classes covering all aspects of labour in detail. There are also two refresher classes for multigravidae and one class a month for mothers who have had a caesarean birth. There is a teenage class and a class for mothers expecting twins. Mothers and their partners are also taken on a one to one basis if it is necessary.

We are also involved with providing postnatal baby care classes and in the education of midwifery students, medical students and visiting midwives and registrars to the hospital.

It is important to assess the level of satisfaction with the preparation for labour and with their childbirth experience. An important aspect of antenatal education is to see mothers post delivery, their feedback in imperative and very helpful to us. Evaluation questionnaires are carried out at regular intervals.

Margaret Fanagan
Kathleen O’Sullivan
Clinical Midwife Manager 2

Pregnancy Yoga Classes

Yoga is an integral part of the antenatal education programme. It is now in its thirteenth year and going from strength to strength with many women coming back in subsequent pregnancies. Many women find coming into the hospital setting very reassuring, giving them a chance to meet other women and keeping them positive, confident and empowered for birth.

The classes are practical and informal giving them the tools to manage birth comfortably. The content incorporates breathing techniques which focuses on exhalation; when the exhalation is long the muscles have time to relax thus helping the woman cope much better with contractions of labour. Gentle safe stretching will counteract tiredness and tone muscles without straining them and promotes healthy blood flow and combats fatigue. It also encourages good posture, eases backache, increases flexibility, strength, endurance and stamina for labour. At the end of each class a deep relaxation and visualisation is given with the women lying down so that they can really relax and let go. This is a very important aspect of the class as it gets the woman prepared mentally for the birth. It helps to release fears, tension, stress and anxiety. It builds self-esteem, self-confidence. It reduces mind chatter and negative beliefs and improves sleep. It develops a greater sense of strength, peace and security around the whole process of giving birth.

With Yoga I believe women can learn to develop all their resources to deal with the instinctive experience of birth.

Carmel Flaherty
CMM2 /Yoga Instructor
Clinical Nutrition and Dietetics

Neonatal Nutrition and Dietetics
This post is linked to the Neonatal Unit and the outpatient baby clinic. The service is available for infants under the care of the hospital for whom there is a concern regarding nutrition or growth. The main focus continued to be infants admitted to the Neonatal Unit with a birth weight ≤1.5kg or ≤32+0 weeks gestation (n=180 – based on dietetic figures). These infants required intensive nutritional input including both parenteral and enteral nutrition support. We succeeded in further increasing the usage of mother’s own breast milk for those infants born ≤1.5kg or ≤32 – 91% of whom received breast milk (exclusively or in combination with formula milk) while in the Neonatal Unit. An impressive 100% of babies born ≤1 kg who received their first feed in the Neonatal Unit, received breast milk as their first feed (according to dietetic records). There were 241 outpatient contacts.

Women’s Health
The service is part time (3 days a week) to Antenatal Education, Obstetrics and Gynaecology and is provided through classes, group education, booked outpatient appointments and to women admitted to the antenatal ward and the dayward. The service is limited and has undergone reorganisation several times to meet prioritised clinical need.

2011 was a busy year with some new initiatives successfully introduced:
• A Lifestyle Class for women with Gestational Diabetes (GDM), providing 1 hour of specific nutrition education (alongside training on self blood glucose monitoring delivered by the CMS Diabetes) has been very successful and will continue in 2012. Women are also seen individually for clinical dietetic review at their first multidisciplinary Diabetes clinic as part of their package of care.
• A private room has been made available at the diabetes clinic (annex) for dietitian reviews. Women were previously advised in the waiting area; this clinical space has been of enormous benefit to the appropriate delivery of the dietetic service as women can be advised with respect for confidentiality and without unnecessary disruption.
• Outpatient clinic appointments were reorganised; clinic hours have been extended with earlier appointments available and shorter individual sessions offered. Timeslots were ‘double booked’ if necessary and strict prioritisation according to evidence based clinic need was applied. Extra clinics were provided in the second half of 2011, and these measures combined succeeded in cutting waiting times for new appointments from 12 weeks down to 2 weeks on average.

Other Activities
Despite limitations in time and cover, both dietitians engaged in continuous professional development and skills updates to maintain competency. We both attended relevant education sessions and conferences, and maintained membership of relevant professional organisations and expert groups. We also contributed to submissions for the National Clinical Programs (Ob/Gyn; Diabetes); participated in the education of hospital and non-hospital staff and students; reviewed and updated information leaflets and diet sheets; contributed to a range of publications; and presented at various national and international meetings and conferences, including the results of an audit of Vitamin D status in preterm infants which were presented as an oral presentation at the European Society of Paediatric Gastroenterology Hepatology and Nutrition Annual meeting, and which won 1st prize as a poster presentation at the Irish Nutrition and Dietetic Institute Annual Study Day.

Roberta McCarthy
Clinical Specialist Dietitian, Neonatology

Sinead Curran
Senior Dietitian, Women’s Health
Clinical Engineering

Clinical Engineering continued to support a wide variety of medical devices through frontline repair and service to functional training for staff and risk assessment. The department continued to maintain the high level of in-house service despite a reduced staff complement for a few months. 2011 saw further hospital spending on replacement of medical equipment, although at a significantly reduced levels to previous years. In particular we were fortunate to undertake the significant project of replacing all of the hospitals volumetric infusion devices.

The department continued its close association with the National Neonatal Transport Program (NNTP), assisting with transports that involved the use of Nitric Oxide, both within Ireland and abroad and also ensuring the systems compliance with HSE ambulances. 2011 saw the start of the building of the new theatre development and Clinical Engineering were instrumental in assisting with the medical device requirements and needs assessments for this project.

During the middle of May the department welcomed Dara Keeley as a new member of staff. Dara’s extensive experience in the telecommunications and electronics fields makes him a terrific addition to the department.

As part of continuing education programmes, Clinical Engineering staff were involved in presentations and articles for various professional bodies, such as the Institute of Engineers and the Biomedical Engineering Association of Ireland. The medical device committee continued to meet on a bi-monthly basis and added to the overall improvement in interactions between the department and the end users.

Karl Bergin  
Clinical Engineering Manager

Occupational Health

Occupational Health endeavours to continue to promote and maintain physical mental and social wellbeing of employees throughout their working life. The significance of such services is paramount in the protection of employee health and more so during times of economic austerity. In 2011, the service was led by Dr. Sheelagh O’Brien, Consultant Occupational Physician and Ms Imelda Keane, Clinical Nurse Specialist Occupational Health.

Activity levels for 2011 were quite high and the total number of Occupational Health Physician Consultations was 251; an increase in 35 consultations compared with 2010. The department received 65 management referrals from line managers in relation to sickness absence levels arising from their departments. There were 169 ‘drop in’ consultations for the Clinical Nurse Specialist and 101 pre employment medicals carried out in addition to 31 vaccine clinics held. The number of reported Occupational Blood/Bodily Fluid exposures for 2011 amounted to 36. Health surveillance programmes were carried out in 2011 with a primary aim to identify problems that can arise in connection with a particular occupation at the earliest possible stage. This included food handlers assessments and skin surveillance. As a result of the skin surveillance programme the Gynaecology clinic have almost eliminated the use of latex products and nitrile gloves have been made available for staff. This project is expected to reach other hospital departments over the course of 2012.

Work is currently in progress to ensure compliance by 2013 with the EU Directive supporting safer working conditions for healthcare workers and the use of sharps in healthcare organisations. This includes a review of sharps devices and related policy and procedure. The purpose of this directive is to achieve the safest possible working environment through risk prevention, training and information.

The reduction in clinical nurse specialist service hours has had a negative impact on service provision and continues to hamper the expansion and development of services.

2011 was yet another busy but challenging year. I would like to take this opportunity to thank all those who contributed to the development and operation of the service throughout the year.

Imelda Keane  
CNS Occupational Health
Pathology and Laboratory Medicine

In 2011, building on the successful accreditation of Anatomical Pathology and Blood Transfusion to ISO 15189, the Microbiology and Haematology participated in inspections. Microbiology was awarded accreditation and at the time of writing the Haematology department has fulfilled all the requirements of the standard and its accreditation is pending a meeting of the INAB board. The work involved in achieving and maintaining accreditation should not be underestimated and congratulations are due to all the staff who have given of the time, expertise and commitment to ensure that this quality accolade is maintained.

The maintenance of our Blood Transfusion accreditation is dependent on sufficient allocation of Consultant Haematologist sessions based at the hospital. Dr Jose Espinoza joined us in a locum capacity to provide these additional sessions during 2011. The hospital is actively seeking permanent allocation of these additional hours.

Service and Scientific developments continued during 2011. The Haematology Department undertook the process of validating two new analysers for Full Blood Count and Coagulation analysis. These will be commissioned in 2012. The Anatomic Pathology Department continued to absorb the considerable additional workload arising from the expansion of Colposcopy services as part of the National Cancer Screening Service. The continued application of lean processes led to an increase in throughput with reduced turnaround time and some reductions in the cost of the service. The Microbiology laboratory successfully converted from the CLSI standard to the agreed European EUCAST model. The commissioning of the new Clinical Chemistry analyser has continued and following extensive validation will be fully commissioned in 2012. As previously noted this has not been without its problems and the staff is to be congratulated for continuing to provide a service while working through the difficulties. Extensive evaluation of a system for first trimester screening has been undertaken in combination with the Fetal Medicine Unit and much of this work was undertaken by Mr Liam O’Connell as his thesis for the BSc in Biomedical Sciences.

