Maternity Unit
ANNUAL REPORT
2002

North Eastern Health Board
Bord Sláinte An Oir Thuaiscirt

Our Lady of Lourdes Hospital Drogheda

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PHILOSOPHY OF CARE

We believe that quality care, wherever provided, is central to the future health of the nation.

Recognising that each woman has different needs and expectations, we endeavour to provide, through informed choice, individualized care throughout pregnancy, childbirth and the postnatal period.

We provide maternity care based on relevant research, which is as flexible as possible within the limits of safety.

Our overall aim is to provide a service, which enables transition to motherhood with a sense of independence, achievement and self-fulfilment, and promotes integration of the baby into the family.

INTRODUCTION

There is a long tradition of statistical analysis in maternity units worldwide, and this is the first annual report to be published from Our Lady of Lourdes' Hospital maternity unit in many years. I thank all members of staff who have contributed the various sections of this report in a timely fashion. Maternity services in the North-East have seen great change: deliveries were suspended in Dundalk and Monaghan in 2001, and the ensuing transfer of services has had maximal impact on this hospital. The Mosney reception centre was opened to asylum-seekers/refugees in 2000, and an increasing proportion of deliveries has been in respect of these, mainly African, women. Meanwhile maternity services in Dublin have been at over-capacity for some time. These factors have contributed to the increasing numbers of patients attending Our Lady of Lourdes' Hospital and the complexity of care required. Perusal of the enclosed report will show that the non national population in particular presents major challenges.

The basis for the obstetric figures presented is the Delivery Suite register, which was initiated in its present format in 2001. All data has been collected by hand: delivery figures and a detailed breakdown of complications and both unexpected and adverse events, together with a review of cases of interest, are presented weekly by the registrar staff at the Departmental meeting. In addition, since 1999, a monthly overview of statistics is collated and presented by midwifery staff: the latter has been the main basis for data collection in the unit. Both the number of parameters to be collected and the degree of sophistication necessary for detailed analysis, have grown over time, and would be enormously facilitated by means of a computerised database. The funding for a maternity information system, together with administrative support, is eagerly anticipated. That said, the detail of the material presented herein, the result of a joint midwifery/ obstetric/secretarial initiative, is similar to that of reports from the maternity units in Dublin.

The local 'care process group' led by Pat Kinder arising from the Review Group Report (2001) met throughout 2002 and continues to date. Through the group, staff and resource issues have been identified, and developments in services have been planned and implemented. Thus, the Louth County Hospital has established itself as the centre for gynaecological day-case activity, with a state-of-the-art day ward and dedicated staff. The antenatal services there continue to be very busy and lighten the load of the Lourdes' Hospital considerably. Meanwhile, an antenatal service has commenced at Navan, and day-case activity looks likely to commence in 2004. The local general management team have been unstinting in their support of these and all other initiatives pursued in the interests of patient care.

No maternity unit can function without the support services whose activities are detailed in this document: these services are delivered to the highest standards. We also acknowledge the assistance we receive from the Dublin Hospitals, particularly haematology, thrombosis/haemostasis, the National Blood Transfusion Service, microbiology, and endocrinology. In the Dublin maternity hospitals colleagues assist through telephone advice, second opinion, and taking over patient care; prenatal diagnosis/expert ultrasound services, gynaecological oncology and urology are probably most commonly used by us.

As part of a general hospital, maternity patients at Our Lady of Lourdes' Hospital enjoy the advantage of immediate recourse to other specialties; this is almost always delivered by our consultant colleagues, and we are indebted to them. Our perinatal mortality rates are testament to all the staff delivering services within and between all five health board hospitals, and the excellence of the neonatal unit, of which we are proud; this is in spite of a significant number of unbooked women arriving in labour. That no woman lost her life as a direct result of pregnancy/delivery is remarkable, and we acknowledge the part played by our anaesthetic, theatre and intensive care staff. Critical care is delivered here on site, whereas in a stand-alone maternity unit the patient would require to be transferred, adding further risk to her situation. Finally, we are fortunate to be in a position to attract midwives and junior medical staff of the highest calibre, who deliver services around the clock. We look to the future hoping that levels of activity continue to be sustained and developed.

Maire Milner MD MRCOG
Consultant Obstetrician Gynaecologist
Our Lady of Lourdes' Hospital, Drogheda

Our Lady of Lourdes Hospital, Drogheda is a 339 bed Acute General Hospital incorporating a Maternity Unit, Regional School of Midwifery and a Regional Neonatal Intensive Care Unit. The Maternity Unit is the only such unit within the Louth/Meath Hospital Group, following the suspension of maternity services at Louth County Hospital, Dundalk.

2002 was another very busy year, reflecting the growth in the catchment population of the hospital, together with a significant increase in the non-national community. The census of population taken in 2002 indicates a total population for counties Louth and Meath, of 235,000, representing a large increase on 1996 figures. Whilst a significant number of mothers living in the region, avail of maternity services in Dublin Hospitals, there is an increasing number of residents from North County Dublin who are choosing to access services in this hospital.

The North Eastern Health Board is committed to ensuring accessible, safe and sustainable maternity and neonatal care for all women and babies of the region.

I wish to pay tribute to all members of staff for their hard work and dedication, in particular, to Declan Collins who made an outstanding contribution to the development of maternity services during his term as my predecessor. We can look forward to continued development of this hospital in accordance with the principles and goals of the National Health Strategy "quality and fairness".

David Gaskin
Group Manager
Louth Meath Hospital Group

STATISTICAL SUMMARIES FOR YEAR 2002

1. Mothers attending the hospital

Total mothers delivered of babies weighing >/=500grammes:	**3254**	

2. Maternal deaths

Maternal deaths	1	

3. Births

Singleton Pregnancies (one baby <500g excluded)	3211	
Twins	42	(1.29%)
Triplets	1	
Babies delivered weighing >/= 500g	3298	
Babies delivered weighing >/= 1,000g	3290	
Babies delivered weighing <2,500g	183	(5.55%)
Babies delivered <37weeks	192	(5.82%)
Unbooked	82	(2.52%)
Babies born before arrival	12	(0.36%)

4. Obstetric outcomes

Induction of Labour	845	(26%)
Episiotomy	448	(13.8% overall) (18.3% of vag del)
Normal delivery	1977	(60.3%)
Ventouse delivery	352	(10.8%)
Forceps delivery	108	(3.3%)
Ventouse & Forceps	18	(0.55%)
Vaginal breech	11	(0.33%)
Caesarean Section	813	(25%)
Failed instrumental del (LSCS after instrumental delivery attempted)	16	(2.93% of inst del)
Shoulder dystocia	21	(0.65%)
PPH>500mls	74	(3.2%)
Manual Removal of Placenta	34	(1.04%)
Foetal blood sampling	92	(2.8%)
Caesearean hysterectomy	1	

5. Perinatal Deaths

Stillbirths	20	
Early Neonatal Deaths	10	
Late Neonatal Deaths	none	
Total	**30**	

6. Perinatal Mortality Rates (PNMR)

Overall PNMR (incl 2 deaths in TSH)	9.1/ 1,000 (30)	
PNMR corrected for lethal malformation	6.36/ 1,000 (21)	
PNMR excluding unbooked cases	5.04/ 1,000 (16)	

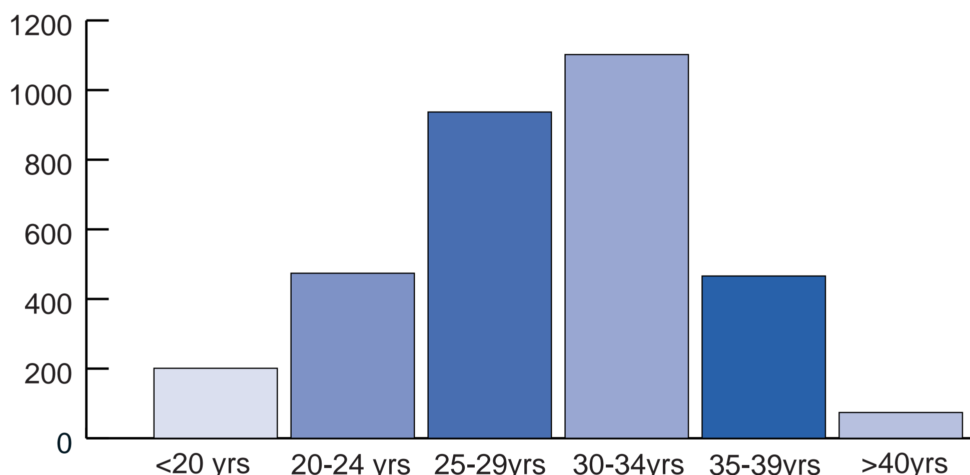
STATISTICAL SUMMARIES FOR YEAR 2002.....

7. Nationality		
Total Non-national	560	(17.2%)
Residing at Mosney	89	
Others	471	

8. Marital Status		
Single	978	30.05%
Separated	14	0.45%
Married	2262	69.5%

9. Maternal Age		
<20 years	201	6.2%
20-24	474	14.6%
25-29	937	2.3%
30-34	1102	33.9%
35-39	466	14.3%
>40	74	2.3%

Maternal Age



10. Parity				
Primigravidae:	1316		40.4%	
Multiparae:	1938		59.6%	
• Para 1		1022		31.4%
• Para 2		556		17.1%
• Para 3		221		6.8%
• Para 4		91		2.8%
• Para 5		28		0.86%
• Para >5		20		0.61%
Total	**3254**			

STATISTICAL SUMMARIES FOR YEAR 2002.....

