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.

Hospital Name	University Maternity Hospital Limerick	**Reporting Month**	**October**
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 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 indicators for the maternity services. Hospitals must populate and publish on a monthly basis (2 months in arrears). Additionally, the statements are discussed at the Hospital Group Maternity Network meetings with the National Women and Infants Health Programme as part of the quality and safety agenda.		

Headings	Ref	Information Areas	2024	
			Month	Year to date
			October	
Hospital Activities	1	Total mothers delivered ≥ 500g (n)	345	3200
	2	Multiple pregnancies (n)	5	65
	3	Total births ≥ 500g (n)	350	3265
	4	Perinatal mortality rate – adjusted (per 1,000 total births)	*0.0 Per 1000	*0.9 Per 1000
	5	In utero transfer – admitted (n)	0	0
	6	In utero transfer – sent out (n)	1	7
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 ◈ Per 1000	0.6 ◈ Per 1000
Delivery Metrics	8	Rate of instrumental delivery per total mothers delivered (%)	16.2%	17.4%
	9	Rate of nulliparas with instrumental delivery (%)	26.6%	31.5%
	10	Rate of multiparas with instrumental delivery (%)	8.9%	8.7%
	11	Rate of induction of labour per total mothers delivered (%)	35.4%	36.1%
	12	Rate of nulliparas with induction of labour (%)	44.1%	43.3%
	13	Rate of multiparas with induction of labour (%)	29.2%	31.6%
	14	Rate of Caesarean section per total mothers delivered (%)	51.6%	44.9%
	15	Rate of nulliparas with Caesarean section (%)	51.7%	47.3%
	16	Rate of multiparas with Caesarean section (%)	51.5%	43.5%
Maternity Services Total Clinical Incidents	17	Total number of clinical incidents for **Maternity Services** (reported monthly to NIMS) (n)	85	555

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 (October) and year (2024)

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.

*The results presented in this report for the "perinatal Mortality Rate – Adjusted (Per 1,000 Total Births)" are subject to change and may increase following the availability of post-mortem results and subsequent clinical confirmation of perinatal mortality reason".

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Signature:

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