All of these developments were undertaken as the staff embraced the changes in working practice dictated by the Croke Park Agreement. Following the retirements of staff in 2010 new faces were brought to the team and internal candidates were successful in seeking promotion. Ms Catherine Doughty was promoted to Senior Medical Scientist in Biochemistry while Ms Sarah Quinn filled the Medical Scientist post. Ms Grainne Kelleher joined the team as Senior Medical Scientist with responsibility for the Quality Management System. Mr John Long took on the role of Senior Anatomical Pathology Technician.

During the year, members of staff attended scientific conferences and participated in Continuous Professional Development. Dr Eoghan Mooney is Honorary Secretary of the Faculty of Pathology of the RCPI. Ms Marie Culliton continues as President of the European Biomedical Scientists and President of the Academy of Medical Laboratory Science in Ireland. Ms Niamh Cahill, Ms Eimear Campion, Ms Aileen Donegan and Ms Catherine O’Neill all successfully completed their Masters programmes in Biomedical Science and Mr John Quigley is continuing his studies for a Masters in Transfusion and Transplantation Science. Their commitment has been commendable, as is the support they received from their colleagues.

The department is proud of their achievements and that it has been able to support the staff in achieving these qualifications which are necessary for their, and our, future.

The capacity of the staff in Pathology to embrace and lead change is commendable. Their practices have been audited and re-audited and they have responded by making necessary adjustments to practice. They have responded to the changes in working hours and payments and have supported their colleagues in their academic studies while continuing to provide a quality service.

Marie Culliton
Laboratory Manager
Pharmacy

In the pharmacy department we provide safe and accurate dispensing of medication to wards, staff and outpatients. We maintain all records for the purchasing, compounding and dispensing of medication. We also provide a ‘stock top-up’ service to theatre and to the NICU.

The economic procurement of medication and maintenance of medication supply is an ongoing challenge with products continually sourced from outside Ireland to maintain an adequate supply within the hospital. Detailed information on all aspects of the pharmacy budget is presented to the Drug and Therapeutics Committee.

We answer medication-related queries from within the hospital, from other hospitals, GPs, community pharmacies, other healthcare professionals and indeed the patients themselves. This includes providing information on choice of product, correct use, dose, possible interactions, possible side effects suitability for use in pregnancy and lactation and use in neonates.

Our clinical pharmacists are involved in prescription review, medication reconciliation and patient counselling. They work closely with medical, nursing/midwifery and other healthcare professionals in preparing drug protocols and administration guidelines.

We present continuing education lectures to medical and nursing staff on topics including medication management, drug use in lactation, IV medication and drug interactions. By highlighting high risk medications during these presentations we hope to minimise the risk of medication errors.

In conjunction with the clinical risk department we report, monitor and review drug errors or ‘near misses’. This system highlights policies which need to be reviewed and updated. We report Adverse Drug Reactions to the Irish Medicines Board and to the relevant drug company to help build up knowledge, particularly on outcomes of drug use in pregnancy.

Considerable time is spent keeping up to date with new and emerging medicines, new indications, cautions and contraindications.

Dorothy McCormack
Chief Pharmacist
Decontamination

The Hospital Sterile Services Department (HSSD) in The National Maternity Hospital is committed to the highest level of quality in the decontamination, disinfection and sterilisation of Reusable Invasive Medical Devices (RIMD).

Sterility assured reprocessing of RIMD is achieved and a quality service is provided to Delivery Ward; Unit 8; Fetal Assessment Unit; Operating Theatre and Gynae Outpatient departments.

The activity levels in HSSD remained high with a total of 31,357 packs processed in 2011.

Quality

The Quality Department saw another year of growth in terms of activity and greater awareness of the concept of healthcare quality. The department has been involved in many initiatives and the growing focus on quality is very much evident hospital wide.

The NMH constantly strives to provide the highest quality healthcare to our patients, their views and experiences are integral to improvement efforts. Our Patient Service User Forum met monthly, collaborating on various improvements and also in the distribution of our Patient Experience Feedback forms. A representative of this user forum is a member of the NMH Clinical Care Programme for Obstetrics & Gynaecology.

Communication with the HSE and HIQA continued on a number of issues especially issues arising nationally pertaining to Correct Site Surgery and Discharge Planning. The Quality department carried out consultative meetings with staff in order to facilitate such review issues.

Q Pulse was re launched earlier in the year. A morning session was held for all staff to attend to ensure all were aware of the functionality of the system in order to eliminate the paper policy system that was in place. There was an exceptional attendance at the relaunch and staff who participated in the interactive sessions found the exercise of benefit.

Audit Training was offered to hospital staff with support for developing key performance indicators and methods to review practice and audit against best practice. A number of sessions were conducted. The Quality Department conducted independent random audits across the spectrum to ensure Quality assurance.

HSE Infection Control Self-Assessment was carried and all identified Quality Improvement Plans (QIPs) continued to be reviewed in a timely fashion and communicated to executive management periodically.

Staff involvement in Quality is essential and the department maximises opportunities to ensure staff have an opportunity to provide feedback. The Quality newsletter continued to be a mechanism for communicating key quality and safety issues as they arose and kept staff informed of new methods of eliminating risk. The Quality newsletter helps communicate tools and methodologies promoting quality of care.

Mandatory Training was provided every month for all staff and all new starters were introduced to Quality Management at Corporate Induction.

The GP Study Day held in November was once again coordinated by the Quality Department. An excellent response was noted where in excess of 350 GPs attended. The evaluations again proved extremely positive and this medium continues to improve the communication with GPs and the hospital through the GP Liaison Committee. Communication with the local network of Public Health Nurses continued with two interactive evening education sessions held.

The Quality Department also continues to be a resource for the hospital in terms of introducing new and improved systems of work.

The concept of Quality Management continues to grow and is an integral part of the overall governance structure of the National Maternity Hospital. It is expected to further develop and improve this structure into 2012.

Geraldine McGuire
Quality Manager
Physiotherapy

The department had another busy year in 2011 with 2,002 new patient contacts and 4,540 treatments in total. The department continues to have a staff of two full-time physiotherapists and two job-sharing physiotherapists.

Physiotherapy Services

- A full-time house Physiotherapist is available to all hospital units both adult and paediatric with a weekend on-call service
- A busy outpatient clinic offering appointments Monday-Friday for musculoskeletal conditions and pelvic floor dysfunction
- A paediatric outpatient clinic three days weekly
- Contribution towards the delivery of the hospital antenatal and postnatal education programmes including the ongoing provision of ‘Healthy Bodies after Birth’ class; a monthly group open to women who delivered in the previous six months.
- Physiotherapy input into lecture programmes for midwifery and medical students (RCSI and UCD)
- Clinical training for UCD undergraduate physiotherapy students
- Opportunities for internships

Continuing Professional Development

- Pilates – Better Hips better backs
- Pilates – Kettle Bells
- Combined approach to the Sacro-iliac joint - Howard Turner
- Visceral Mobilisations for Pelvic floor dysfunction
- CFI study day

Research

The Physiotherapy team continued to contribute to the ReFORM (Researching Education for Motherhood) study in collaboration with Vivienne Brady HRB Clinical Research Fellow TCD. This is expected to conclude in 2012.

Judith Nalty
Physiotherapy Manager
Radiology

The Department of Paediatric Radiology was established in 1984 with the appointment of a Paediatric Radiologist, Dr. Veronica Donoghue. The department has developed over the years and provides a range of ultrasound and radiographic services to the hospital’s paediatric patients. Dr. Eoghan Laffan was appointed as the second Paediatric Radiologist in 2009. The adult services are provided by Dr. Risteard O’Laoide, who was appointed in 1999.

Services Provided For Paediatric Patients

- General radiographic examination on all neonates admitted to the Intensive Care Unit and the Nursery and all infants attending the outpatient clinics. The majority of this work is portable radiography.
- Fluoroscopic Gastrointestinal Contrast studies required on all infants admitted to the hospital and those attending the outpatient clinic
- Micturating Cystogram studies required on infants attending the hospital
  - Ultrasound and Doppler service to the infant inpatients and outpatients of the hospital.
  - Ultrasound examinations on infants of the hospital at risk for congenital hip dysplasia
  - MR examinations on infant patients of the hospital via the Radiology Department, Children’s University Hospital, Temple Street, D1.
  - Fetal MR examinations on patients attending the hospital via the Radiology Department, Children’s University Hospital, Temple Street, D1.
  - CT examinations on newborn patients of the hospital via The Children’s University Hospital, Temple Street, D1.
- Limited Ultrasound service. Referrals are currently limited to patients referred by National Maternity Hospital consultants. The types of examinations are limited to upper abdominal examinations and transabdominal and transvaginal pelvic examinations. Emergency Ultrasound (including Doppler Ultrasound) examinations are performed at St. Vincent’s Hospital.
- Elective and emergency CT examinations via The Radiology Department, St. Vincent’s Hospital
- MR examinations via the Department of Radiology, St. Vincent’s Private Hospital. Examinations include staging of cervical cancer and uterine cancer, MR characterization of ovarian masses and MR Urography
- Interventional Radiology procedures via the Department of Radiology, St. Vincent’s Hospital. Procedures include emergency nephrostomy and abscess drainage.

A total of 8126 examinations were performed in 2011; 6408 infant examinations and 1718 adult examinations. 219 of the adult examinations were hysterosalpingograms 1953 of the infant examinations were hip ultrasounds.

Services Provided For Adult Patients

- General radiographic examinations required on all patients of the hospital
- Intravenous Urograms and selective Fluoroscopic examinations on patients of the hospital
- Limited Ultrasound service. Referrals are currently limited to patients referred by National Maternity Hospital consultants. The types of examinations are limited to upper abdominal examinations and transabdominal and transvaginal pelvic examinations. Emergency Ultrasound (including Doppler Ultrasound) examinations are performed at St. Vincent’s Hospital.
- Elective and emergency CT examinations via The Radiology Department, St. Vincent’s Hospital
- MR examinations via the Department of Radiology, St. Vincent’s Private Hospital. Examinations include staging of cervical cancer and uterine cancer, MR characterization of ovarian masses and MR Urography
- Interventional Radiology procedures via the Department of Radiology, St. Vincent’s Hospital. Procedures include emergency nephrostomy and abscess drainage.

A total of 8126 examinations were performed in 2011; 6408 infant examinations and 1718 adult examinations. 219 of the adult examinations were hysterosalpingograms 1953 of the infant examinations were hip ultrasounds.
Social Work

The Social Work Department offers a support, advocacy and counselling service, together with advice and information to patients of the hospital and their families. We seek to support individuals and families practically, emotionally and psychologically. The priority of the department is the safeguarding of the welfare and well-being of children. The approach of the department is inter-disciplinary and multi-sector. Linking and liaising with statutory and voluntary community services is an important aspect of the service which is confidential except where the welfare of a child is at risk.

The following services are provided for by the Medical Social Workers:

- Child Protection
- Adoption
- Substance Abuse
- Teenage Pregnancy
- Domestic Violence
- Oncology
- Tracing and Reunion
- Bereavement
- Information Requests.

Further detail on all of our services can be found in the Clinical Report.

Overview

The current economic climate is impacting on the resilience and coping abilities of individuals and families. It is affecting the well-being of persons due to increased financial pressures and the added stress and strain on parenting, relationships and support networks. This is resulting in an increased demand for service which is happening at the same time as the availability of community services and resources is declining. The gap between need and demand for service and available resources is widening. This contributes to problems and stresses as there are delays in receiving services, or services are no longer available. People who have problems, are vulnerable and lacking support networks are tipping into crisis. Unfortunately it can be expected that these contextual realities within which the department operates will not only continue but worsen over the short term.

There was a notable rise in referrals relating to domestic violence. The launch of the HSE policy on domestic and gender based violence in 2011 which firmly puts the emphasis on child welfare and protection in the domestic violence situations was timely. There is a strong correlation between domestic violence and/or sexual violence and child abuse.

The updated Childrens First guidelines was launched in 2011.

The decision of the hospital not to seek accreditation in relation to the Adoption Act 2010 meant that search and reunion service had to cease and discussions were required with the Adoption Authority and the HSE with regard to the transfer of files to the HSE.

The hospital received monies from the International Bazaar Fund for refurbishment of facilities relating to the service to parents.

Linen Guild

The Linen Guild has continued to support the work of the department. They have been particularly supportive in problems raised regarding accommodation and unemployment. The department is very appreciative of their work and generosity to patients facing difficulties.

Loretto Reilly

*Head Medical Social Worker*
Chaplaincy

The Chaplaincy Department is staffed by two chaplains. The local parishes priests, Fr. John Gilligan of Westland Row and Fr. Paul St. John of City Quay provide a much appreciated on-call service at night and at weekends. Ministers from other Churches and faiths are also available when required.

The Chaplaincy Department provides spiritual and emotional support to patients, their family members and to hospital staff. Both sacramental and pastoral care is available to all. Chaplains accompany parents and families in celebrating the birth of their new babies, and are often called upon to bless them. Parents of babies in the Neonatal Unit are also offered the support of chaplaincy services. Much of the chaplain’s time is spent accompanying those who experience loss, whether through miscarriage, stillbirth or neonatal death. Chaplains also accompany women who experience gynaecological loss. Through sensitive listening the chaplains seek to respond with empathy and understanding, and in so doing enable those they encounter to cope with their loss. Practical support around interment decisions is also offered at this time of shock, confusion and distress.

The chaplains perform formal specific roles in bereavement such as a blessings, baptisms, naming ceremonies and funeral services. The chaplaincy office provides a private space for ministering to bereaved parents and to staff members. There are also other unspecified and unplanned ministries which arise from day to day in ward visitations. Ministry often occurs for instance informally with staff and patients on corridors or other public areas throughout the hospital.

The Chaplaincy Department organises liturgies to celebrate various religious and significant occasions in the life of the hospital. In 2011, the following were held: Blessing of Throats, Ash Wednesday Liturgy; Liturgies for final year students; Good Friday Liturgy; Mass for deceased staff; Service of Prayer for an ill member of staff, Lighting of the Christmas Tree, Christmas Eve Mass. Communion Services on Holy Days were also provided.

The Annual Remembrance Service took place in October in St. Andrew’s Church, Westland Row. This service honours the short lives of babies who were lost in the hospital during the year and also acknowledges the grief experienced by their parents and families. This year’s service was very well supported by many staff members and it was attended by approximately 1,500 people, indicating the importance parents, families and staff attach to this commemorative event. There was a notable increase this year in the number of parents who requested that their baby’s name be included in the Book of Remembrance which is on permanent display in the hospital oratory.

The Chaplaincy Department bade farewell this year to Jo Young Lee who regretfully left after a number of years of unstinting service to this Department and the Hospital, and welcomed Eithne O’Reilly in her place.

We wish to acknowledge the on-going co-operation and goodwill of all of our colleagues throughout the hospital which augments the service provided by the Chaplaincy Department.

Sr. Marion Ryan
Ms. Eithne O’Reilly
Chaplaincy Department
Theatre Development

While the National Maternity Hospital’s long term goal remains to move to the St. Vincent's University Hospital campus, current economic realities have extended the timeline for that event. This goal, recognised in the KPMG report (2008), recommended the move as the best option for the future of the NMH. The setting of a maternity unit co-located with an acute hospital with access to clinical support is the preferred model of care. Unfortunately due to current HSE budget constraints it has not been possible to formalise a date for such a move.

While this is disappointing for staff and patients, funding was provided by the HSE for an additional theatre. The hospital’s design team were tasked to go back to basics and maximise the benefits from the limited funding available.

The resultant development has been the product of the combined efforts of very many people and their commitment to address and resolve deficiencies within the hospital. The teamwork required to get the project to conclusion is a testament to the resolve and determination of many people within the hospital. While there have been many challenges, the guiding principle has been to seek the best available solution, in the interests of patient safety, within the budgetary constraints of the project.

Planning permission was granted in December 2010 and the tender process commenced thereafter. The tender was awarded in February 2011 and works commenced in May 2011.

To avoid disruption to the Neonatal Intensive Care Unit (NICU) during construction, an upgraded HTM 3031 compliant HEPA filtered AHU system was installed. This enabled the air pressure in the NICU to be at a positive pressure with respect to surrounding areas. The main AHU including chiller and boiler was installed in May. The opportunity was taken to upgrade the NICU including sinks, gases and power.

The Theatre Development included a two storey extension at third and fourth floor of the existing hospital building with attached five storey emergency fire escape stairwell. The works include some internal remodelling at third floor level to re-arrange theatre accommodation. A new entrance was opened up to improve circulation and flow through the space. The new brightly decorated patient waiting area affords privacy and comfort for patients and partners at the entrance. The staff changing areas were upgraded and a disabled access bathroom was installed. The sluice room and preparation room were completely upgraded and new storage rooms created.

The theatre development project includes an anaesthetic room, scrub room and a modern operating theatre with state of the art equipment and controls, including audio visual equipment to facilitate teaching.

While the development of the new theatre brought many challenges, staff responded positively and minimised disruption to patients and visitors wherever possible. The provision of the new theatre space will have a positive impact on the overall patient experiences and patient safety for many years to come.

Martin Creagh
Project Manager

New Theatre completed at the end of the year.
Education

University College Dublin School of Medicine and Medical Science

Undergraduate students attend the hospital in four iterations for a period of six weeks during their clinical studies. The module is coordinated with university lectures to provide a comprehensive grounding in all aspects of reproductive medicine.

The John F. Cunningham Medal is awarded annually to the student who graduates with the highest grade in Obstetrics and Gynaecology, together with highest grade in their final assessment; the winner this year is Dr. Siobhan Neville. The Kieran O’Driscoll Prize is awarded each year to the student who attains the highest grade in Obstetrics and Gynaecology; the winner this year is Mr. David Brennan.

Professor Colm O’Herlihy

Royal College of Surgeons in Ireland

Thirty-nine undergraduates from the Royal College of Surgeons attended the National Maternity Hospital for their six weeks rotation in Obstetrics, Gynaecology and Neonatology; nineteen students in January/February and twenty in February/March. Again, the students have responded very well to their time and teaching in the hospital.

The programme was co-ordinated by Professor Dermot Mac Donald, Dr. Rizmee Shireen, Tutor (Obstetrics and Gynaecology), and Dr. John Murphy (Neonatology).

Twenty-two of our students achieved honours in their final Obstetrics and Gynaecology examination at the RCSI. Mr Scott Chicotka was awarded the NMH/RCSI medal for achieving the highest marks amongst the RCSI students who attended the National Maternity Hospital. In addition to the intensive obligatory learning programmes on computer the students, while rotating through all areas of the hospital receive lectures, tutorials and ‘hands on’ demonstrations and teaching from Consultants and various other members of hospital staff. This excellent performance reflects the enthusiasm of all those taking part in the teaching programme.

Professor Dermot Mac Donald

Education and Practice Development

The Education and Practice Development Department provides practice and educational support to midwifery and nursing staff, student midwives, multidisciplinary teams and our community partners. The Education and Practice Development department works in collaboration with the Centre of Midwifery Education (CME) based at the Coombe Women’s and Infants University Hospital. The CME together with the three Dublin Maternity Hospitals develop and host varied postgraduate education programmes to enhance learning opportunities for registered nurses and midwives. Some of the courses offered include Critical Care for the Obstetric Patient, Management Skills, Preceptorship programmes and Breastfeeding Courses.