11. Gestational Age

<28weeks	10	0.30%
28-31	26	0.79%
32-36	156	4.73%
37-41	3084	93.5%
42+	22	0.67%
Total	**3298**	

12. Birth Weight

500- 999grammes	8	0.2%
1000-1499	22	0.7%
1500-1999	44	1.3%
2000-2499	109	3.3%
Total <2.5kg	**183**	**5.5%**
2500-2999	406	12.3%
3000-3499	1079	32.7%
3500-3999	1112	33.7%
4000-4499	425	12.9%
4500-4999	84	2.5%
>5000	9	0.3%
Total	**3298**	

13. Inductions

Prostin:	626	
ARM to induce:	142	
Oxytocin to induce:	77	
Total:	**845**	**(26%)**

14. Private patients:

14. Private patients:	725	(22.8%)

15. Address by County

Louth	1610	49.5%
Meath	1046	32.1%
Dublin	299	9.2%
Monaghan	231	7.1%
Cavan	51	1.6%
Other Counties/NFA	18	0.5%

16. Perineum

First degree tear:	452	
Second degree tear:	503	
Third degree tear:	14	
Total Episiotomy:	448	(13.8% overall) (18.3% of vag del)
Episiotomy at instrumental delivery:	328/478=	68.62%
Overall Intact perineum rate:	1024=	31.47%

17. LSCS, Episiotomy & Instrumental Delivery rates by Parity

(for this exercise, LSCS for twins was counted as one delivery)

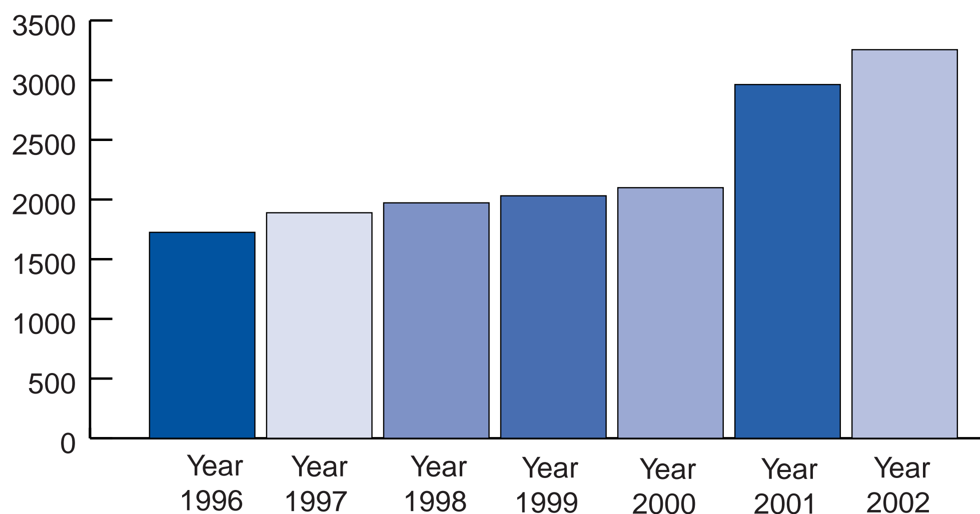
Primipara (1316 mothers/ 1320 deliveries)		
LSCS	340/ 1316	= 25.8%
SVD	634	= 48.1%
Ventouse	249	=18.76%
Forceps	72	=5.4%
F + V	24	=1.8%
Total Instrumental Del		**= 25.96%**
• Episiotomy rate		
At instrumental delivery:	276/345	=80%
At SVD:	73/634	=11.5%
Multipara (1938mothers/ 1959 deliveries)		
LSCS	468/ 1938	= 24.15%
SVD	1368	=69.4%
Ventouse	108	=5.48%
Forceps	17	=0.86%
Total Instrumental Del		**= 6.4%**
• Episiotomy rate		
At instrumental delivery:	52/125	= 42%
At SVD:	47/1368	= 3.4%

18. Caesarean Sections: Robson classification

Group	Overall CS Group	rate
1 Nulliparous, single cephalic, >37w in spontaneous labour	84/ 745	=11.2%
2 Nulliparous, single cephalic, >37w, induced	131/ 420	=31.1%
LSCS before labour	43	
Total	174/463	= 37.5%
3 Multiparous excl previous LSCS single cephalic >37w in spontaneous labour	31/980	=3.1%
4 Multiparous excl previous LSCS single cephalic >37w, induced	25/353	=7%
LSCS before labour	37	
Total	62/390	= 16%
5 Previous LSCS single cephalic >37w	283/403	=70%
One previous LSCS	180/300	= 60% or 40% vbac rate
>1 previous LSCS	103	
6 All nulliparous breeches	57/60	= 95%
7 All multiparous breeches (incl prev lscs)	35/36	= 97.2%
8 All multiple pregnancies (incl prev lscs)	20/43	= 46.5%
9 All abnormal lies (incl prev lscs)	16	
10 All single cephalic, < 36w (incl prev lscs)	50/119	= 42%

TRENDS OVER THE YEARS

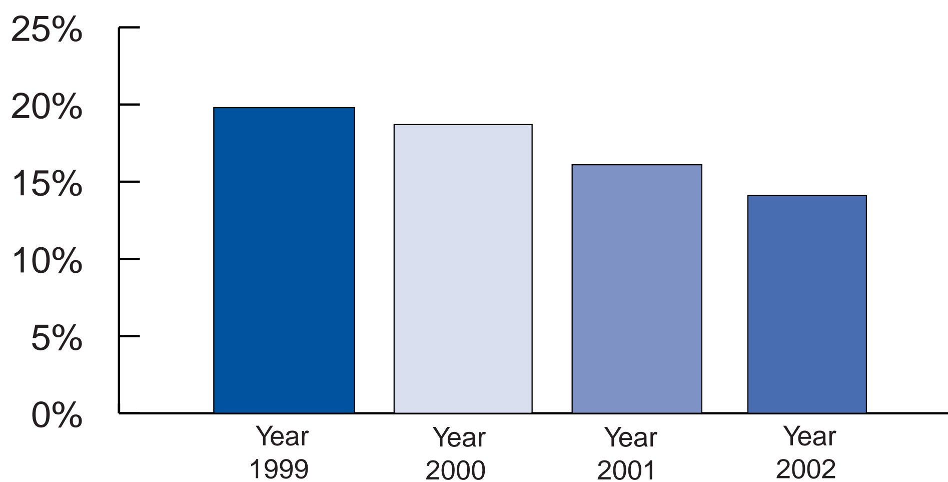
Mothers delivered:	
1996	1725
1997	1889
1998	1972
1999	2031
2000	2099
2001	2963
2002	3255



LSCS Rates:	
1999	24.1%
2000	24.4%
2001	22.3%
2002	25%

Primiparity:	
1999	41.2%
2000	43%
2001	42%
2002	40.4%

Instrumental Rates



Instrumental Rates:	
1999	19.8%
2000	18.7%
2001	16.1%
2002	14.1%

Caesarean Hysterectomies:	
1999	0
2000	2
2001	0
2002	1

Maire Milner MD MRCOG
Consultant Obstetrician Gynaecologist
Anne Keating
CNM3 Labour Ward

PERINATAL MORTALITY REPORT - 2002

1. 1st week Neonatal deaths:

Total	**10**
Anomaly	6
Unbooked:	0

2. Stillbirths:

Total:	**20**
Anomaly	3
Unbooked (all normally/formed)	5

Total Perinatal Mortality Rate: (>/=500g)

Uncorrected & unbooked:	20 + 10	or	30/ 3298 =
9.1/1,000			
Corrected & including unbooked:	17 + 4	or	21/ 3298 =
6.36/1,000			

Corrected /booked PNMR for OLLH Drogheda: 12+4= 16/ 3173 =5.04 / 1,000

The last published National Perinatal Statistics (ESRI) in 1999 reported a corrected PNMR of 5.7/ 1,000. In 2001, the corrected PNMR for the Coombe Women's, National Maternity (Holles Street) and Rotunda Hospitals in Dublin were 4.7, 6.26 and 6.1 per 1,000 births >/= 500grammes.

Perusal of the deaths will reveal that 34% of perinatal deaths were to non-national mothers, twice that expected on the basis of their proportion of deliveries (17%).

STILL BIRTHS

1. Unexplained

Primigravida, non-national, very little English, 21 years old. Booked at 25weeks, found to be anaemic (9g/dl) . Seen at 27 & then DNA until 34 +5 weeks. No foetal heart beat detected in ANC. Returned 3 days later in labour & delivered a stillborn, apparently normal male infant 1.985kg.

Autopsy declined

Placental histology showed nil significant

2. Unexplained Unbooked

30 year old primigravida, non-national with little English, booked in Sligo, attending for combined antenatal care there. Attended to OLLH at 30 weeks with absent foetal movements, & foetal heart absent. Labour induced over 2 days with prostaglandins, & had normal delivery of male infant weighing 1.02kg.

Autopsy showed normally formed macerated stillborn male infant

Placental histology unremarkable

3. Unexplained

Primigravida, 38 years. On thyroxine replacement following radioactive iodine for Grave's disease. Booked at 11w, scan= dates. Seen at 30 & 34w, all well.
Referred by GP at 35+2w, foetal movements not felt for 2 days. Foetal heart absent, intrauterine death on ultrasound. Prostaglandin induction, SVD of normally formed male infant 2.355kg
Autopsy showed normally formed macerated stillborn male infant
Placental histology was unremarkable

4. Unexplained Unbooked

Non-national, 21 years, no English, unbooked. Para 4 +0 One previous attendance, when possibly 28-30w, with abdominal pain, all well on ultrasound, for review 2 weeks later. Did not attend for further visits. Seen at query 33 weeks with pain, foetal heart absent, intrauterine death on ultrasound. Breech delivery of female infant 2.04kg with nuchal cord x 3, thick meconium, and a small retroplacental clot present. Went home against advice after delivery.
No Autopsy. Placental histology unremarkable

5. Unexplained

Personal patient, 38 years, Para 2, vaginal deliveries, alive & well. Uneventful pregnancy, attended at 38 weeks query foetal heart present, referred for CTG. Felt to be showing ominous decelerations, but maternal pulse in retrospect. Brought to Theatre for emergency LSCS, but scan carried out & foetal heart absent. **LFTs showed marked elevations in transferases & mildly elevated bilirubin**, normal platelets & renal function. Patient induced with prostaglandins, & proceeded to deliver a stillborn female infant weighing 3.275 kg. Referral to gastroenterologist, who reviewed all blood-work & noted "...consistent with mild-to moderate liver injury ...perhaps she had fatty liver of pregnancy"....
Placental histology unremarkable. Autopsy declined.

6. Unexplained

Para 2+3, two previous SVDs, 1989 & 1991. Consecutive miscarriages by 3 in the past. Personal patient, uneventful antenatal care. Admitted 24w with spotting: Anti-D given. Seen by GP with diminished movements, at 38w. Fetal heart auscultated on sonicaid. Attended elsewhere for CTG 3 days later, intrauterine death confirmed. Prostaglandin IOL, SVD of normally formed 2.2kg female infant. Autoantibodies negative
Autopsy: Possible intrauterine stress in lungs, histology non-supportive of this Placenta histology showed chorio-amnionitis, query significance, & acute villitis. TORCH screen negative.

7. Unexplained

35 year old para 3. Investigations for infertility & IVF for first pregnancy, twins 1997, full-term, caesarean section, 1 neonatal death at 4 weeks due to septicaemia.
Two subsequent term deliveries by c/section at 1998 & 2000, alive & well. Booked at 13 weeks, uncertain dates. Attended for combined care at 15, 20, 28, 30 & 32 weeks, & all well. Seen at 33weeks with absent foetal movements, stillbirth confirmed. Delivered by LSCS, macerated female infant 1.49kg, breech presentation.
Autopsy declined. Placental histology unremarkable

8. Unexplained

41 years old, para 6, all alive & well, vaginal deliveries. Booked at 11 weeks, unsure of dates. Had combined care in Louth County Hospital, seen at 12, 30, 34, 37, 39, 40+2 weeks. Liquor adequate at Term visit, given appointment for 1w later. Presented at Term + 5 days with no movements, foetal heart not detectable. Returned for induction with prostaglandins, normally-formed male infant weighing 3.85kg delivered normally.
Autopsy declined. Placental histology unremarkable.

9. Unexplained

34 years, Para0+0 Booked at 16weeks, scan=dates.
Seen at 28, 32, 36, 38, 39 and 40 +5w. At 40+5w, liquor volume normal, cervix unfavourable, foetal movement chart given.
Seen at 40+10 by appointment in foetal assessment unit, liquor volume normal, CTG reassuring, induction booked for next day.
On presentation next day, foetal heart absent, intrauterine death on ultrasound.
SVD of infant weighing 4.2kg, significant shoulder dystocia requiring 2 manoeuvres
Autopsy declined
Placental histology showed early chorio-amnionitis, with some age-related changes of placenta, i.e. oedema & congestion, query significance

10. Unexplained

Para1, 28years, LSCS, for PET at 40w,
Personal patient. Booked at 14w, seen 14, 15, 24, 28, & 32w
Presented at 34 weeks with diminished foetal movements, intrauterine death confirmed on ultrasound, no liquor, baby measuring 29w.
Failed prostaglandin induction, LSCS 1.22kg male infant.
Autopsy: normally formed male infant, maceration, no other anomaly
Placenta histology showed some broadening & fibrosis of chorionic villi, query significance

11. Unexplained/Chronic hepatitis & HIV positive Unbooked

26year old Para 2 non-national, 1998 & 2000, birth-weights unknown, alive & well. Initial contact was from St James' STI unit, patient booked in Galway, attended St James' from 28 weeks, known to be HIV & Hepatitis B positive, moved to Drogheda & we were asked to take over her care. Patient was telephoned by ANC staff several times over next few days, did not attend, until 32+3 weeks 'itching all over', inability to sleep. She had ceased to take her antiretroviral treatment. On presentation, the patient was jaundiced, and foetal heart not detected. All LFTs & bilirubin levels elevated consistent with chronic hepatitis. Induction with prostaglandins & delivered of a female infant weighing 1.6kg.
Facilities for Autopsy in face of risk of infection not available
Placental histology unremarkable.

12. Unexplained / Sickle cell disease

32 years old non-national, Para 1 + 0. (LSCS for breech, 41w) Booking weight 105kg. Known Sickle-cell carrier. Unsure of dates, 21 day discrepancy scan & dates. Booked at 19w, attended 28, 35, & 37w. Random sugar 5.1 at 35w when glycosuria++.
Presented 39w in early labour, intrauterine death on ultrasound, SVD 2.6kg male infant HbA1c 7.6 (4.5- 7.5).
Histology of placenta showing 'extensive cell sickling in intervillous spaces...patchy acute villitis....sickle cell disease a likely factor'
Autopsy showed normally formed infant with 'evidence of intrauterine stress in lungs....sickle cell disease may have been a factor, but evidence is not conclusive'

13. Placental infarct/ possible abruption and transplacental haemorrhage

39 year old lady, Para 5, all alive & well, last baby 1996, 2 subsequent miscarriages. Booked at 9 weeks, ultrasound gave three week earlier EDD. Attended 20, 27, & 38weeks. All well at 38+3 weeks, but reattended 5 days later with no foetal movements. Induction carried out, delivered of stillborn female infant, 3.17kg, apparently normally-formed. Some evidence of abruptio placentae (organised moderate-sized clot) at delivery & histology showed a 3cm infarct in placenta. Kleihauer test was also positive at 5/high power field, indicating transplacental bleeding.
Autopsy declined **Placental histology 3cm infarct**

14. PET

30 years old Para 2 non-national: 1 previous c/section, 1 svd in Africa, weights unknown
Booked at 15w, scan=dates, seen at 23& 29w. GTT because of glycosuria, normal. Seen at 33w, 145/95, 1+proteinuria, admitted. Bloods and scan normal and growth above 5th centile. 24-hour urine collection 1037mg/ 24hours. BP settled at 140/90. MSU showed UTI, allowed home on oral antibiotics. Seen 8 days later in Day Unit with BP 140/95-105, proteinuria +3, EFW 2kg, liquor plentiful. Exhorted to come in but declined, assured she would come for admission next day. Telephoned by Ward sister. Arrived on ward 2 days later, no foetal heart beat detected, now 35weeks. Prostaglandin 2mg given twice, further 1mg given 1 week later, eventually delivered 38w by LSCS.
Autopsy declined **Placental histology showed fibrous tissue of chorionic villi & intervillous fibrin, possibly PET-induced.**

15. PET/placental abruption Unbooked

30 year old non-national (booked in Dublin) Para3, unbooked, gestation unknown, no notes. Transferred by ambulance from Louth County Hospital, with abdominal pain, clinically concealed major abruptio placentae with foetal heart absent. Significant DIC- managed in conjunction with haematologists, St James'Hospital. Transfused with red cells, cryoprecipitate. SVD within hours of normally formed male infant 2.14kg with large retroplacental clot & large PPH (1500mls). Placenta 370g with 3cm infarct
Autopsy declined

16. Placental abruption Unbooked

Para 0+1 29years, non-national. Unbooked. (Booked in Dublin). Presented with severe PET, multiple fibroids, bleeding & discomfort over a weekend. Ultrasound 843g, large anterior fibroid filling lower uterus, dexamethasone & pethidine given. Transferred to delivery suite 36 hours later, foetal heart absent, transverse lie, clinically major abruption. LSCS, fresh stillborn male infant, with retroplacental haemorrhage. Mother managed in ICU for 7 days with severe hypertension requiring nitroprusside, renal failure, pulmonary oedema, eventually recovered.
Autopsy not carried out
Histology of Placenta was consistent with accidental haemorrhage

17. Placental abruption

21 year old primigravida. Booked for combined care at Louth County Hospital at 24 weeks Scan= dates. Seen at 32 weeks, BP 135/85, U&E & LFTs checked & normal. Asked to return 2 weeks later, but day prior to visit at 34w, sudden onset of pains. Presented to Louth County Hospital, referred to OLLH. Bleeding on arrival, no foetal heart detected, ARM carried out. Epidural was inserted, the patient decompensated & had not progressed in labour. Emergency LSCS was carried out, abrupted placentae with couvelaire uterus found, & stillborn male infant weighing 2.495kg delivered. She was managed postnatally in ICU.
Autopsy not done. Placental histology was unremarkable

18. Anencephaly

29 year old Para1 +1 Normal delivery at 39w 1994: Booked at 10w, scan=dates. Seen at 13, 27, 33, 37, 38w. At 38+5w, examined vaginally, head not felt and scan carried out when diagnosis of anencephaly made.
Prostaglandin induction, face-to-pubes delivery of 6lb 14oz male infant
Autopsy not carried out

19. Patau's syndrome

38 years old Para 2 +1. Previous c/sections x 2. Booked at 17+w, abnormal head shape and cardiac views. Karyotype, Patau's syndrome/trisomy 13. Seen 2-weekly, at 33w liquor diminished with foetal tachycardia & poor prognosis explained. Presented 5 days later with contractions, intrauterine death & c/section carried out. Female infant 1.75kg
Autopsy not carried out
Placental histology showed acute villitis only

STILL BIRTHS.....

20. Anencephaly

Para 1+ 1, 37 years. Had one child, ventouse delivery, 7lb 11oz. Smoker, asthmatic. Booked at 15w, ultrasound with vaginal probe in view of maternal habitus. Diagnosis of foetal scoliosis + query exencephaly, same confirmed. Possible amniotic band syndrome. Progressed to anencephaly with polyhydramnios, seen on a 2-weekly basis. Presented with SROM at 32weeks, progressed to SVD of female infant 1.33kg.

Placental histology showed chorioamnionitis

No Autopsy

NEONATAL DEATHS

1. Hydrops Down syndrome

Primigravida 33 years, booked at 12 weeks, scan= dates. Further scan at 23+ weeks normal. Seen at 20 & 28 weeks, attended at 37 weeks with diminished foetal movements. Ultrasound by the registrar suggested query pleural effusion/cardiac anomaly/diaphragmatic hernia. Poor CTG, situation discussed & proceeded to LSCS. A hydropic female infant weighing 4kg in poor condition, clinically features of Down syndrome delivered.

2. Anencephaly Unbooked

27 years, non-national, unbooked (attended in Limerick), arrived by ambulance 0300hours with SROM. Gestation unclear, query 35 weeks. No presenting part in pelvis, scanned by registrar & anencephaly found. Limerick telephoned, diagnosis confirmed. Hepatitis B positive. Became pyrexial next day & delivered a male infant 1.28kg.

3. Encephalocoele

36 years old Para 2, SVDs x 2, both at 41 weeks. Both children alive & well. Subsequent miscarriages at 7 & 17 weeks in 2000 & 2001. Booked at 6 weeks, wished to have progestogens but explained not evidence-based. Followed 2-weekly, head-shape not normal at 14-week scan, confirmed large encephalocoele. Seen 2-weekly for remainder of pregnancy, developed hydramnios & lie remained unstable. Required LSCS at 41 weeks as lie remained oblique. Female infant weighing 2.8kg with large encephalocoele & poor respiratory effort delivered. Apgar scores 2, 1, & 0 at 1, 5, & 10 minutes.

4. Patau's syndrome

Personal patient, Para 1, 39 years, nil of note in past history.
Antenatal scans: 12 weeks normal, 15 weeks increased nuchal thickening. At 20 weeks, ventriculomegaly, and thickened area posterior to the cisterna magna.
Apgars 8 & 9 at 1 & 5 minutes, weighing 2.85kg.
Karyotyping demonstrated Trisomy 13.

5. Urethral agenesis/Hypoplastic lungs

Booked at 24 weeks, distended fetal bladder & bilateral hydronephrosis: ?Urethral agenesis. Confirmed in Rotunda, together with reduced thoracic diameter query pulmonary hypoplasia. Attended in labour at 31 weeks, breech presentation, & decision made for LSCS. Female infant 1.5kg delivered. Intubation, surfactant given.

