

## Maternity Patient Safety Statement Feidhmeannacht na Seirbhíse Sláinte Health Service Executive

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

This Statement is used to inform local hospital and hospital Group management carrying out their role in safety and quality improvement. The objective in publis the Statement each month is to provide public assurance that maternity services are delivered in an environment that promotes open disclosure.  It is not intended that the monthly Statement be used as a comparator with other units or that statements would be aggregated at hospital Group or national level.	Hospital Name	St Luke's General Hospital	Reporting Month	March 2018
Purpose & Context  Purpose & Context  • HSE Midland Regional Hospital, Portlaoise Perinatal Deaths, Report to Minister for Health from Dr. Tony Holohan, Chief Medical Officer, 24 February 2014; and  • HIQA Report of the Investigation into the Safety, Quality and Standard Services Provided by the HSE to patients in the Midland Regional Hospital, Portlaoise, 8 May 2015.  It is important to note tertiary and referral maternity centres will care for a higher complexity of patients (mothers and babies), therefore clinical activity in these centres will be higher and therefore no comparisons should be drawn with units that do not look after complex cases.		This Statement is used to inform local carrying out their role in safety and querthe Statement each month is to provide are delivered in an environment that purely in the statement of the monthly Statements of the statements would be aggrassists in an early warning mechanism escalation. It forms part of the recommendation of the Minister for Health from Dr. February 2014; and  HIQA Report of the Investigates Services Provided by the HS Hospital, Portlaoise, 8 May 2014. It is important to note tertiary and reference of the statements will be higher and therefore in the statement of the same statement in the statement of the stat	al hospital and hospital auality improvement. The de public assurance the promotes open discloss atement be used as a correspendent at hospital Grown for issues that requiremendations in the following pital, Portlaoise Perinat Tony Holohan, Chief Mation into the Safety, Quest to patients in the Michael Michael Control of the Comparisons should	Group management in e objective in publishing at maternity services ure.  omparator with other oup or national level. It re local action and/ or wing reports: al Deaths, Report to the ledical Officer, 24 uality and Standards of dland Regional  will care for a higher al activity in these

	Ref	Information Areas	2018	
Headings			March	Year to date
Hospital Activities	1	Total mothers delivered ≥ 500g (n)	125	375
	2	Multiple pregnancies (n)	0	5
	3	Total births ≥ 500g (n)	125	379
	4	Perinatal mortality rate – adjusted (per 1,000 total births)	0 Per 1,000	2.638522427 Per 1,000
	5	In utero transfer – admitted (n)	0	0
	6	In utero transfer – sent out (n)	3	10
Major Obstetric Events	7	Total combined rate (per 1,000 total mothers delivered) of major obstetric events for the following four obstetric metrics:	0.00	0.00
		<ul> <li>Eclampsia;</li> <li>Uterine rupture;</li> <li>Peripartum hysterectomy; and</li> <li>Pulmonary embolism.</li> </ul>	Per 1,000	Per 1,000

	Ref	Information Areas	2018	
Headings			March	Year to date
Delivery Metrics	8	Rate of instrumental delivery per total mothers delivered (%)	20.0%	15.5%
	9	Rate of nulliparas with instrumental delivery (%)	34.8%	25.5%
	10	Rate of multiparas with instrumental delivery (%)	11.3%	9.6%
	11	Rate of induction of labour per total mothers delivered (%)	14.4%	19.2%
	12	Rate of nulliparas with induction of labour (%)	17.4%	25.5%
	13	Rate of multiparas with induction of labour (%)	12.5%	15.5%
	14	Rate of Caesarean section per total mothers delivered (%)	37.3%	44.4%
	15	Rate of nulliparas with Caesarean section (%)	37.0%	50.4%
	16	Rate of multiparas with Caesarean section (%)	37.5%	41.0%
Maternity Services	17	Total number of clinical incidents for <b>Maternity Services</b> (reported monthly to NIMS) (n)	23	64
Total Clinical Incidents				

## **DEFINITIONS**

(n) = Number

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

The Maternity Patient Safety Statement for St Luke's General Hospital provides up to date information for management and clinicians who provide maternity services in relation to a range of patient safety issues for March 2018.

The information in this Statement is a core element of clinical governance and management of maternity services within the above hospital and the Ireland East Hospital Group.

Hospital Group Clinical Director:

Hospital Group Clinical Director: Kevin O'Malley/Risteard O'Laoide

W. Smily. Signature: Mary Day

Hospital Group CEO:

Signature:

Date: 31st May 2018