Education

The National Maternity Hospital continues to offer Midwifery programmes in partnership with University College Dublin (UCD). The BSc midwifery programme currently has 79 students. The Higher Diploma Midwifery programme has 22 students currently to complete in March 2012. Twenty students successfully completed midwifery studies in 2010 from the Higher Diploma of Midwifery programme and celebrated their graduation on 11th March 2011.

Congratulations to the following students were awarded prizes at the 2011 Charter Day: The hospital Gold Medal was presented to Clare Cowan (Higher Diploma) and Sarah Gleeson (BSc Midwifery). The Elizabeth O Farrell Medal 2010 was presented to Celine O Brien (Higher Diploma) and Nicola Kerr (BSc Midwifery). The Director of Midwifery Award was presented Jane Langenbach (Higher Diploma) and Nadine Smith (BSc Midwifery). In 2010 Helen Martin (BSc) was awarded the Dr HH Stewart Medical Scholarship in Midwifery for her assignment – a literature review “Investigating the safety of home births when compared to births in a hospital setting”.

The National Maternity Hospital continues to provide clinical experience for public health student nurses as well as maternity care placements for General BSc student nurses. Our links with the Liberties College continues and the hospital was able to provide clinical placements for ten students undertaking a FETAC Level 5 Health Care Assistant course. Feedback from students is positive. A number of former students have been successful in their application to General Nursing programmes.
Practice Development

The National Maternity Hospital continues to be involved in conjunction with the RCSI in the education of Registered Nurse Practitioners (RNP). Continued support has been very positive and beneficial to the women in our care. In 2011 UCD developed the programme and there are a number of staff pursuing the course there also.

The roles of the Advanced Midwife/Nurse Practitioners and Clinical Specialists are continually effective in driving midwife/nurse-led initiatives. Their enhanced roles and specialist knowledge lends support to all the clinical staff. The National Maternity Hospital provided continued support to allow for continued professional development in these areas. The department continues to assist and facilitate qualified staff with further education programmes in third level Institutions. Financial constraints have been more limiting over the last year however, funds have been available to support enhanced practice in specialist areas. This has proved that there is continued staff commitment to ongoing personal professional development and lifelong learning. Five scholarships were awarded to staff undertaking Masters programmes.

The National Maternity Hospital hosted a National Midwifery Conference in 2011 and a Multidisciplinary Medication Management Study day which were both well attended. There has been a re-launch of the Journal Club with multidisciplinary presentations and some from outside the hospital.

There is continued networking with our affiliated HEI partners and proposed new projects are being pursued. Our links with our academic partner UCD continues to be enhanced by ongoing research projects facilitated through The Joint Research Network. This ensures continued support for the improvement and advancement of practices which will enhance the service we give to the women and babies in our care.

Maureen Kington
ADOM/N Clinical Practice Development Co-ordinator

Patricia Feeley
Education Co-ordinator
General Support Services

Backcare and Ergonomics Programme

This programme is now an integral part of the mandatory staff training at the National Maternity Hospital. Our training team includes Carmel Flaherty, Lucille Sheehy, Orla Gavigan, Imelda Keane and Martin Creagh. We have three new team members Catriona Cullen, Kevin Mulligan and Maureen Hastings.

We run both clinical and non-clinical manual handling courses. All categories of staff are obliged to do this training with a refresher course after three years. If there has been an accident or near-miss a course must be done after this. We run courses on a monthly basis for new and refresher staff. Extra courses are provided for student midwives pre and post registration training. As of this year all training has to be at FETAC level 6 so further training has commenced and will be completed by December 2012.

We trained a total of 200 staff in 2011. Manual handling policy and risk assessments are available in all departments.

We are now almost up to our full complement of high-low beds/electronic beds on the wards. Mechanical aids e.g. roller boards, rope ladders, slide sheets and a hoist are available to protect staff from injury. We encourage staff to use mechanical aids at all times when required.

We endeavour to improve best practice at all times.

Carmel Flaherty
CMM2/Manual Handling Co-ordinator

Casemix Programme

The National Maternity Hospital continues to participate in the National Casemix Programme and was once again grouped with the other two Dublin maternity hospitals for Casemix related funding purposes by the HSE in 2011.

Casemix is the comparison of Activity and Costs between hospitals by measuring each individual hospital’s output and costs. This data is then used to compare the average costs for each type of case to the average costs of all other Hospitals in the group for similar cases. The more cost efficient hospitals will benefit within the Casemix budget funding programme whilst those who are least cost effective by comparison with others within their group will lose out. Casemix combines two areas of Hospital activity (HiPE) and costs (Specialty Costing).

HIPE (Hospital Inpatient Enquiry)

HIPE deals with the coding and classification of the Hospitals activity using internationally designed and recognised coding models that have been in use in this hospital for some years now. Currently the model used for coding is ICD 10 AM. The source data for HIPE is the patient chart.

In 2011 all encounters within hospitals including, Inpatient, Daycase and Outpatient were captured and included in Casemix for comparison purposes. Therefore it is now extremely important to separately identify these episodes and classify them accordingly. It is also of vital importance that all patient care episodes are described and coded at clinician level so that they might be correctly recoded in HIPE and appropriately rewarded in Casemix.

Specialty Costing

Specialty Costing involves a process of analysing and reallocating hospital costs firstly to individual departments within the hospital and then further analysed to allocate the costs to the individual specialities (and eventually to individual procedures within that specialty).

This area of cost allocation requires extensive cost analysis and liaising with many departments to assess the analysis of their provision of service to each of the specialities. Many thanks to all departments who so willingly provided the required information.
The National Maternity Hospital had a negative budget adjustment of €337,885 based on 2010 outturn.

As always there are challenging times ahead. Costs are a constant factor and activity levels are high. Budgetary constraints prevail and are becoming more and more the order of the day. Cost per treatment episode may increase and our cost competitiveness may be compromised as a result. As always Casemix funding adjustment will be based on the level of activity and the quality of the data that we provide. The Hospital continues to attach great emphasis and importance to the HIPE/Specialty Costing Program and to which the cooperation of all, is essential and very much appreciated.

Tommy Hayden
Management Accountant

Facilities Engineering

The Facilities Engineering Department comprises of the Engineering and Environmental Departments.

The responsibility of the department is to maintain the fabric and structure of the hospital buildings together with the mechanical, electrical and equipment services contained within. Such services include power, light, heating, water, medical gases, drainage, lifts, waste, energy management, environmental management and emissions. Given the ageing infrastructure, the demands for these services have increased over the years. The Facilities Engineering Department strive to maintain the highest standards of facilities and services regardless of infrastructural restraints in order to sustain a hospital environment in which patients can be treated effectively. With the turn in the economy in 2011 capital allocations for the hospital were reduced, however the hospital still secured finances for a number of key capital works.

The Neonatal Intensive Care Unit (NICU) undertook a complete refurbishment, this included painting of the unit, the replacement of the old sash windows with new double glazing windows, installation of new Air Handling Unit (AHU), new flooring as per HTM61, upgraded light fittings in the area and additional patient examination lights.

This refurbishment has improved the hospital NICU’s ability to meet healthcare, health and safety, and hygiene requirements set for such a facility in a healthcare building.

There are on-going works in the development of a new operating theatre on the third floor of the main hospital building; the construction is due to be completed in early 2012. This project has a major impact on Facilities Engineering Staff as most of the services must be tied in with the hospital existing services and the department must maintain continual services for the hospital. The Engineering Department continued to review the enabling works for the new Theatre project. The new theatre facility will improve services to patients and staff alike. Mr. Martin Creagh, Health & Safety Officer was appointed to co-ordinate the Theatre Development and refurbishment of the ICU in addition to his normal duties and his expertise was invaluable in undertaking these projects.

In February 2011 the hospital Facilities and Clinical Engineering Department installed examination light fittings in all Delivery Ward rooms 1 to 10. The installation
of the examination lights was deemed to be a significant improvement in patient care.

There is an ongoing painting programme in place which targets patient and clinical areas. To date around 65% of hospital clinical areas have been painted since the programme started in 2010. The areas painted were selected through internal and external audits and from unit managers, some of the areas completed include the Outpatient Department, Physiotherapy Department, two postnatal ward toilets and shower rooms, Delivery Ward suites.

A new cold water tank was installed in mid 2011 which resulted in an increase in the hospital water storage capacity.

All the above contribute to the hospital facilities, hygiene and infection control improvements, the hospital Engineering Department will continue in its endeavours to improve facilities in the Hospital to meet infection control and hygiene requirements subject to funding availability.

Engineering

In 2011, the Engineering Department responded to 3,436 day to day work requests through the internal requisition works request method and 136 emergency call-ins outside normal working hours (on-call facility). This includes but is not limited to planned preventive maintenance, plumbing, electrical, mechanical, carpentry and communication services on a daily basis as well as all highlighted non-compliances from the internal monthly hygiene audits. Workloads have increased again in 2011; the increase in works can be attributed to the ageing fabric and structure of the building, in staff and patient expectations and the rising expectations on services and facilities driven by changing standards in healthcare.

The Engineering Department is constantly looking for value for money in all areas to reduce expenditure. Naturally the day to day maintenance and upkeep of the building was also undertaken and we undertook a maintenance survey of all wards, units and departments, the results of which were tabulated and submitted to the Executive Management Team for budget approval.

The Engineering Department agreed to accommodate FÁS and invited apprentices to complete part of their training phases under the scheme of the Redundant Apprentice Placement Scheme (RAPS). The apprentices are the first to be trained in their respective trades in plumbing electrical, carpentry at the National Maternity Hospital. The RAPS scheme is totally financed by FÁS and is a benefit to the hospital and to the Engineering staff who train them. These apprentices have received specific training and assessment in their respective trades and engineering issues that relate to the NMH on a hospital standard. The scheme will run into 2012 and a number candidates will pass through a training programme at the National Maternity Hospital.

Environmental

The Environmental Department at the National Maternity Hospital sets objectives and targets each year to increase its environmental performance under the headings of Energy Management, Waste Management, Water Consumption, Discharge to Drain, Green Procurement Management, Training and Awareness and General Environment Management. The National Maternity Hospital is the first ISO 14001 accredited hospital in Ireland for its Environmental Management System.

During the year, the department set out sixteen major key objectives and targets such as introducing organic recycling segregation which resulted in 13.26 tonnes of food waste being diverted from landfill, attained a Display Energy Certificate (DEC), increasing hospital dry recycling by 10% and training 50% of the National Maternity Hospital staff on the Hospital Environmental Waste Management System.

All waste produced, energy consumed and water within the hospital is monitored on a continuous basis. In 2011 the hospital produced a total of 378.7 tonnes of waste and 433,404 litres of waste in all areas of the hospital such as Healthcare Waste, Domestic Waste, Chemical Waste, Recyclable Waste and Hazardous Waste. The hospital’s total recorded energy consumption between electricity and natural gas in 2011 was 5,187,432 kWh which saw an average decrease of 1.12% when compare to 2010 energy consumption and far less than the average estimated increase of 10% which was estimated taking into account new operating theatre development and the installation of hot-well plant for the Hospital Sterilised Service Department (HSSD). The main aim of the Department is to ensure the commitment of the hospital to continual improvements and prevention of pollution as much as possible.

Frederick Byrne
Acting Facilities Engineering Manager
General Services

The General Services Manager is responsible for the provision and development of support services in the hospital. 2011 was another busy year in terms of activity for the National Maternity Hospital. However, despite the less than ideal infrastructural facilities, Support Services Staff continued to work hard to ensure a quality service for our patients.

Hygiene

Over the last couple of years and in particular with the advent of the HIQA inspections and associated public reports, hygiene in healthcare has become more topical. As good hygiene practices is one of the fundamental factors in managing and controlling the spread of infection we welcome this increased public attention to hygiene in our hospitals. Hygiene as defined by HIQA is not confined to just environmental cleaning but also incorporates hand hygiene, linen, sharps, waste management and the management and cleaning of medical devices and equipment.

In terms of measuring our effectiveness in managing hygiene, a number of performance indicators have been identified and are constantly monitored and evaluated. Hygiene key performance indicators include – hand hygiene audits, alcohol gel use, patient complaints, patient surveys, staff surveys, training attendance rates, absenteeism rates and hygiene audits. The hygiene key performance indicators showed improvement even with the high activity, tighter resources, less staff and an ageing building. The National Maternity Hospital building’s design presents a number of challenges to the effectiveness of our cleaning programmes in terms of space available for patients, storage of equipment, access for cleaning and the number of surfaces which are in poor condition. Many floor coverings require replacing and walls require painting throughout the building.

The effective in-house hygiene auditing system continued to operate in 2011. Hygiene audits are conducted by the hygiene committee including members of the Executive Management Team using our hygiene audit tool. These audits are undertaken by the Ward and Department Managers and also the Engineering, Catering and Housekeeping departments. The updated schedules of the audit non-conformances and details of how any deficits identified have been addressed are compiled for review by the Hygiene Team and Committee. Any items not closed out e.g. the items requiring capital expenditure, are then retained on a master list by the hospitals EMT who will prioritise works programme with engineering as funding becomes available.

In 2011 the extensive painting programme introduced to address some of the deficits identified through the hygiene audit process continued. The hospitals house committee have adopted this audit process and use the same hygiene audit tool for their audits. This gives an important independent dimension to our in-house auditing process. Also, as a number of the house committee members are members of the hospital board and finance committees, it ensures the hospital board are directly involved in monitoring and managing hygiene. Following review the house committee have agreed to continue to use this audit process into 2012.

This programme of auditing and reviewing is assisting us in improving the overall hygiene performance of the hospital. This is proving effective as evident from our hygiene key
performance indicators including surveys and audits have shown improvement throughout the year and we will continue to build on this for 2012.

The National Hospitals Office issued a Hygiene Audit Tool to all hospitals in 2010. This audit tool was based in the HIQA standards and allows hospitals to self assess and score themselves against the prescribed standards. It also requires organisations to establish Quality Improvement Plans and to continuously work to close these out. It was envisaged that a peer review self assessment programme would commence in 2011 to evaluate hospitals performance and compliance with these standards. In preparation for these peer reviews, we have had to upload our Evidence of Compliance (EOC) and hyperlink this back to standards to allow for efficient audit by the peer review team. Although this was a huge task, it ensures that our supporting hygiene EOC documentation will be more accessible and easier to review and manage for hygiene committee members through the electronic shared hygiene drives.

In 2011 the new HIQA Infection Control Standards which incorporate hygiene were adopted. HIQA have advised that they will only audit against these Infection Control Standards from now on. The Hospital has conducted a self assessment using the infection control standards and implemented a Quality Improvement Plan to address any deficits identified through the self assessment process.

The Household Department lost a number of staff through the Government early retirement schemes and as these staff could not be replaced, this created some substantial challenges for management to maintain service standards.

Negotiations with Household’s primary union began in January and continued throughout the year to achieve flexible scheduling arrangements in the wake of 2010’s staffing reductions. It was necessary to modify the department’s operation to maintain exceptional levels of patient service. The ‘Public Service Agreement’ process was utilised to achieve this and agreed solutions were ratified in August.

Apart from the significant changes to staff rosters and duties, a number of other operation changes occurred in 2011. The introduction of an improved micro-fibre flat-mopping system in the hospital provided the floors with a cleaner finish and greater dust removal performance. Trials were conducted between two industry-leading products to determine results and solicit staff feedback. The French-based ‘Concept Micro-fibre’ proved the most effective and most popular, with the greatest flexibility in cleaning performance.

In keeping with this review of cleaning operations, the examination of cleaning chemicals resulted in substantial modifications to the range of products used. Expensive ‘ready-to-use’ products were replaced with more effective dispensed products that better serve the hospital’s cleaning requirements.

Emphasis continued to be placed on assuring appropriate training for all support staff. In 2011 we managed to persuade a contractor to provide the industry recognised BICS Training (British Institute of Cleaning Science’s Training) to all household staff free of charge saving NMH over €30K. Household staff will, on successful completion of the BICS training, receive the ‘Cleaning Operator’s
Proficiency Certificate. The training for this internationally-recognized accreditation began in October and will carry through into 2012 until all Household staff members have completed it. This training ensures that cleaning practices in the hospital are in line with recognized ‘best practice’. Also, for the third year in a row, all household staff fulfilled their certification requirements in Manual Handling and an attendance level of 95% was achieved in the annual Mandatory Training sessions.

One of the important service improvements required to comply with best practice was to segregate Catering and Cleaning functions and staff at ward level. Following considerable work and commitment from both Household and Catering Management and input and involvement of staff, the segregation programme was agreed and implemented. With good management the segregation programme was achieved without additional resources and has delivered financial savings and increased efficiencies in 2011 and will continue to do so for 2012.

Traditionally from June to September six locums are recruited to provide holiday relief to the Housekeeping department however in 2011 the department continue to provide service without engaging any summer locum cover.

Security
Brinks Security continued to be contracted to supply security services to the hospital in 2011. The electronic clocking system was upgraded and is monitored closely to ensure full patrols of the entire hospital and grounds are conducted in a timely manner which assures a positive visible security presence at all times. A core group of experienced, trained security officers are consistently rostered to the National Maternity Hospital site thereby ensuring continuity and specific experience and site knowledge is maximised to assure the highest levels of security at all times.

The theatre development had significant impact on the space available for staff parking in 2011. Thanks to effective planning and the goodwill and cooperation of staff our security officers were able to manage the parking and assured this important facility continued to function throughout all phases on the theatre development.

Switch
The fulltime Switch operators traditionally provided a seven day service with reduced cover on weekends however, as a value for money initiative the Porters have taken over the telephone answering function on Sundays. Further cost saving initiatives saw the switch service hours reduced during the week also. We now have 2.5 WTE as opposed to 3 full time switch operators manning the Switch. I am pleased to report, with the support and cooperation of Switch staff in operating a revised roster, the hours of cover by the Switch operators remains from 8.30am to 9pm Monday to Friday and 9am to 5pm on Saturdays. This service development continues to operate well with good co-operation from Switch and Portering Staff in maintaining a seamless professional phone service at all times.

Laundry
The Laundry Department orders, distributes, collects and returns all linen in the hospital to ensure adequate supplies at all times. Linen includes all general hospital linen, doctor and laboratory coats, scrub suits for theatre, mats and curtain services. The activity in the hospital has a direct effect on workload. Unfortunately, due to space constraints there is limited storage facilities available at ward level so current activity requires additional more frequent stock deliveries and collections by the laundry Team. Despite the challenges, Joe Staunton, Laundry Services Manager, and his team continued to supply a seamless service.

Portering
The Portering Service provides services 24/7 to cover Front Hall/Reception, Theatre, Delivery Ward, Laboratory, and House Porter duties. It is with credit to Ken Ray, Head Porter along with his team that these front line services continued to be delivered seamlessly and the hospital functioned as one to assure quality services for our patients.

As in recent years, the volumes of patients, ageing building and poor infrastructure will continue to cause some additional challenges for the hospitals support services staff. These challenges include restricted access for cleaning and, given ward configurations, limited storage space for housekeeping equipment, laundry and waste skips among other things. Also, given current high levels of activity there continues to be a constant need to add and remove beds to cater for demand and to create additional operational space in the wards as far as is practical.
The EMT and board will continue to pursue the HSE to fund the hospitals interim and long term development plans to address these infrastructural and resource deficits and in the meantime every effort will continue to be made by support services staff to ensure that standards are maintained and improved, within the given resource/infrastructural constraints, for the benefit of patients and staff.

Tony Thompson  
*General Services Manager*

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**Catering**

The Catering Department of the National Maternity Hospital has once again had a very productive year meeting all the demands due to the increased productivity in the hospital. We have continued to receive positive feedback from patients, visitors and staff members who have availed of our catering facilities and from all events leading up to the inauguration of our new Master, Dr. Rhona Mahony.

The department has continued to support education and training programmes and continuing to undertake Mandatory training on an annual basis.

Catering was involved with the promotion of the National Cultural Diversity week in November 2011. Catering contributed to this week by providing multi-cultural dishes from around the world in the staff canteen throughout the week. Staff members contributed their ideas which added to its success making it the most successful year to date. The Catering Department were involved with all other departments, working together on many large maintenance projects with the result of making all work areas in catering a better and safer place to work.

During 2011 the Catering department was sad to see Kathleen Curley, Catering Manager, Anne McWeeney, Chef Grade 2, Rita Dunne, Carmel Kavanagh and Chrisanta Kelly, Catering Assistants leave due to retirement. They all provided a loyal and long service to the department.

Our communal goal is to deliver financial savings and increased efficiencies in 2012. We are looking forward to an extremely productive year with the implementation of new menus for patients and staff and the reintroduction of evening tea service to all patients.

Finally, I would to thank all the personnel in the Catering Department for their continued hard work and support in helping to achieve our goals.

George Timmons  
*Catering Manager*
Human Resources

Although activity was not as high as 2010, 2011 still recorded the second highest level of mothers delivered after a record breaking 2010. The hospital appreciates enormously the hard work undertaken by all staff in ensuring the high standard of care provided to patients continues during these challenging times.

From an organisational Human Resources (HR) perspective the 2010 challenges remained the same last year - i.e. how to best deploy available staffing resources and support the workforce in the provision of a quality service to patients and to do so on an ever decreasing budget. Terms including value for money, exploring more effective and cost efficient work practices/structures, greater flexibility, upskilling all regularly featured during 2011.

Under the Croke Park Agreement a range of change proposals aimed at driving efficiencies were agreed and implemented following a series of meetings with staff representatives. For example in both the Household and Catering Departments a number of historic entitlements and privileges that were adversely impacting on the efficient delivery of service have now ended. In addition some new work practices have been introduced. Through the cooperation and flexibility shown by staff the net result of these changes means that these departments are now better aligned to meet the service needs of patients and the hospital overall. Given the current economic climate and sever funding shortfall provided to the hospital by the HSE the drive for greater efficiencies and value for money will continue in 2012.

Part of the HR function is to support, where possible, the development of the workforce through the provision of organisational training and development initiatives. The unfortunate reality is that because the hospital is so busy and with the increased strain on staffing resources it is not always possible for staff to be freed up to

Staff Satisfaction Survey

December 2011

<table>
<thead>
<tr>
<th>Question</th>
<th>Response Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1. I feel part of a team working to provide (directly or indirectly) a better service to our patients</td>
<td>91</td>
</tr>
<tr>
<td>Q2. I am empowered to make decisions necessary to do my job</td>
<td>85</td>
</tr>
<tr>
<td>Q3. I feel I am kept informed of what is going on at the NMH</td>
<td>60</td>
</tr>
<tr>
<td>Q4. My direct supervisor/manager is open to hearing my ideas and suggestions</td>
<td>80</td>
</tr>
<tr>
<td>Q5. I have flexibility to balance the needs of my work life and personal life</td>
<td>77</td>
</tr>
<tr>
<td>Q6. I like working at the NMH</td>
<td>89</td>
</tr>
<tr>
<td>Q7. I understand what is expected of me at work</td>
<td>95</td>
</tr>
<tr>
<td>Q8. I get praise/recognition when I do a good job</td>
<td>60</td>
</tr>
<tr>
<td>Q9. I believe I make a real contribution to what the hospital is trying to achieve for our patients</td>
<td>87</td>
</tr>
<tr>
<td>Q10. Overall communications around the hospital is good</td>
<td>59</td>
</tr>
<tr>
<td>Q11. I feel I can approach my manager if I have an issue to discuss</td>
<td>82</td>
</tr>
<tr>
<td>Q12. I am satisfied with the hospital’s hygiene services, facilities and and environment</td>
<td>74</td>
</tr>
</tbody>
</table>

Response Rate: 13%
engage in such initiatives. That said there were a small number of hospital wide training programmes organised during 2011.

The diversity awareness training programme continued in 2011 with over 50 staff attending the one day session. In addition 377 staff attended the mandatory training programme during the year. This training incorporates a number of subjects including fire safety and infection control.

Analysis of some HR key performance indicators showed that turnover at the hospital was 3.2% for 2011, a sharp decline over 2010 (9.0%). This is partly attributed to the number of staff that left the hospital in 2010 under the government early retirement and voluntary redundancy schemes.

The hospital recorded a sickness absence rate of 4.2% in 2011, similar to the figure recorded for the previous year (4.1%). A breakdown of the figures reveals that the percentage absence rate for the first half of 2011 stood at 4.4%. New guidelines to assist managers on managing staff attendance were introduced during the summer of 2011. These helped to reduce the absence rate at the hospital for the second half of the year to 3.3%.

The annual staff satisfaction survey was conducted in late 2011. The goal was to achieve a minimum satisfaction rate of 70% for each of the 12 statements on the questionnaire. It was encouraging to see that this figure was exceeded in 9 out of the 12 statements. The three statements that scored below 70% each returned a satisfaction rating of 60% and each had a common link between them – communications.

In response to one simple statement ‘I like working at the National Maternity Hospital’, 89% of respondents agreed or strongly agreed. This overwhelming positive response is a reflection of the strong collegial bond that exists at the hospital.

Although 2011 was another very busy year at the hospital staff managed to find time to socialise with their colleagues. Events organised included the Christmas party, one or two charity fund raising/social events and of course the NMH Ball in November which was a huge success.

Information Management

Information Management is the collection and management of information from one or more sources and the distribution of that information to one or more audiences. One of the key factors successful Information Management is to generate interest among users.

Improving information management practices is a key focus for many organisations across both the public and private sectors. Effective information management is not easy; there are many systems to integrate, a huge range of business needs to meet and complex organisational (and cultural) issues to address.

Information and knowledge is a key organisational resource. By guaranteeing high quality information, core data can be provided for service planning, randomised clinical trials, research and epidemiological studies. High quality data can form the foundations for policy makers, families of high-risk infants and the public.

The Information Officer works closely with IT and Patient Services departments along with administrative and medical staff in the hospital. The prime areas of the role are:

- Extracting and analysing information from hospital information systems to assist management decisions and to highlight changing / emerging trends
- Coordinating Health Service Executive and Department of Health and Children activity returns as well as media requests and parliamentary questions as they arise
- Producing internal hospital activity reports
- Publication of the hospitals Annual Report and Annual Clinical Report
- Developing and designing internal information systems in conjunction with relevant hospital stakeholders
- Providing an information service for the dissemination of hospital information internally and also providing information to external agencies e.g. media, other hospitals/medical agencies.
Data Protection

Privacy and Data Protection law is a rapidly growing area. The Data Protection Acts applies to the processing of personal data by data controllers. Data protection in the National Maternity Hospital is about each staff member and patient’s fundamental right to privacy. Data protection requirements complement the strong ethical obligations imposed on health professionals in relation to their patients.

Fionnuala Byrne
Information Officer

Information Technology
Systems Status

The Information Technology (IT) Department is an extremely busy department, managing and implementing anything up to 20 separate IT projects at one time, in conjunction with the day to day frontline support issues.

During 2011 Karl Bergin acted as IT department head, to oversee new projects and the transition period due to the retirement at the end of 2010 by the former manager Ann O’Connor.

Work continued on the national replacement project for the obstetrical and neonatal clinical information systems. It is hoped that this system will be replaced in early 2013.

Migration of all relevant data servers to the new permanent location in the ‘Mosaic’ building was completed in 2011 and vital network infrastructure was replaced in the main networking hubs within the hospital. This allows for extension of the hospital network, with the ever increasing number of attached computers and devices. In conjunction with Brandon Technologies the upgrading of storage on our SANS configuration took place. This facilitated the virtualisation of more physical servers and creation of new virtual servers as required.

A limited trial of a print management solution was put in place to investigate the feasibility of this as an option for the hospital. This project was undertaken with key personnel from the purchasing department and Datapac print management providers.

A bespoke theatre data management system was created by Nelson Figueroa, who worked closely with clinical and nursing staff to achieve a system that would meet the needs of a busy theatre environment.

The fiber optical triangulation project was completed, allowing for improved network redundancy.

The HSE iSoft PAS replacement project restarted towards the end of 2011, with Karl Bergin being appointed as project lead. Cathal Keegan was appointed as IT Department manager, taking up the role early in December. The PAS replacement project is a significant body of work, effecting most clinical and administrative users in the hospital and will be a welcome replacement to the aging system currently in use.

Karl Bergin
Information Technology Manager (Acting)

Cathal Keegan
Information Technology Manager (from Dec)

Patient Services

The Patient Services Department aims to support the hospital's care systems by providing professional and effective administrative support to both clinical and non-clinical areas within the hospital.

In 2011 the Patient Services Department continued to provide administrative services across the hospital in the following areas:

Admissions, Antenatal Education, Baby Clinic, Birth Notification, Central Booking, Central Dictation, Chart Retrieval, Colposcopy, Community Midwives, Early Transfer Home, Fetal Assessment Unit, Gynaecological Clinic, Medical Records, Neonatal Unit, Out of Hours Unit, Outpatients Department, Physiotherapy, Radiology, Satellite Antenatal Clinics and Social Work Department. The Patient Services Department also co-ordinates the Ward Clerk Service throughout the hospital.

Patient requirements and service needs are constantly changing. We in the Patient Services Department are determined to meet these challenges. In 2012 we will be working on patient information documentation, self assessments, audits and quality improvement plans. We look forward to another challenging year ahead.
I would like to thank all the members of the Patient Services Department for their dedication and flexibility in 2011. They play a vital role in providing support for the Patient Services function in the hospital and the wider community. Finally, I would like to thank the Executive Management Team for their continued support of the Patient Services Department.

Alan McNamara  
Patient Services Manager

Medical Records

With an increase in activity and services the Medical Records Department was extremely busy in 2011, however we continued to provide an efficient and effective service. The Medical Records Department comprises of the Chart Retrieval, Birth Notification, Satellite Clinics and Administrative Access Areas.

In 2011 the department received 1,040 written requests for information through our administrative access area. These requests ranged from general queries to full copies of medical charts from patients, general practitioners and other health care agencies.

There are approximately 10,500 active charts in circulation each month within the hospital. On average our chart retrieval area receive 300 phone requests, 380 written requests and 325 charts to be retrieved for clinic lists on a weekly basis.

A weekly chart management report is created which records and audits all duplicate, missing and temporary charts. In 2011 we had only 9 missing charts outstanding. This works out at 0.007% of active charts in circulation for the year.

The Medical Records Department is also responsible for closing off non continuing pregnancies and in 2011 this saw 3,351 charts being closed off by our staff members.

I would like to thank all of the staff members in Medical Records team for their hard work and dedication and for creating a pleasant working environment in an extremely busy department.

Gayle Reilly  
Assistant Medical Records Manager

Purchasing and Supplies

2011 saw my first full year as Purchasing Manager in The National Maternity Hospital. A special thanks to my staff; it is due to their professionalism that we continue to be a department which no one notices. Believe me, if we did not have the products available when necessary, it would be a very different story.

Activity in the hospital stayed at a very high level, with the Purchasing and Supplies Department having to manage the provision of supplies to meet this service delivery requirements.

Last year saw the implementation of two joint tenders for the NMH and Coombe Women and Infants University Hospital - a household tender, a provisions tender, with approx 2,000 line items between the two contracts.

Currently we are concluding a Print Management project. This has given us a great insight into the printing needs, requirements and costs of printing in differing departments within the hospital. We are now in a better position to maximise our printing resources with the minimum cost implication

2011 saw the introduction of a new HSE Procurement, Portfolio and Category Management project. The National Maternity Hospital has been actively involved in this group with membership on a group establishing a national framework for the procurement of drapes, surgical attire, single use packs, as well as a framework for consumables used in Hospital Sterile Services Departments across the country.

We anticipate tendering activity for 2012 across both NMH and the Coombe Women and Infants University Hospital for medical and surgical equipment. We will also continue working with the HSE on the National Procurement Portfolio and Category Management project.

2011 saw some improvements in our storage capabilities. We installed new storage facilities in Unit 8 (NICU) and also in Theatre. This will allow both departments to control their stock and also make it easier for their staff to access supplies quickly. We also installed a new hoist which, as well as improving the access to the stores department, has reduced H&S issues to both the staff and suppliers.
Looking towards 2012, in the context of the serious financial constraints facing the national economy and indeed the hospital, it is clear that this will be a particularly challenging year for the department. We will continue to look at reducing our cost base while ensuring we can deliver the products in a timely and efficient manner to our internal customers.

I am confident that with the continued support and commitment of all staff within the hospital, all challenges presenting to us will be faced head-on and overcome.

*Damian McKeown*  
*Purchasing & Supplies Manager*

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**Partnership**

Partnership can be described as a relationship between management, unions and staff aimed at improving both the hospital as a workplace and the service we provide to our patients. One of the signs that Partnership is thriving in the National Maternity Hospital is the enhanced communications and inclusive multidisciplinary approach being adopted in our daily business.

The Partnership Committee consists of an equal number of management and union nominees. The hospital management nominated Mary Brosnan, Director of Midwifery and Nursing, Ronan Gavin, Secretary/General Manager, Tony Thompson, General Services Manager, Marie Culliton, Laboratory Manager and Lauri Cryan, Human Resources Manager. Margaret Cooke was nominated by the Irish Nurses Organisation, Shay Higginbotham by the Crafts Union, Anya Curry by the MLSA, Paul Noctor by IMPACT, Jackie Larkin by SIPTU and Miriam Griffin also by SIPTU.

The Committee is co-chaired by a representative of both management and unions, currently Tony Thompson and Paul Noctor. In addition, the expertise and services of Seosamh O’Maolalai Facilitator from the National Health Service Partnership has been extremely beneficial in guiding us on the path to true Partnership.

Although The National Partnership Committee has disbanded, the NMH committee have agreed to continue the good work with our Staff and Management Communications Forum, ‘Partnership Committee’. This is a positive reflection of the value both staff and management place on the positive engagement and communications this forum offers us all.

Partnership has become an integral part of National Maternity Hospital operations and will be crucial in facing future challenges of the evolving healthcare environment. On that note we look forward to the rest of 2012 and beyond. Through Partnership we are better positioned to meet the challenges of the future.

*Tony Thompson*  
*General Services Manager (Partnership Co-Chair)*
### Income And Expenditure

Extracts from the Hospitals Income and Expenditure Account For the Year Ended 31 December 2011

<table>
<thead>
<tr>
<th></th>
<th>2011</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ordinary Income</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Miscellaneous</td>
<td>5,155</td>
<td>5,315</td>
</tr>
<tr>
<td>Treatment Charges</td>
<td>14,771</td>
<td>13,186</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>19,926</strong></td>
<td><strong>18,501</strong></td>
</tr>
<tr>
<td><strong>Ordinary Expenditure - Pay</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical NCHD’s</td>
<td>4,365</td>
<td>4,490</td>
</tr>
<tr>
<td>Consultants</td>
<td>5,656</td>
<td>5,867</td>
</tr>
<tr>
<td>Nursing</td>
<td>22,888</td>
<td>22,284</td>
</tr>
<tr>
<td>Para-Medical</td>
<td>3,661</td>
<td>3,735</td>
</tr>
<tr>
<td>Housekeeping</td>
<td>1,521</td>
<td>1,845</td>
</tr>
<tr>
<td>Catering</td>
<td>1,441</td>
<td>1,624</td>
</tr>
<tr>
<td>Porters</td>
<td>927</td>
<td>1,011</td>
</tr>
<tr>
<td>Maintenance</td>
<td>312</td>
<td>357</td>
</tr>
<tr>
<td>Administration</td>
<td>5,569</td>
<td>5,868</td>
</tr>
<tr>
<td>Pensions</td>
<td>3,512</td>
<td>3,446</td>
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<tr>
<td>VHSS Lump Sums</td>
<td>1,896</td>
<td>1,020</td>
</tr>
<tr>
<td>VHSS Refunds</td>
<td>36</td>
<td>15</td>
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<tr>
<td>Voluntary Redundancy Scheme</td>
<td>0</td>
<td>616</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>51,784</strong></td>
<td><strong>52,178</strong></td>
</tr>
<tr>
<td><strong>Ordinary Expenditure - Non Pay</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicines, Blood &amp; Gases</td>
<td>2,130</td>
<td>2,385</td>
</tr>
<tr>
<td>Laboratory Expenses</td>
<td>1,647</td>
<td>1,477</td>
</tr>
<tr>
<td>Medical and Surgical Appliances</td>
<td>3,733</td>
<td>4,272</td>
</tr>
<tr>
<td>X-Ray Expenses</td>
<td>47</td>
<td>114</td>
</tr>
<tr>
<td>Provisions</td>
<td>480</td>
<td>397</td>
</tr>
<tr>
<td>Heat, Power and Light</td>
<td>392</td>
<td>330</td>
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<tr>
<td>Cleaning and Washing</td>
<td>664</td>
<td>772</td>
</tr>
<tr>
<td>Furniture, Hardware and Crockery</td>
<td>43</td>
<td>63</td>
</tr>
<tr>
<td>Bedding and Clothing</td>
<td>77</td>
<td>80</td>
</tr>
<tr>
<td>Maintenance</td>
<td>978</td>
<td>792</td>
</tr>
<tr>
<td>Transport and Travel</td>
<td>159</td>
<td>188</td>
</tr>
<tr>
<td>Finance</td>
<td>601</td>
<td>721</td>
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<tr>
<td>Office Expenses</td>
<td>566</td>
<td>739</td>
</tr>
<tr>
<td>Education, Training</td>
<td>245</td>
<td>379</td>
</tr>
<tr>
<td>Computer Expenses</td>
<td>547</td>
<td>587</td>
</tr>
<tr>
<td>Miscellaneous</td>
<td>1,283</td>
<td>1,305</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>13,592</strong></td>
<td><strong>14,601</strong></td>
</tr>
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</table>

#### Deficit for Year

<table>
<thead>
<tr>
<th>Description</th>
<th>2011</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Excess of Expenditure over income</td>
<td>45,450</td>
<td>48,278</td>
</tr>
<tr>
<td>Less : Annual Allocation</td>
<td>44,482</td>
<td>48,012</td>
</tr>
<tr>
<td><strong>(Deficit)/Surplus</strong></td>
<td><strong>-968</strong></td>
<td><strong>-266</strong></td>
</tr>
</tbody>
</table>
## Cumulative Figures