6. Imperforate anus/cardiac

Primipara, 2 previous miscarriages. Booked at 16 weeks, seen at 28 weeks by consultant, uss for reassurance NAD. Seen at 34 weeks, exposure to varicella, found to be immune. Admitted at 37weeks in spontaneous labour, rapid labour & SVD, male infant 2.68kg.

7. Previable

Non-national Para 4, 3 x LSCS, all in Africa. Booked at 15w, scan=dates. Presented at 21 + 6 with bleeding, membranes bulging. Delivered later that night of male infant weighing 500g.

8. Hypoxic Ischaemic Encephalopathy

Primigravida, 28 years booked at 11 weeks, scan=dates. Uneventful CANC to term+6 days, liquor plentiful & cervix effacing. Referred to MDU at term+10, liquor diminished, one 3cm pool only. Prostaglandin induction. Next day, Bishop scores of 4 & 5 at 0600 & 12midday respectively, CTGs reactive. Established in labour, 1545 in labour ward. Foetal heart auscultated with sonicaid & satisfactory, CTG not carried out. Head visible 1820 hours, 1923 hours SVD of live male infant 3.66kg, nuchal cord loose & fresh meconium present.

9. Query Simpson-Golabi- Behmel Syndrome Query asphyxia

19 years old Primigravida, booked at Louth County Hospital Dundalk at 17w, scan= 19 weeks. CANC to 41 weeks, uneventful. Hb 9.9g/dl at 37 weeks. Assessed at 41 weeks in ANC, liquor adequate, cervix reasonable. Scheduled for induction at 40+8 days by scan. Bishop's score 3, Prostaglandin 2mg & 2mg given at 2200 & 0630 hours, CTGs excellent. ARM at 1600 hours, 3 cm dilated, clear liquor, oxytocin commenced at 1915 hours. CTG baseline 155/min, very reactive with accelerations. Fully dilated at 0000hours. Active pushing commenced 0100 hours, CTG continued satisfactory, assessed at 0200hours as presenting part not visible. Head high & vaginal delivery not possible, proceeded to LSCS. Continued on CTG after transfer to theatre, & foetal tachycardia 170-180 (but reactive) developed. Epidural topped up but at 0258 said to be inadequate & GA administered. Baby delivered at 0307, apgar of 3 at 1minute.

10. Mitochondrial Chain Defect

Primigravida, booked in Louth County Hospital at 14 weeks, 27 years. Parents first cousins, family history of mental handicap. Uneventful CANC to 37 weeks. Presented at 38+4 weeks with no foetal movements for 48 hours, & bradycardia on scan at 70/minute. Counselled by consultant regarding possible adverse outcome, but expeditious delivery by LSCS of female infant weighing 3.1kg.

Maire Milner MD MRCOG
Consultant Obstetrician Gynaecologist

DEPARTMENT OF NEONATOLOGY

ACTIVITY LEVELS

In-Patient:

The number of admissions, readmissions and transfers from other hospitals are outlined in Table 1.

Table 1:

	2002	2001
Total number of admissions	496	528
Number of baby days	5251	5566
Average number of infants per day	14.4	15.3
Level 1 (ICU) days	455	386
Level 11 (High Dependency) days	935	960
Level 111 (Special Care) days	3861	4210
TPN days	511	557

Table 2: Transfers in and out of NICU:

	OUT = 30	IN = 23
Crumlin	16	9
Temple Street	5	3
Holles Street	4	4
Rotunda	2	4
Coombe	2	2
Dundalk	0	1

- Of the 53 transports, 11 were carried out by the National Transport Team

Out Patient Clinics:

2 out patient neonatal clinics per week are held within Our Lady of Lourdes Hospital. These included:-

• NICU review clinic:	Room 109: Number of patients reviewed	364
• Developmental Clinic:	Number of patients reviewed	376
Total		**740**

26 infants required review in an OPD in our Lady's Hospital Crumlin and Temple Street.

NEONATAL MORTALITY

There were 10 Neonatal deaths (Table 3). Six (60%) had a major congenital malformation. Two of these infants with congenital defects were not admitted to the NICU, but remained in the Labour Ward with the parents.

Of the remaining five infants, one was pre-viable at 22 weeks (500g) gestation and was not resuscitated at birth, but was included in our figures. One further preterm (22 weeks gestation, 560g) infant was born and died before arrival and was not included in the figures. Three further infants were critically ill from birth. One died on day four of life and had features of hypoxic ischaemic encephalopathy. Another infant, born with poor Apgar scores, failed to respond to resuscitation in the labour ward. The final infant was born at term and was critically ill from birth. He died at four days of age and post mortem diagnosis was of a rare metabolic condition called a respiratory chain defect.

In summary, the Neonatal Mortality figures for Our Lady of Lourdes Hospital Drogheda for 2002 were as follows:-

- Neonatal Mortality Rate 3.04 / 1000
- Corrected Neonatal Mortality Rate 2.1 / 1000

Our Neonatal Mortality figures compares favourably with the figures for southern Ireland. The most recent figures available for Ireland are for 2001 and were presented at the 2002 Irish Perinatal Society (K Muthalaly, S. Gormally, Irish Journal Med Science 2002). The Neonatal Mortality rates for Ireland (2001) are as follows:-

- Neonatal Mortality Rate 3.9 / 1000
- Corrected Neonatal Mortality Rate 1.2/ 1000

On examining the causes of death, there was an increased incidence of Lethal Congenital Defects, compared to the national average (Table 4). The asphyxial group accounted for 20%, greater than the national average. However this is difficult to interpret because of the small number (two babies).

Vermont Oxford Database

From January 2003, all NICU data is being entered into the Vermont Oxford Database in a prospective manner. Therefore the 2003 Annual report will contain an in depth analysis of NICU activity and outcome figures (both in terms of mortality but also morbidity).

As part of the Oxford Neonatal Network we will be in a position to compare our mortality and morbidity figures against Units of similar size in Ireland and across the USA, for 2003.

Table 3:

Birth Weight	Gestation	Delivery	Apgar	Age at death (approx)	Cause of death
1. 4000g	37	Em. LSCS	11,35, 510	29 hours	• Down's syndrome • Hydrops fetalis • Parvovirus infection
2. 1280	35	SVD	11,11,010	10 minutes	• Anencephaly
3. 2820	Term	Elec. CS	21, 15		• Large encaphalocoele
4. 2850g	39	SVD	81, 95	Day 18	• Pataus syndrome
5. 1500g	31	Em. LSCS	31, 510	3 hours	• Renal dysplasia • Megaureters • Hypoplastic lung
6. 2680	37	SVD	91, 105	Day 2	• Imperforate anus • Persistent fetal circulation • Malrotation of intestine • Pneumonia
7. 500g	22	SVD	-	-	• Previable
8. 3660g	Term	SVD	2!,45,510	Day 4	• Hypoxic Ischaemic encephalopathy
9. 4550g	Term				• Flat at delivery • Unresponsive to resuscitation • Hypoxic ischaemic encephalopathy • ? Simpson Golabi Behmel syndrome
10.3100g	38	Em LSCS	11,15,110	Day 4	Respiratory Chain Defect

Table 4:

	Drogheda 2002	Irish Data 2001
Congenital defects	60%	39%
Prematurity	10%	30%
Asphyxia	20%	12%
Other (including not stated)	10%	19%

Dr. Siobhan Gormally
Consultant Neonatologist and Paediatrician

MATERNAL DEATH (LATE)

One Patient

Age 33, non-national Lady, single, Para 2. Two previous SVDs in Africa, 1992 & 1997. Birth weights unknown. Known asthmatic on medication. Attended a Dublin Hospital with goitre in July, compression of Trachea on X-ray, not for surgical intervention in pregnancy.

Booked at 39 weeks, previous scans in two other Irish Hospitals at 12 & 28 weeks. Sickledex positive & mild anaemia. Presented with history of SROM at 40 weeks 22 hours earlier. Had a normal delivery, of a male infant weighing 3.42 kg. Septic screen negative on baby and went home on day 2.

Came to Casualty and admitted 3 months post delivery with acute asthma, but discharged herself against advice. Was brought in dead to Casualty at OLLH on evening of next day.
Coroner's autopsy:
1. Consistent with acute asthma.
2. Multinodular goitre.

RUPTURED UTERUS (THREE PATIENTS)

1.

Age 32, booked in Louth County Hospital at 12 weeks, scan= dates.
Para 7 + 1. One previous LSCS.
Admitted at 32 weeks with small APH
Came at 36 weeks with pains. Continued over two days, brought to theatre for LSCS. The uterine scar had ruptured, & the baby's hand was coming through.
2.42kg, female infant, apgars 3 & 7 at 1 & 5 minutes. Family planning organised postnatally.

2.

Age 19, booked in Louth County Hospital.
Para 2. One previous LSCS.
39+6 weeks, arrived in labour. LSCS for foetal distress. The uterine scar had ruptured, & the baby's ear & cord were coming through.
2.78kg, male infant, apgars 9 & 10 at 1 & 5 minutes.
Arterial ph 7.26
Venous ph 7.35
Family planning discussed postnatally.

3.

see Caesarean Hysterectomy, next page

CAESAREAN HYSTERECTOMY (ONE PATIENT)

Age 27, Para 2, previous LSCS x 2 for eclampsia & severe PET respectively.
In hospital on- &- off from 23 weeks for APH/placenta praevia.
Elective LSCS for anterior placenta praevia at 37+6 weeks, counselled regarding risks of caesarean hysterectomy preoperatively. At operation, large haematoma visible over lower segment, consistent with a silent rupture. Placenta found to be accreta, extensive bleeding at LSCS. **Transfused 10 units of blood products.** Bleeding seemed to settle, sent to ICU. Returned to theatre 4 hours later, hysterectomy carried out. **Transfused further 20 units of blood products.**
Histology confirmed a rupture of the uterine scar.
The patient made a full postoperative recovery.

IN-UTERO TRANSFERS

The issue of interhospital transfer is nowhere more relevant than to the North Eastern Health Board, where maternity deliveries have been suspended on two hospital sites. This has had major implications, primarily for patients & their families, but also for health care providers inside & outside the region. All healthcare facilities which may deal with obstetric patients should have procedures in place for coordination of emergency interhospital transfers, so that access to regional & tertiary perinatal centres can be simplified, appropriate clinical decisions about transfer requests are facilitated, & senior advice is given for complex problems. Since 2001, all in-utero transfers to and from Our Lady of Lourdes hospital are arranged/accepted through a consultant only. At the time of writing, a protocol on such transfers has been drawn up by a multidisciplinary group within the NEHB & is in the advanced stages of agreement.

