

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 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 Hospital, Kilkenny	Reporting Month	May 2017
that do not look after compley 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 put it is not intended that the monthly Statements or that statements would be aggrassists in an early warning mechanism escalation. It forms part of the recommescalation. It forms part of the Investigation of the Inve	I hospital and hospital of pality improvement. The de public assurance that promotes open disclosuratement be used as a corregated at hospital Grown for issues that requirmendations in the followital, Portlaoise Perinata Tony Holohan, Chief Mation into the Safety, Quation into the Safety, Quatio	Group management in e objective in publishing at maternity services are. Important with other out 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

	Ref	Information Areas	2017	
Headings			May	Year to date
Hospital Activities	1	Total mothers delivered ≥ 500g (n)	117	610
	2	Multiple pregnancies (n)	1	7
	3	Total births ≥ 500g (n)	118	617
	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)	6	29
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	
			May	Year to date
Delivery Metrics	8	Rate of instrumental delivery per total mothers delivered (%)	17.9%	13%
	9	Rate of nulliparas with instrumental delivery (%)	26.5%	24.6%
	10	Rate of multiparas with instrumental delivery (%)	11.8%	6.8%
	11	Rate of induction of labour per total mothers delivered (%)	18.8%	18.2%
	12	Rate of nulliparas with induction of labour (%)	24.5%	22.3%
	13	Rate of multiparas with induction of labour (%)	14.7%	16%
	14	Rate of Caesarean section per total mothers delivered (%)	41%	36.9%
	15	Rate of nulliparas with Caesarean section (%)	49%	42.7%
	16	Rate of multiparas with Caesarean section (%)	35.3%	33.8%
Maternity Services Total Clinical Incidents	17	Total number of clinical incidents for Maternity Services (reported monthly to NIMS) (n)	22	103

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

DEFINITIONS

(n) = Number

Signature:

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 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 May 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 Mary Day

Hospital Group CEO:

Signature:

25th July 2017 Date: