

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.

 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. 	Hospital Name	St Luke's General Hospital, Kilkenny	Reporting Month	Dec 2015
	Purpose & Context	 This Statement is used to inform local carrying out their role in safety and quather Statement each month is to provid delivered in an environment that promulation is not intended that the monthly State or that statements would be aggregated in an early warning mechanism for issues of the recommendations in the early warning mechanism for issues of the recommendations in the early warning mechanism for issues of the recommendations in the early warning mechanism for issues of the recommendations in the early warning mechanism for issues of the recommendations in the early warning mechanism for issues of the recommendations in the early warning mechanism for issues of the recommendations in the early warning mechanism for issues of the recommendations in the early warning mechanism for issues of the recommendations in the early warning mechanism for issues of the recommendations in the early warning mechanism for issues of the recommendations in the early warning mechanism for issues of the recommendations in the early warning mechanism for issues of the recommendations in the early warning mechanism for issues of the recommendations in the early warning mechanism for issues of the recommendations in the early warning mechanism for issues of the recommendations in the early warning mechanism for issues of the recommendations in the early warning mechanism for issues of the recommendations in the early warning mechanism for issues of the recommendations in the early warning mechanism for issues of the recommendations in the early warning mechanism for the investigation of the recommendation of	ality improvement. The e public assurance that otes open disclosure. ement be used as a con- ed at hospital Group or r ues that require local ac n the following reports: tal, Portlaoise Perinatal ony Holohan, Chief Me tion into the Safety, Qua E to patients in the Midl rral maternity centres w abies), therefore clinical	objective in publishing maternity services are mparator with other units national level. It assists ction and/ or escalation. Deaths, Report to the dical Officer, 24 ality and Standards of and Regional Hospital, ill care for a higher activity in these centres

Headings	Ref	Information Areas	2015 Month December
Hospital Activities	1	Total mothers delivered \geq 500g (n)	159
	2	Multiple pregnancies (n)	3
	3	Total births ≥ 500g (n)	162
	4	Perinatal mortality rate – adjusted (per 1,000 total births)	0
	5	In utero transfer – admitted (n)	0
	6	In utero transfer – sent out (n)	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

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			2015
Headings	Ref	Information Areas	Month
			December
Delivery Metrics	8	Rate of instrumental delivery per total mothers delivered (%)	17.6%
	9	Rate of nulliparas with instrumental delivery (%)	13.2%
	10	Rate of multiparas with instrumental delivery (%)	4.4%
	11	Rate of induction of labour per total mothers delivered (%)	34.6%
	12	Rate of nulliparas with induction of labour (%)	21.4%
	13	Rate of multiparas with induction of labour (%)	13.2%
	14	Rate of Caesarean section per total mothers delivered (%)	34.6%
	15	Rate of nulliparas with Caesarean section (%)	12.6%
	16	Rate of multiparas with Caesarean section (%)	22.0%
Maternity Services	17	Total number of clinical incidents for Maternity Services (reported monthly to NIMS) (n)	
Total Clinical Incidents			21

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 (\geq 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 the month of December 2015.

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(s): Risteard O'Laoide/Kevin O'Malley

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Signature:

Hospital Group CEO

Mary Day

Signature:

26th February 2016

Date: