

Maternity Patient Safety Statement

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

 Purpose & Context This Statement is used to inform local hospital and hospital Group management in carrying out their role in safety and quality improvement. The objective in publishing the Statement each month is to provide public assurance that maternity services are delivered in an environment that promotes open disclosure. It is not intended that the monthly Statement be used as a comparator with other units or that statements would be aggregated at hospital Group or national level. It assists in an early warning mechanism for issues that require local action and/ or escalation. It forms part of the recommendations in the following reports: HSE Midland Regional Hospital, Portlaoise Perinatal Deaths, Report to the Minister for Health from Dr. Tony Holohan, Chief Medical Officer, 24 February 2014; and HIQA Report of the Investigation into the Safety, Quality and Standards of Services Provided by the HSE to patients in the Midland Regional Hospital, Portlaoise, 8 May 2015. It is important to note tertiary and referral maternity centres will care for a higher complexity of patients (mothers and babies), therefore clinical activity in these 	Hospital Name	St. Luke's Hospital, Kilkenny	Reporting Month	March 2017
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 loca carrying out their role in safety and que the Statement each month is to provid are delivered in an environment that put it is not intended that the monthly Statunits or that statements would be aggrassists in an early warning mechanism escalation. It forms part of the recomm HSE Midland Regional Hosp Minister for Health from Dr. February 2014; and HIQA Report of the Investigat Services Provided by the HSE Hospital, Portlaoise, 8 May 2 It is important to note tertiary and references will be higher and therefore not be and the and therefore not be and the and therefore not be and therefore not be and the and the and therefore not be and the and therefore not b	I hospital and hospital uality improvement. The de public assurance the promotes open disclose tement be used as a c gregated at hospital Gre m for issues that requir mendations in the follow bital, Portlaoise Perinat Tony Holohan, Chief M ation into the Safety, Q SE to patients in the Mi 2015.	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

			2017	
Headings Ref Information Areas		March	Year to date	
Hospital Activities	1	Total mothers delivered ≥ 500g (n)	129	380
	2	Multiple pregnancies (n)	1	5
	3	Total births ≥ 500g (n)	130	185
	4	Perinatal mortality rate – adjusted (per 1,000 total births)	0 per 1,000	0 per 1,000
	5	In utero transfer – admitted (n)	0	0
	6	In utero transfer – sent out (n)	5	16
Major Obstetric Events	7	 Total combined rate (per 1,000 total mothers delivered) of major obstetric events for the following four obstetric metrics: Eclampsia; Uterine rupture; Peripartum hysterectomy; and Pulmonary embolism. 	0.00 per 1,000	0.00 per 1,000

Headings	Ref	Information Areas	2017	
			March	Year to date
Delivery Metrics	8	Rate of instrumental delivery per total mothers delivered (%)	11.6%	11.1%
Metrics	9	Rate of nulliparas with instrumental delivery (%)	22.5%	22.7%
	10	Rate of multiparas with instrumental delivery (%)	6.7%	5.7%
	11	Rate of induction of labour per total mothers delivered (%)	20.2%	16.3%
	12	Rate of nulliparas with induction of labour (%)	22.5%	17.6%
	13	Rate of multiparas with induction of labour (%)	19.1%	15.7%
	14	Rate of Caesarean section per total mothers delivered (%)	37.2%	35.0%
	15	Rate of nulliparas with Caesarean section (%)	42.5%	41.2%
	16	Rate of multiparas with Caesarean section (%)	34.8%	32.2%
Maternity Services Total Clinical Incidents	17	Total number of clinical incidents for Maternity Services (reported monthly to NIMS) (n)	24	57

Please note that the activity data published above is based on the information available when the report was compiled.

DEFINITIONS

(n) = Number

Nulliparas = Women who have never had a previous pregnancy resulting in a live birth or stillbirth (\geq 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 Hospital, Kilkenny provides up to date information for management and clinicians who provide maternity services in relation to a range of patient safety issues for March 2017.

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

Hospital Group Clinical Director:

Kevin O'Malley/Risteard O'Laoide

VanDa

Signature:

Mary Day

Hospital Group CEO:

Signature:

Date:

27th April 2017