1.Transfers into OLLH 2002

There were 35 women transferred in 2002; 27 from Louth County Hospital Dundalk, 6 from Cavan, & 2 from Dublin hospitals. The reasons for transfer were as follows: labour/ threatened labour (13, of whom 5 preterm), PPROM (2), PET (7), APH (3), already delivered (2), diminished FMs (2) & medical/surgical problems (6). Of the 35, 18 were <37weeks, & 31 had delivered within 72 hrs of arrival. There were 8 babies weighing <2.5kg. There were higher proportions of teenagers (6/17%) & primigravidas (19/54%) than in the hospital population.

2.Transfers out of OLLH 2002

There were 5 women transferred in 2002, all to Dublin maternity hospitals; two because of hydrops, at 33 and 31 weeks. A twin pregnancy at 23 weeks with SROM was eventually transferred back and delivered here. There was one transfer at 32 weeks with PET as there was no NICU cot available, and a diabetic patient booked in Dublin who was admitted here with dyspnoea was transferred back at her request.

MULTIPLE PREGNANCY

Total number 43 (1.32%)

Twins: 42	**Triplets:**	**1**
Perinatal deaths:		None
Non-national rate:	8/43=	18.6%
Prematurity rate <34 weeks:	9/43=	20.9%

Gestational age (weeks)	
<28	1
28-31	1
32-36	15
37+	26
Total	**43**

Birthweight (kg)	
>2.5	36
2-2.49	35
1-1.99	15
<1k	1
Total:	**87**

Parity:		
Para 0:	10	23%
Multiparous:	33	77%
Para 1:	17	
Para 2	11	
Para 3	4	
Para >/=4	1	
Total	**43**	

Maternal Age:	
> 35y	10
30-33y	23
<30y	10
Total	43

Caesarean Section: 20 (46.5%)

Indications for LSCS:	
Twin 1 breech:	8
Nonreassuring CTG in labour:	3
Placenta praevia:	2
APH:	2
Previous lscs	1
Twin-twin transfusion:	1
Hydramnios in one sac:	1
Triplets:	1
LSCS for Twin 2 (brow presntn):	1

There were no perinatal deaths in twins or triplets in 2002. The nationality profile of mothers with multiple pregnancy mirrors that in the hospital population, while the older maternal age & higher parity profile is in keeping with multiple pregnancy. The prematurity rate is in line with that reported in other series.

The caesarean section rate is rather lower for multiple pregnancy than reported elsewhere. Our 2002 series were almost all rather advanced in gestation, however, with only two sets below 32 weeks. There was only one instance of caesarean section for second twin, because of brow presentation in a baby which weighed 2.84kg.

VAGINAL BREECH DELIVERY

Second twins:		**8**
Neonatal Death	500g	1*
Unexplained stillbirth	2.04	1**
Unexplained stillbirth	1.02kg	1**
Total		11

* see neonatal deaths
** see stillbirths

Trial of vaginal delivery for the mature singleton normal infant presenting by the breech is no longer offered at this hospital, in line with recent studies and practice elsewhere.

Maire Milner MD MRCOG
Consultant Obstetrician Gynaecologist

ANTENATAL OUTPATIENT SERVICES

	Antenatal	Postnatal
Our Lady of Lourdes Hospital		
No. Sessions	442	43
New Patients	2017	0
Reviews	9990	376
Total	12007	376
Louth County Hospital		
No. Sessions	101	0
New Patients	477	0
Reviews	1983	0
Total	2460	0
***Navan Outreach Clinic (commenced 18th November 2002)**		
No. Sessions	5	0
New Patients	38	0
Review	5	0
Total	43	0

OUR LADY OF LOURDES OUTPATIENT CLINICS

The outpatient department provides quality antenatal and gynaecological services to the women of the region.

We aim to:
* Empower women who attend, regarding their overall health.
* Meet the expectations of the clientele availing of the service.
* Provide an efficient service that is safe, accessible and woman centred (National Health Strategy 2001).

Outreach Antenatal Clinic Services

Mosney	Developed as a result of need for midwife led booking session for refugee/ asylum seekers in advanced pregnancy.
Navan	Growing center of population.

NAVAN ANTENATAL CLINIC

This clinic, innovated in 2002, was established in response to a number of factors, including the increasing numbers of women from the Navan area attending Our Lady of Lourdes Hospital, Drogheda for ante-natal care, limited space on the Drogheda site and in response to the recommendations of the Kinder Report (2001)

The clinic is housed in the North Eastern Doctor-on-Call prefab on the campus of Our Lady's Hospital, Navan. Three rooms are currently available for use. Clinic times are 10.00 - 13.00 hours each Monday. The clinic is staffed jointly by Drs. O'Coigligh and Doyle, who attend the clinic on alternate Mondays. The Consultant is accompanied by his/her respective SHO and Registrar. Midwifery staffing consists 2 midwives from the ante-natal clinic, Drogheda.

ANTE NATAL INFECTION IN PREGNANCY

HIV Positive: 4 delivered their babies in Our Lady of Lourdes, 1 miscarried and 4 transferred to other hospitals. *Country of origin:*	**9 Booked antenatal care.** Nigeria South Africa Kenya	 7 1 1
Hepatitis B Positive: *Country of origin:*	**17 Patients** Nigeria Zimbabwe Ghana	 15 1 1
Hepatitis C Positive *Country of origin*	**1 Patient** Ireland	
Syphilis *Country of origin*	**1 Patient** Russia	

DIVERSITY OF NATIONALITIES ATTENDING ANTE-NATAL CLINIC IN 2002

Albanian	Ghanian	Portuguese
Amercian	Indian	Romanian
Angolan	Irish	Russian
Australian	Iranian	Scottish
Belgian	Ivory Coast	Sierra Leonese
Bosnian	Kenyan	Slovakian
Cameroon	Latvian	Spanish
Canadian	Lithuanian	South African
Chinese	Malaysian	Thai
Congolese	Nigerian	Togolese
Czech	Pakistani	Ukranian
English	Filipino	Venezuelan
French	Polish	Welsh
		Zimbabwean

UNIT 2 POSTNATAL WARD

2002 Service Activity Levels

- Bed capacity = 30
- Bed occupancy (Unit 1 & Unit 2 combined) = 88.2%
- Average length of stay = 3.1 days
- Teenage pregnancy rate = 6.1% of total no. of mothers delivered.
- Breastfeeding Initiation rate = 52% Discharge rate = 49%

- PKU sampling at weekends (PHN's not available in community) = 452
- Infants requiring HB Electrophoresis = 15
- Hepatitis B Positive Mothers = 16
- Hepatitis C Positive Mothers = 3
- HIV Positive Mothers = 3

Assessment & Re-Admission rates 2002	ASSESSMENTS AT WARD LEVEL POST DISCHARGE		RE-ADMISSIONS	
April- July 2002	22	2.0%	25	2.3%
Oct-December 2002	50	4.3%	20	1.7%

% Total number of deliveries.

UNIT 2 POSTNATAL WARD.....

Targets attained

- Provision of a quality standard of care to antenatal and postnatal patients during periods of high activity and increasing bed occupancy rates.
- Outpatient returns assessed at ward level post discharge up to six weeks post delivery.
- 24-Hour telephone support to parents post delivery.
- Occasional transitional neonatal care carried out at ward level.
- Expertise of three Lactation Consultants and one Breastfeeding Clinical Nurse Specialist.
- Involvement in the Annual Bereavement Service.

- **Evaluation of Service**
  Quality care questionnaire
  Maintenance and auditing of statistics on teenage pregnancies, infectious diseases, infants admitted to NICU and re-admissions.
  Recording of Daily Unit Activity
  Feedback from parent craft reunions
  Clinical Governance meetings

Ann Marie Connor
CMM2 Postnatal Ward

FOETAL ASSESSMENT UNIT/ MATERNITY DAY UNIT

Ultrasound Scans

Total Ultrasound scans in 2002: 5785

Inpatients:	1079
Outpatients:	4100
Day Unit	606
Total	**5785**

Maternity Day Unit

Total number attending 2002: 1389

CTG monitoring:	839
Scans (see above)	606
BP monitoring	259
GTT	337
Varicella Zoster vaccination	6
Total	**1389**

The FAU/MDU Department is located in the Maternity unit, and provides obstetric ultrasound scanning for inpatient & outpatient activity, & other intermediate care on an outpatient basis for women whose pregnancy has deviated from the normal. The work is carried out in two rooms, staffed by three full-time midwives, with an office staffed by a full-time secretary. A protocol for the management of post-dates pregnancy was agreed & introduced in December 2001 in line with the RCOG recommendations. There has been increasing involvement by medical staff, both Consultant and NCHD in foetal assessment/biophysical scoring/liquor volume, to allow conservative management of the post-dates scenario to 10 days post term.

Winifred Barkey
Foetal Assessment Unit

RCSI /ACADEMIC LINKS

The department of obstetrics and gynaecology was approached by Professor Harrison in 2001 with regard to the inclusion of Our Lady of Lourdes hospital in the undergraduate teaching programme of RCSI. The appointment of a lecturer at registrar level, who would participate in teaching but continue a level of clinical work commensurate with training was proposed to the North Eastern Health Board. The Human Resources' department was highly supportive, and the post came into being on January 2002. The first incumbent of this post, Dr Mukhtar innovated the Early Pregnancy Assessment Unit, which is now well-established and is appreciated by the patients it serves.

There are thrice-yearly intakes of fourth-year medical students from RCSI, who join the Department for 6-week periods. Organisation of their attachments, Tutorials, & clinical teaching on the wards are all part of the Lecturer's remit, in conjunction with Dr Milner and the other consultants. This post is not currently accredited/recognised for higher training, although it is hoped that this will be in the future. The students are made very welcome by patients and staff, and have we believe found their stay with us both enjoyable and fruitful. We are grateful to the support of RCSI and Professor Harrison, and are hopeful that these links will in the near future be further strengthened by designation of Our Lady of Lourdes as a teaching hospital.

Maire Milner MD MRCOG
Consultant Obstetrician Gynaecologist

DEPARTMENT OF GYNAECOLOGY

The provision of gynaecology services in the Louth-Meath Hospital Group in 2002, as in other years, has been contingent on access to elective theatre time. The majority of gynaecology workload is elective in nature and therefore tends to suffer when emergency work impinges on available theatre time. The transfer of trauma to the Lourdes Hospital site has therefore had a predictable knock-on effect on gynaecological elective surgery.

There is a policy in the unit of limiting the number of new patients seen in Outpatients depending on operating capacity, in an effort to maintain a reasonable waiting time for procedures. This has resulted in a referral to outpatient review time of up to 6 months.

In 2002 there were 227 gynaecology outpatient sessions.