Extracts from the Hospitals Income and Expenditure Account For the Year Ended 31 December 2011

<table>
<thead>
<tr>
<th></th>
<th>2011</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>€ '000</td>
<td>€ '000</td>
</tr>
<tr>
<td><strong>Deficit Brought Forward</strong></td>
<td>-615</td>
<td>-349</td>
</tr>
<tr>
<td><strong>Deficit transferred from Income &amp; Expenditure</strong></td>
<td>-968</td>
<td>-266</td>
</tr>
<tr>
<td><strong>Deficit Carried Forward</strong></td>
<td>-1,583</td>
<td>-615</td>
</tr>
</tbody>
</table>

## Balance Sheet

Extracts from the Hospitals Balance Sheet as at 31 December 2011

<table>
<thead>
<tr>
<th></th>
<th>2011</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>€ '000</td>
<td>€ '000</td>
</tr>
<tr>
<td><strong>Fixed Assets</strong></td>
<td>67,886</td>
<td>67,180</td>
</tr>
<tr>
<td><strong>Current Assets</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stock</td>
<td>534</td>
<td>475</td>
</tr>
<tr>
<td>Debtors</td>
<td>7,479</td>
<td>7,846</td>
</tr>
<tr>
<td>Cash &amp; Bank</td>
<td>600</td>
<td>95</td>
</tr>
<tr>
<td><strong>Total Current Assets</strong></td>
<td>8,613</td>
<td>8,416</td>
</tr>
<tr>
<td><strong>Current Liabilities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Creditors</td>
<td>10,022</td>
<td>8,857</td>
</tr>
<tr>
<td><strong>Total Current Liabilities</strong></td>
<td>10,022</td>
<td>8,857</td>
</tr>
<tr>
<td><strong>Net Current Liabilities</strong></td>
<td>-1,409</td>
<td>-441</td>
</tr>
<tr>
<td><strong>Non Current Liabilities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Loans from Funds</td>
<td>-1,682</td>
<td>-1,682</td>
</tr>
<tr>
<td><strong>Net Assets</strong></td>
<td>64,795</td>
<td>65,057</td>
</tr>
<tr>
<td><strong>Represented By:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Capitalisation Account</td>
<td>66,336</td>
<td>66,630</td>
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Activity Analysis

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Mothers Delivered

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<th>2004</th>
<th>2005</th>
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<th>2008</th>
<th>2009</th>
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<th>2011</th>
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<tbody>
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<td>271</td>
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<td>293</td>
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<td>0</td>
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<td>201</td>
<td>216</td>
<td>208</td>
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<td>292</td>
<td>527</td>
<td>558</td>
<td>561</td>
<td>621</td>
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</table>

Community Midwives Deliveries
Major Operations* 1775 1921 1958 1947 2043 2318 2301 2327 2478 2384
Minor Operations 1885 1782 1735 1890 2020 1799 1886 2183 2067 2136
Total 3660 3703 3693 3837 4063 4117 4187 4510 4545 4520

*includes Caesarean Sections

Unbooked Outpatient Attendances (Out of Hours) 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011
Obstetric/Gynaecology 4237 4306 4566 4698 5491 6246 6286 7641 8060 7904
Paediatrics 608 741 892 747 823 765 831 730 594 520
Total 4845 5047 5458 5445 6314 7011 7117 8371 8654 8424
Outpatient Attendances

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<tr>
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<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
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<tbody>
<tr>
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<td>36256</td>
<td>34435</td>
<td>34884</td>
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<td>59086</td>
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Unbooked Outpatient Attendances (Within Hours)

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* not including unbooked attendances
Fetal Medicine Unit Attendances

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<th>2006</th>
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<th>2008</th>
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Inpatient Discharges

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</table>
### 2011 National Maternity Hospital Caesarean Section Analysis as Classified by the Ten Groups

<table>
<thead>
<tr>
<th>Groups</th>
<th>Overall Caesarean Section Rate (%)</th>
<th>Number of CS over total number of women in each group</th>
<th>Contribution made by each group to the overall hospital population %</th>
<th>CS rate in each group %</th>
<th>Contribution made by each group to the overall CS rate %</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Nulliparous, single cephalic, &gt;=37 weeks, in spontaneous labour</td>
<td>1977/9250 (21.4%)</td>
<td>178/2387</td>
<td>25.8 (2387/9250)</td>
<td>75 (178/2387)</td>
<td>1.9 (178/9250)</td>
</tr>
<tr>
<td>2. Nulliparous, single cephalic, &gt;=37 weeks, induced and CS before labour</td>
<td></td>
<td>476/1367</td>
<td>14.8 (1367/9250)</td>
<td>34.8 (476/1367)</td>
<td>5.1 (476/9250)</td>
</tr>
<tr>
<td>2a. Nulliparous, single cephalic, &gt;=37 weeks, induced</td>
<td></td>
<td>385/1276</td>
<td>13.8 (1276/9250)</td>
<td>30.2 (385/1276)</td>
<td>4.2 (385/9250)</td>
</tr>
<tr>
<td>2b. Nulliparous, single cephalic, &gt;=37 weeks, CS before labour</td>
<td></td>
<td>91</td>
<td>1.0 (91/9250)</td>
<td>100.0 (91/91)</td>
<td>1.0 (91/9250)</td>
</tr>
<tr>
<td>3. Multiparous (excluding prev. CS), single cephalic, &gt;=37 weeks, in spontaneous labour</td>
<td></td>
<td>30/2751</td>
<td>29.7 (2751/9250)</td>
<td>1.1 (30/2751)</td>
<td>0.3 (30/9250)</td>
</tr>
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<td>4a. Multiparous (excluding prev. CS), single cephalic, &gt;=37 weeks, induced</td>
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<td>8.7 (809/9250)</td>
<td>5.8 (47/809)</td>
<td>0.5 (47/9250)</td>
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<tr>
<td>4b. Multiparous (excluding prev. CS), single cephalic, &gt;=37 weeks, CS before labour</td>
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</tr>
<tr>
<td>5. Previous CS, single cephalic, &gt;=37 weeks</td>
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<td>10.1 (937/9250)</td>
<td>60.8 (570/937)</td>
<td>6.2 (570/9250)</td>
</tr>
<tr>
<td>6. All nulliparous breeches</td>
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<td>204/219</td>
<td>2.4 (219/9250)</td>
<td>93.2 (204/219)</td>
<td>2.2 (204/9250)</td>
</tr>
<tr>
<td>7. All multiparous breeches (including prev. CS)</td>
<td></td>
<td>113/133</td>
<td>1.4 (133/9250)</td>
<td>85.0 (113/133)</td>
<td>1.2 (113/9250)</td>
</tr>
<tr>
<td>8. All multiple pregnancies (including prev. CS)</td>
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<td>2.3 (212/9250)</td>
<td>63.2 (134/212)</td>
<td>1.4 (134/9250)</td>
</tr>
<tr>
<td>9. All abnormal lies (including prev. CS)</td>
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<td>0.4 (36/9250)</td>
<td>100.0 (36/36)</td>
<td>0.4 (36/9250)</td>
</tr>
<tr>
<td>10. All single cephalic, &gt;= 36 weeks (including prev. CS)</td>
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<td>127/337</td>
<td>3.6 (337/9250)</td>
<td>37.7 (127/337)</td>
<td>1.4 (127/9250)</td>
</tr>
</tbody>
</table>
Activity Analysis Definitions

Mothers Delivered: Women who deliver at least one baby >=500g. Babies Born: babies >=500g.

Theatre Activity
Major Operations: This figure reflects the number of women who had at least one major operation.
Minor Operations: This figure reflects the number of women who had at least one minor operation and no major operations.

Unbooked Outpatient Attendances (Out of Hours): attendances between 4pm and 8am weekdays and 24 hours a day on weekends and on bank holidays.

Unbooked Outpatient Attendances (Within Hours): attendances between 8am and 4pm at the Outpatient and Gynaecology Clinics.

Paediatric (Out of Hours): attendances to the ‘Baby Couch’ when the Baby Clinic is closed (after 1pm weekdays and 24 hours a day on weekends and bank holidays).

Fetal Medicine Unit Attendances
Attendances at Fetal Medicine Unit during normal office hours: 8am – 4pm weekdays
These can be classified into the following groups:
• Early Pregnancy Assessment Unit
• All Booked Attendances
• Fetal Echo
• High Risk
• Rhesus
• Unbooked/Emergency*

*these are unbooked attendances (referrals from Outpatients) and attendances by Inpatients on wards.

Outpatient Activity Includes all attendances at all Outpatient clinics between 8am and 4pm weekdays. Fetal Medicine Unit attendances are separate, does not include Synagis or any Unbooked Obstetric or Gynaecology Attendance (given separately).

Inpatients and Day Cases
Obstetric Inpatient Specialty = Obstetrics: Discharges from all obstetric wards regardless of length of stay aswell as discharges from the Gynaecology Ward where length of stay >0.
Gynaecology Inpatient Discharges from Gynaecology Ward where length of stay >0.
Neonatal Inpatient Specialty = Neonatology: discharges from the neonatal unit.
Gynaecology Day Case Where Specialty = Gynaecology: Booked day case procedures as well as discharges from Gynaecology Ward where admission date = discharge date.
Obstetric Day Case Where Specialty = Obstetrics: Booked day cases from Antenatal Day Ward as well as booked day cases from Gynaecology Ward.
Casualty Where ‘Ward Code at Discharge’ = Casualty

*Inpatient and Day Case definitions have been amended this year in order to be consistent with HIPE definitions.

Neonatology Inpatients also include babies admitted to the neonatal unit for ‘Observation’ - these have only been included since late 2007.