

## **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.

This Statement is used to inform local hospital and hospital Group management carrying out their role in safety and quality improvement. The objective in publish 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 lever 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 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.	Hospital Name	University Maternity Hospital Limerick	Reporting Month	May
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.  Maternity Safety Statements form part of the suite of key performance indicator the maternity services. Hospitals must populate and publish on a monthly basis months in arrears). Additionally, the statements are discussed at the Hospital Group Maternity Network meetings with the National Women and Infants Health		This Statement is used to inform local carrying out their role in safety and querthe Statement each month is to provise are delivered in an environment that put it is not intended that the monthly Statements or that statements would be againsts in an early warning mechanist escalation. It forms part of the recommendation of the recommendation of the second management of the second management of the Investigation of the Invest	I hospital and hospital adality improvement. The depublic assurance the promotes open disclosuratement be used as a corregated at hospital Grom for issues that requirmendations in the followoital, Portlaoise Perinat Tony Holohan, Chief Mation into the Safety, Quest to patients in the Microscopial maternity centres whether the suite of key perst populate and publish statements are discussivation.	Group management in e objective in publishing at maternity services ure.  omparator with other oup or national level. It e local action and/ or wing reports: al Deaths, Report to the edical Officer, 24  uality and Standards of dland Regional  will care for a higher al activity in these be drawn with units  formance indicators for a on a monthly basis (2 ed at the Hospital

			2023	
Headings	Ref	Information Areas	Month	Year to date
			May	
Hospital Activities	1	Total mothers delivered ≥ 500g (n)	344	1586
	2	Multiple pregnancies (n)	4	27
	3	Total births ≥ 500g (n)	348	1613
	4	Perinatal mortality rate – adjusted (per 1,000 total births)	0.0 Per 1000	0.0 Per 1000
	5	In utero transfer – admitted (n)	0	0
	6	In utero transfer – sent out (n)	2	5
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.	0.0 <b>♦</b> Per 1000	0.0 <b>♦</b> Per 1000
Delivery Metrics	8	Rate of instrumental delivery per total mothers delivered (%)	15.1%	15.1%
	9	Rate of nulliparas with instrumental delivery (%)	25.0%	26.5%
	10	Rate of multiparas with instrumental delivery (%)	7.7%	7.6%
	11	Rate of induction of labour per total mothers delivered (%)	36.0%	36.1%
	12	Rate of nulliparas with induction of labour (%)	40.5%	39.9%
	13	Rate of multiparas with induction of labour (%)	32.7%	33.5%
	14	Rate of Caesarean section per total mothers delivered (%)	39.8%	42.7%
	15	Rate of nulliparas with Caesarean section (%)	47.3%	46.5%
	16	Rate of multiparas with Caesarean section (%)	34.2%	40.2%
Maternity Services Total Clinical Incidents	17	Total number of clinical incidents for <b>Maternity Services</b> (reported monthly to NIMS) (n)	57	231

## **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

♦ An executive decision was made to return major obstetric events presenting to our general hospital, giving a clearer picture of obstetric management. This is likely to raise our figures when compared to hospitals not returning data from general hospitals. This is particularly relevant to pulmonary embolism numbers.

The Maternity Patient Safety Statement for (University Maternity Hospital Limerick) provides up to date information for management and clinicians who provide maternity services in relation to a range of patient safety issues for the month of (May) and year (2023)

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

Hospital Group Clinical Director: Mr. Brian Lenehan

Signature:

Hospital Group CEO Ms Colette Cowan

Signature:

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