New patients	1,020
Review patients	2,663
Total	**3,683**
Day Cases totalled	1,020

Gynaecological Theatre Activity 2002

Laporotomy

TAH	41
TAH BSO	64
TAH BSO Omentectomy	1
Subtotal Hysterectomy +/-BSO	8
Salpingo-oophorectomy: single or bilateral	17
Ovarian Cystectomy	12
Laparotomy/ various	30
Laparotomy/Ectopic	12
Myomectomy	5
Appendicectomy	2

Laparoscopic

Laparoscopic TL	38
Open TL	2
Operative laparoscopy	14
Laparoscopic management of ectopic	4
Laparoscopy/+/-& dye	103
Laparoscopy + Hysteroscopy	21
Appendicectomy	1

DEPARTMENT OF GYNAECOLOGY.....

Vaginal

Procedure	No.
Vaginal hysterectomy	32
Vag Hysterectomy + repair	31
Pelvic Floor Repair	14
Anterior Repair	14
Posterior Repair	6
Manchester Repair	2
ERPC	347
Hysteroscopy D+C	299
Hysteroscopy D+C/insertion of Mirena	36
Insertion of Mirena	3
LLETZ	88
Thermal balloon	5
Cervical Suture	6
Diathermy to cervix	6
Colposcopy	2
Cystoscopy	9
EUA	11
Transvaginal Tape (TVT)	4
Division Vaginal septum	1

Vulval

Procedure	No.
Bartholin's abscess/cyst	26
Diathermy to warts	5
Excision of vulval lesion/biopsy	6
Excision of vaginal lesion/biopsy	5
Refashioning of perineum/granulation	7

Return to OT

Procedure	No.
Re-open for bleeding/haematoma	7
Re-open for drain tip	1
Dehiscence	2
Refashioning of scar	3

Early Pregnancy Assessment Unit

The early pregnancy assessment service commenced in April, 2001. It was transferred to a dedicated unit within the confines of the gynaecological unit in May 2002. Demands on the service increased dramatically with the closure of Dundalk and Monaghan Maternity units. This service was set up to streamline the care of women with bleeding in early pregnancy and to avoid unnecessary out-of-hours attendances and admissions. The provision of such a service tends to increase the number of early pregnancy scans being performed.

The nature of the service encompasses assessment, transvaginal/abdominal sonography
and a care plan for all women who have complications in early pregnancy. The management of such complications in a unit of this nature has dramatically reduced the need for women to be hospitalised, thus reducing bed occupancy and length of stay.

The informed and individualised management decisions and availability of support for each patient both at the time of miscarriage and afterwards is a very positive development for the women of the North East.

There were 1,499 attendances in the EPAU in 2002 with 413 miscarriages being recorded. The discrepancy in numbers is partly due to the fact that not all attendees subsequently miscarry, but also that a proportion of these women have more than one scan. This service is greatly appreciated by those who attend it, not least because of the sensitive way in which they are treated by the dedicated staff.

The Consultants would like to express their thanks to all staff from the Outpatient Department, Wards, Bed Management, Waiting List Office, Theatre as well as Physiotherapy and Radiology who work so hard, often in difficult circumstances, to enable us to provide a Gynaecology service to women in the Louth-Meath area.

Dr. S. O'Coigligh
Consultant Obstetrician/Gynaecologist
Mary Sweeney
CNM2 Gynae Floor

DEPARTMENT OF GYNAECOLOGY.....

Day Services, Louth County Hospital

In an effort to provide as effective a service as possible four Consultants undertook the provision of Daycase surgery in the Louth County Hospital. This proved very successful and the work undertaken by all staff in organizing and running this service is very much appreciated by the patients cared for. A total of 714 patients underwent a total of 724 daycase procedures in theatre during the year. Of these 337 had pre-operative assessments done in Dundalk.

The Gynaecology clinic in Dundalk has of course continued to be busy with 229 new patients being seen during the year and 774 return patients being reviewed.

Operating Theatre - Louth County

The theatre department in the Louth County Hospital is committed to achieving health and social gain and improving the health status of the population of the region. With the commencement of gynaecological day case lists we have been successful in providing an efficient service. This has been achieved through team effort by medical, nursing, and administrative personnel. Our vision for the future is to increase activity, shorten waiting lists and times and provide an ongoing quality service for both providers and the patients.

January 2002 -	December 2002
LLETZ	60
Hysteroscopy	193
D&C	202
Laparoscopies	83
Laparoscopies & Dye Test	18
Insertion of Mirena	47
Colposcopies	63
Smears	21
Laparotomy	2

Siobhan Lines, Theatre Sister
Louth County Hospital

COLPOSCOPY SERVICE

Currently, Our Lady of Lourdes Hospital provides the only colposcopy service in the whole of North Eastern Health Board. As in other years, there was only one clinic a week in 2002 served by one consultant - Dr Finian Lynch and a colposcopy nurse, Karen Clinton, who has continued to provide personal and supportive care for our patients despite various other hospital commitments. Excellent secretarial support is an integral part of the service.

In the year 2002, a total of 186 new referrals attended the colposcopy clinic compared to 100 in 2001. The various indications for referral and number of cases requiring treatment are shown in Table 1.

Table 1: Cytological indications for referral to the clinic and the number of cases treated by LLETZ in 2002.

Indications	First Visits	Number treated by LLETZ
CIN 1/BNA	48	20
CIN 2	36	25
CIN 3	65	62
Unsatisfactory smears	24	3
Suspicious Cervix	11	0
Cervical Polyp	2	2
Total	186	112

Table 2 details the histological breakdown of reports of LLETZ biopsies processed and reported in our laboratory in 2002. The number of normal or negative biopsies stood at 7 out of 112 specimens or 6.25% which is well below the recommended standard of 10% by the British Society of Colposcopy and Cervical Pathology (BSCCP). The bulk of the cases referred to the service were high-grade neoplasia (CIN 2/CIN 3) which accounted for over 75% of the cases. However the actual numbers of invasive and micro-invasive diseases detected were small at one each or 0.89%.

Table 2: histological analysis of the LLETZ Biopsies.

HISTOLOGICAL ANALYSIS OF LLETZ BIOPSIES

Normal	7 ((6.25%)
CIN 1	16 (14.29%)
CIN 2	25 (22.32)
CIN 3	60 (53.58%)
Glandular neoplasia	2 (1.78%)
Micro invasion	1 (0.89%)
Invasive neoplasia	1 (0.89%)
Total	**112**

Computer audit and image management systems have been installed. However, owing to staff constraints, it has not yet been possible to store and retrieve relevant reports from these systems. For the unit here to run effectively as the regional centre that it is, the appointments of a full time colposcopy nurse and a secretary are neccessary. This would be in keeping with the recommendation by the National Cervical Cancer Screening Committee. Irrespective of shortcomings, the team led by Dr Lynch deserve praise for their results.

The unit is indebted to our Pathologists, Drs Leonard McDonnell and John Ryan as well as the Cytologist Sonja Aylward who continue to produce their reports within record times. Also special thanks to Malachy Stringer, whose IT skills have facilitated retrieval of histology reports from the database.

I joined the team only in April 2003, and so had no input to the service in 2002 apart from writing this report. My contributions to the unit will be reflected in the next report.

Dr Etop Akpan
Consultant, Colposcopy Unit

DEPARTMENT OF ANAESTHESIA

2002 was a challenging year for the Department of Anaesthesia in that there was an increase in both numbers and complexity of obstetric cases.

From September 2001 we welcomed the assistance of a specifically trained Anaesthesia Nurse for all emergency Caesarean Sections.

In November 2002 we welcomed Dr Juliet McAleese, Consultant Anaesthetist to the department.

Regional Analgesia Service

Both low dose epidural infusions and combined spinal epidurals were used to provide pain relief for 914 of expectant mothers in labour, giving an Epidural rate of 28%.

Epidural block in labour (% of total mothers delivered)

2000	27%
2001	26%
2002	28%

We note with appreciation the enthusiasm and dedication of our NCHD's without whom we could not provide a regional analgesia service on demand at all times.

Anaesthesia for Caesarean Section

The total number of Caesarean Sections was 813.

Of these	99	(12.2%) were performed under General Anaesthesia.
	556	(68.4%) were performed under Spinal Anaesthesia
	158	(19.4%) were performed under Epidural Anaesthesia

Of the total, 460 (57%) were emergency cases and 353 (43%) were elective cases.

Anaesthesia Assessment

This was provided by the Anaesthesia Consultant on call as the need arose. The most common consultation was regarding risks and benefits of Epidural Analgesia for labour in the expectant mother who had previously sustained a back injury. Expectant mothers with cardiac disease were also assessed.

Intensive Care

The majority of patients with Pre-Eclampsia were cared for post delivery on the labour ward. Two of these patients required CVP and Arterial monitoring and were admitted to the ICU.

ICU Admissions

Gynaecology 9 patients
Obstetrical 9 patients (this includes unexpected vaginal delivery in the unit)

Reasons for obstetric admission:

Haemorrhage	5
PET	2
Airway Problems	1
Thromboembolic Disease	1

Three of the Obstetric patients admitted to ICU (30%) were non national mothers. The total percentage of non national mothers in 2002 was 17%. The high admission rate to ICU demonstrates the challenge of caring for this patient group.

Dr. P. Connolly
Consultant Anaesthetist

DEPARTMENT OF MIDWIFERY

MANAGEMENT GRADES IN POST 2002

Grade		Number
Nurse Manager for women & Children's services	x	1
CMM 3	x	2
CNM 3	x	1
CMM2	x	12
CMS	x	2
CMM1	x	4
Staff Midwives / Staff Nurses	x	88 WTE
Nursery Nurses	x	7 WTE
Health Care Assistants	x	9.5 WTE
Midwife Tutors	x	3 WTE

INTRODUCTION

2002 was a year of tremendous change in the maternity unit and one of our busiest years in recent times with 3254 births. This represents the largest number of births in the Unit since the 1970's

The cessation of services in Dundalk and Monaghan Hospitals combined with the number of non-national women attending the hospital increased our activity by 41% in 2001 and a further 10 % by the end of 2002.

These changes, though welcome, placed great pressure on services in the Maternity Unit. Despite the increase in activity staff continued to promote individualised holistic and family centered care.

The publication of the Review of Maternity Services (2001) suggested greater challenges for the coming years with a recommendation for the opening of Midwifery Led Units. This model emphasizes the importance of midwives as primary caretakers of normal birth and places women at the centre of the process, as the decision-maker of her care. Midwives welcome these recommendations and are actively working with colleagues both in the hospital and regionally to bring them to fruition.

All of these new initiatives in the North East will help us retain and recruit midwives. In spite of the national shortage of midwives we were able attract, develop and retain high calibre professional midwives. The majority of our student midwives also chose to remain on our staff.

NEW INITIATIVES ACHIEVED IN 2002

- The commencement of an Antenatal Booking Clinic at the Mosney Health Centre made services more accessible to women who are seeking asylum in this country.
- An antenatal outreach clinic also commenced in Navan that is responsive to the needs of women in their local community.
- A new format Midwifery/Obstetric chart was introduced in the Unit.
- Installation of a Kinder Guard Security system for the Unit
- Launch of information booklet for parents/ families of babies in NICU
- "Birth Rate Plus" workload analysis was carried out.
- Greater links with the teenage population was achieved through a project funded by the National Partnership Forum.

Staff education and training remained high on our agenda and to that end, funding was provided and support given by the Board. Many of our midwives availed of education which added to the learning and research developments within the Unit.

CONTINUING EDUCATION AND DEVELOPMENTS

In association with out Medical colleagues we continued with ongoing education programmes such as Neonatal Resuscitation Programme, CPR, Basic Life Support, Venepuncture and Cannulation.

The following members of the midwifery team have obtained or are studying for:

- M.Sc in Midwifery x 5
- B.Sc in Nursing x 1
- Higher Diploma in Diagnostic Imaging x 1
- Higher Diploma in Quality Healthcare

Other education programmes supported and funded were:
Clinical Nurse / Midwife Specialist Development Programme
Development Programme for new Health Service Managers

Midwives on the Education committee organized a National study days for midwifery colleagues around the country. This was entitled 'Choice for Women in Childbirth: Myth or Reality ' and was well supported

Staff were also facilitated and funded to attend in service and other study days/workshops/conferences on the following topics:

- The Critically Ill Obstetric Patient
- 18 Hour Breastfeeding Course
- Advanced Life Support in Obstetrics
- Conference on Developmental Care
- Emergencies in Midwifery
- Fetal Monitoring in Practice Study Day
- Risk Management Study Day
- Professional Issues for Nursing and Midwifery Practice
- Introduction to Obstetric Ultrasound
- Recognizing and responding to Violence against Women
- Information day on Asylum Seekers and Refugees
- Traveler Awareness Study Day
- Quality Management
- 'Seasons' Bereavement Training
- Basic Life Support
- Neonatal Humidification Study Day
- Issues regarding Neonatal Transport
- Alternative therapies in Pregnancy
- Information Technology Programmes
- Safety Protection Seminar
- STABLE Study Day
- REASON Conference U.K.

In conclusion I would like to thank Colette McCann, Nurse Manager for Women & Children's Services, the midwife managers, all members of the midwifery/nursing staff and the members of the multidisciplinary team for their huge commitment during the year. I also acknowledge their tremendous hard work, commitment and dedication to women and their families and for their support to me and for each other. I would like also to extend my thanks to the midwifery team in the Regional School of Midwifery for their commitment to providing high quality midwifery education.

Ms. Mary Duff
Director of Nursing and Midwifery Services

DEPARTMENT OF MIDWIFERY.....

REGIONAL SCHOOL OF MIDWIFERY

The Principal Midwife Tutors are Patricia Larkin and Jean Carragher (1WTE) and in addition there are two Midwife Tutors(2 WTE).
The Regional School of Midwifery in partnership with University of Dublin, Trinity College, provides pre-registration and post-registration midwifery education for midwives, student nurses, student midwives, and other personnel who are involved in caring for women and their families during pregnancy, labour and the puerperium. The aim of the midwifery school is to provide excellence in education and research in order to inform and develop excellence in midwifery care. The Postgraduate Diploma continues to develop and the staff have made several changes to the course in response to evaluations from practice staff and students. The continuous assessment of clinical practice tool was developed in 2001 and continues to develop in response to input from practice and academic staff.

Carmel Bradshaw Midwife Tutor has been appointed external examiner to the Postgraduate Diploma in Midwifery Programme in 2001. The School of Midwifery continues to be involved in the development and delivery of the Pilot Diploma in Midwifery Programme ('Direct Entry'). This programme is a tripartite arrangement between University of Dublin Trinity College, The Rotunda Hospital Dublin and Our Lady of Lourdes Hospital Drogheda.
The programme commenced in June 2000 and will be completed in June 2003.

The staff at the school of Midwifery continue to receive support for continuing education and professional development. One member of staff completed the Postgraduate Diploma in Clinical Health Sciences in education in September 2002 and another member of staff commenced the programme that year. Two members of staff have commenced their Masters Degrees.

Patricia Larkin
Principal Midwifery Tutor

DEPARTMENT OF PARENTCRAFT

The Parentcraft Department encompasses Antenatal Education, Breastfeeding Promotion and support, and midwifery- led clinics.
This is an exciting and challenging time for childbirth Education as women stress the need and desirability to be able to make informed choices about their maternity care.

The aim of our Antenatal Education is to enable women and their partners to exercise these choices by making explicit all options available and empowering them by providing information concerning practices known to be safe and effective and those which are not.
Classes are an opportunity to mix socially and develop support networks.

Mothers are encouraged to book classes early due to ever-increasing demand. They normally commence around 30 weeks gestation and run over a five-week period.
Classes are held Monday to Thursday evenings, and the average size of a class would be 15-20 couples. Partners are encouraged to attend all classes.

The attendance at classes in Our Lady of Lourdes, Drogheda (2002) =76% of mothers delivered.

A Saturday Class is held once every six weeks, as a crash course of the 5- week programme, originally planned for "late bookers" but due to demand is booked as a priority. Places are limited to 15 couples.

We also hold a **Young Mums Class** for under 21yr olds every six weeks on a Saturday 10am-4pm. This was highlighted in 2000 as an area of concern due to the high incidence of teenage pregnancies in Louth.
A Teenage friendly letter is sent out to all under-21 year olds booked at the hospital one week prior to the class. We would have 8-20 young girls accompanied by their partner/parent/both attend this class.

A Refresher Class is held one evening every 3 weeks for Mums who have had a baby already, or attending the hospital for the first-time.
This class is centred around the needs of the woman. A physiotherapist is available for 1/2 hr at the beginning of the class to review breathing techniques, followed by a midwife updating on current hospital policies and procedures and a tour of the Unit.

Reunion Classes for those who attended the 5- week programme (generally primigravidas) is held approximately 6-8 weeks from completion of their course. These were set up as a Quality Initiative to assess individual needs, plan future care and empower the consumers by participating in decision-making. They allow parents an opportunity to network and provide social support, and the information obtained provides feedback to the Multidisciplinary Team on the quality of care delivered and received. This allows for positive feedback and any deficiencies in the service to be identified, corrective action to be taken and future progress to be continuously monitored.

Three Midwives work in the **Parentcraft Department** (2WTE) sharing the workload to cover classes in the Louth County Hospital, and the **YIP** project (Youth Initiative in Partnership) based at Clanbrassil St. Dundalk for under 21yr olds .
As far as possible the same midwife follows a group through the 5-week programme to provide continuity and allow Mums to identify with a member of staff, should they encounter any difficulties during the antenatal/postnatal period.
A team of physiotherapists rotate in the Unit, and the 2nd class of the programme is carried out by one of their team.
Light refreshments are provided for those attending the refresher class and the Saturday Classes.

The Parentcraft Midwives staff a midwife's clinic, Tuesday, Wednesday and Thursday afternoons alongside our medical colleagues.

The promotion and support of **Breastfeeding** is high on our agenda. Two lactation Consultants form part of the

DEPARTMENT OF PARENTCRAFT.....

Parentcraft Team. All **breastfeeding** mothers are visited daily, for individual advice & support. As a member of the **Baby Friendly Hospital Initiative** since October 1999, Our Lady of Lourdes Hospital is committed to the successful implementation of the **10 Steps** to successful breastfeeding as outlined by WHO/Unicef. This involves supporting and promoting informed parental choices through the provision of appropriate, accurate and unbiased information, discussion and instructions.

Breastfeeding Initiation Rate for 2002 = 52%
Breastfeeding Discharge Rate for 2002= 49%

Follow-up support for clients following discharge is available, by drop-in and phone-in, particularly for breastfeeding problems. In summary, the Parentcraft Team strive to provide a Quality Service in line with the four principle concepts of the Health Strategy.

Ms. Philomena Fadden,
Ms. Mary McGarrell.

DEPARTMENT OF PHYSIOTHERAPY

Physiotherapy in Women's Health

Currently there are 1.0 WTE Senior Physiotherapist and 0.5 WTE staff physiotherapist allocated for assessment and treatment within Women's Health. This includes services for referrals of an obstetric or gynaecological nature as well as continence issues. Patients are referred via Consultants. The following a brief overview of services offered and new patients treated within Our Lady of Lourdes Hospital, Drogheda during 2002.

1. Physiotherapy Obstetric/Gynaecology Outpatients:

The referral statistics below are divided up according to primary conditions and complaints. Patients are seen in the physiotherapy department. Treatment modalities include manual techniques and electrotherapy (access to low-level laser, ultrasound, co-planar interferential, pulsed electromagnetic energy, TENs and EMS) as deemed necessary and appropriate.

Ante Natal Primary Referral:	
Carpel Tunnel Syndrome	16
Low Back Pain	20
Symphysis Pubis Dysfunction	29
Sacro-Iliac Pain	70
Thoracic Pain	8
Urinary Complaints	3
TOTAL:	**146**

Post Natal Primary Referral:	
Diastasis of Rectus Abdominis	3
Diastasis Symphysis Pubis	5
Disorders of Sacrum	4
Painful Perineum	4
Coccydynia	3
Dyspareunia	5
Other Musculoskeletal	14
TOTAL:	**38**

When the integrity of the pelvic floor muscle support and control mechanisms is compromised, pelvic organ dysfunction may result. Interventions aimed at restoring support are either surgical or conservative, focusing on fascial or muscular elements respectively. Surgical interventions cases of facial laxity may successfully restore organ position within the pelvis in cases of prolapse. Where organ function is compromised, however, restoration of position does not necessarily restore function. This has led to a push for the initial approach of management of urinary incontinence to be conservative and aimed at improving muscle control.

New Continence Referrals with in 2002

Urinary Stress Incontinence	129
Urge Incontinence	26
Other Urinary Complaint	2
Incontinence of Faeces	8
Giggle Incontinence	1
TOTAL:	166

It has been reported that 28% of women leak urine either frequently or occasionally and that there is a gradual increase in the prevalence of incontinence with age. To date, studies have concentrated on the role of pelvic floor muscle exercises in treating stress incontinence and many randomised controlled trials have shown them to be an effective form of conservative treatment. The results of treatment are encouraging with 75% of genuine stress incontinence being resolved or significantly improved with physiotherapy intervention).

2. Ante-Natal Classes:

The physiotherapy class is one within a course of five classes forming an ante-natal course. This is organised through ParentCraft within the hospital. Physiotherapy staff also participate in one-off refresher classes. Physiotherapy topics include: exercise in pregnancy; education on pelvis; postural adaptations; breathing, relaxation and positions of ease; perineal massage and pelvic floor/abdominal/ROM exercises.
Results from study by Mason et al, 2001 identified that women who performed regular ante-natal pelvic floor exercises reported fewer post-partum stress incontinence symptoms.
New Attendees in 2002 Ante-Natal Classes: 627

3. In-Patient Post-Natal:

Physiotherapist provides post-natal advice and education on the wards in the AM of Monday to Friday. Currently all patients are seen individually. Each patient is given a handout on post-natal exercises and post caesarean section mothers are additionally advised on chest care, bed exercises and adapted positioning.
Mothers seen for routine post-natal education in 2002: 2527

4. Gynaecology In-Patient

Patients are seen in the gynaecology ward post-operatively. Physiotherapy input includes: advice and info; instruction on posture/positioning; chest care; bed exercises; instruction on pelvic floor exercises and mobility. If follow-up outpatient physiotherapy is deemed appropriate, appointments are arranged in the physiotherapy OPD.

Post-Op Gynae Referral	New Referrals
Sub-Total Abdominal Hysterectomy	12
Total Abdominal Hysterectomy	96
Vaginal Hysterectomy	40
Gyn - Laparotomy	47
Gyn - Laparoscopy	10
Oophorectomy	52
Vaginal Repair	38
Urethral Repair	1
TOTAL:	296

Martha Kennedy Love
MCSP SRP

DEPARTMENT OF PATHOLOGY

Blood Transfusion:

Women for whom Blood requested:	927
Units of Blood requested:	2094
Units of Blood used:	300
	(14.3%)

Beta HCG:

512 requests

Ovarian Cancer Markers:

169 requests

Histology:

Placenta	264
Autopsy	11
Uterus + Ovaries	172
Products of Conception	439
Uterine Curettings	452
LLETZ	136
Ovary/Ovarian Cyst	120
Endometrial Polyp	30
Cervical Polyp	50
Cervical Biopsy	43
Skin/Skin Tags	10
Peritoneal Fluid	26
Cervix	11
Vulval Biopsy	22
Vaginal Biopsy	4
Omentum/Biopsy	12

Malachy Stringer
Senior Medical Laboratory Scientist

Cytology

Total number of cervical smears received from all users (hospital and GPs)

	Year	Total
Number of Smears	2000	3530
Number of Smears	2001	4627
Number of Smears	2002	4851

Number of Borderline	324	=	6.6%
Number of Mild Dyskaryosis	113	=	2.3%
Number of Moderate Dyskaryosis	45	=	0.93%
Number of Severe Dyskaryosis	48	=	0.99%
Unsatisfactories		=	7.5%

Sonja Aylward
Head Cytologist

DEPARTMENT OF RADIOLOGY

Overall activity increases year on year. This includes increased activity from the maternity hospital proper including N.I.C.U. and Unit 1 and 2. Ultrasound examinations continue to increase in number. This is especially demanding with the number of portable cerebral and abdominal ultrasounds performed in N.I.C.U.

Portable radiography in the neonatal I.C.U. remains extremely demanding.

There has been no replacement or new equipment provided in the last few years. The present equipment is satisfactory however it will have to be budgeted for replacement in the next couple of years.

As always the service delivered by the Department of Radiology during the year is due to the excellence and dedication of our radiographic and clerical staff to whom I wish to express my appreciation.

Special Care Nursery Examinations 2002

Examination	Total
Portable Abdomen	190
Portable Chest	517
Barium studies	4
Skeletal Survey	4
CT Scan	5
Ultrasound	263
Others	35
Total	**1018**

Examinations for 2002 for Maternity Department

Examination	Total
Abdomen in Pregnancy	0
Chests	18
Pelvimetries	0
Hystrosalpingograms	6
I.V. Urography	1
Venograms	1
Total	26

Ultrasound Examinations

Examination Type	No. Examinations
Abdominal Scan	134
Pelvic Scan	437
Trans-vaginal Scan	87
Total	658

Examination Type	No. Examinations
Paediatric Chests 2002	42

Dr. Maurice McMahon
Consultant Radiologist in charge of Radiology Department

DEPARTMENT OF RISK MANAGEMENT

In 1999 the Chief Executive Officer of the North Eastern Health Board established a steering group to establish Risk Management within the board with terms of reference as follows:

To design and implement a clinical risk management system which will allow for the identification and management of risks to patient safety, quality of care and patient outcome arising from failures in professional performance and or failures of processes and systems.

A UK risk management consultancy company, Healthcare Risk Recourses International (HRRI) were contracted to undertake high-level risk assessments of all the Board's Services. In response to the detailed risk assessment reports, the board developed a Corporate Risk Management plan. HRRI carried out the high-level risk assessment in the Obstetric Department in 2001. A Risk Advisor was appointed in December 2001. Early in 2002, the Risk Advisor's input in the Obstetrical Department involved working with the Labour Ward Manager who had recently introduced clinical incident reporting into the department.
The Risk Advisor provided formal Risk Awareness Training to promote an open and supportive culture, encouraging staff to report incidents and near misses. One of the particular areas of interest was the management of patients presenting at hospital sites that had ceased provision of maternity services in the NEHB. The Regional Obstetrical transfer Policy was finalised, and all attendances at non- obstetric sites are now monitored to ensure compliance with the policy.
The processes developed in the Obstetric Department in 2002 to facilitate risk management were incident reporting, risk awareness training, implementation of the recommendations detailed in the HRRI risk assessment report and incident review.

From January 1999 weekly clinical governance meetings had been established in the obstetrical department. This is a multi-disciplinary forum to discuss clinical issues and help minimise the likelihood of serious failures in standards of care; these meetings continue to date. Ownership of Risk Management is imperative for all staff working in maternity services: it is an integral part of the work of clinicians and managers. Improving safety for patients and staff is what it is all about.

Irene O'Hanlon
Group Risk Advisor

DEPARTMENT OF NUTRITION & DIETETICS

The workload for this department in relation to obstetrics is increasing all the time. Not only are total delivery numbers increasing, but also our antenatal population is becoming progressively more obese. This is in line with the experience of other departments and other sections of the population. A recent study in our Irish antenatal population reveals that 51% are overweight and 20% obese by WHO standards, at their booking visit.

The numbers of women with both impaired glucose tolerance & gestational diabetes have been progressively increasing. We are very grateful to the assistance & experience of both our physician colleagues, and the diabetic nurse specialist within Our Lady of Lourdes' Hospital, and all the health professionals who assist in the management of these women. However the need for a dedicated service staffed by a physician/endocrinologist in this area has become obvious in 2003.

The following numbers were seen in 2002 following requests for dietetic intervention.

Gestational Diabetes and Impaired Glucose Tolerance 176

Other patients referred for dietetic intervention as there maybe factors implicated in poor nutrition outcome are

- Adolescent mothers where pregnancy follows soon after menarche.
- Women more that 20% above or 10% below ideal body weight - at booking
- Immigrant women who maybe consuming an inadequate diet in this country
- Vegans or vegetarians
- Women who have a limited food budget or who may have food management problems
- Women who describe poor eating habits on discussing diet
- Women suffering from an eating disorder past or present - previous history of anorexia, bulimia or binge eating disorder.
- Women with closely spaced pregnancies.
- Women with preexisting medical complications such as diabetes, coeliac condition, gastrointestinal disease, crohns or ulcerative colitis.
- Women suffering from anaemia.
- Women suffering from hyperemesis.

The ideal would be to employ a dietitian to provide a full time service in the Maternity unit and hopefully in time this post will be sanctioned.

Grainne Bogue
Dietetic Manager

HEALTH PROMOTION CORNER

DROGHEDA HEALTHY CITIES
&
OUR LADY OF LOURDES HOSPITAL
DROGHEDA

HELP FOR SMOKERS

Mon-Thursday 9am - 5pm / Friday10am - 2pm
041 98 74732 & 041 98 74790
BLEEP 243

REPORT ON SMOKING CESSATION SERVICES FOR MATERNITY UNIT

MATERNITY STAFF
Doctors/midwives/staff constantly gives information to patients who smoke and refer them to the HPC

PHONE ROOM ANNOUNCEMENT
Regularly announced help for smokers & x smokers at HPC

AWARENESS
MAMS & DADS Brochure produced - approx 1,400 distributed to date
These are issued in BOUNTY PACKS & displayed around the hospital
Smoking Cessation Counsellor visiting Post Natal wards with literature asking if parents are concerned about creating a smoke free environment for new baby
EX-SMOKERS Competition currently in progress

ADMISSION LETTERS
All patients are informed before admission that this is a no smoking hospital

EDUCATIONAL EQUIPMENT
Smoking suit / Nicorette cigarette / Death of a Lung material displayed
CO Monitor testing available daily
BABY DOLL & COT
Literature displayed beside doll in cot at HPC and Ante Natal Clinic
HP SMOKING STAMP on literature

ACTION PLAN
- Possible Smoking Cessation Counsellor attending at Ante Natal clinic, ensuring all patients & partners who smoke are offered support
- **POST NATAL SURVEY** - follow up to Ante Natal Survey, asking if parents are continuing to be smoke free
- On going promotion - dangers of smoking/passive smoking
- Further awareness through more literatures at Ante Natal / Post Natal classes
  (ie visit by Smoking Cessation Counsellor)
- Regular one-day Smoking in Pregnancy awareness day

Bridie Clarke
Smoking Cessation Counsellor

Pastoral Care Department

The Pastoral Care Department is staffed by four full time ministers, one part time church of Ireland minister, and one part time Presbyterian Chaplain, clergy of other denominations are available on request.

There is an oratory located in the main hospital building and mass is celebrated there each day for both staff and patients.
There is also an oratory located in the maternity, this is open day and night and mass is celebrated here regularly.

The Pastoral Care Department is seen as an integral and necessary part of the whole healing process, and is seen as complementing the work of other hospital personal in providing holistic care. This we do by providing sacramental, pastoral and counselling care.
Every effort is made to meet the patients needs especially at times of crisis, bereavement and loss. The Pastoral Care Department works closely with other staff in providing, support and encouragement in dealing with parents trauma, during this time parents are encouraged to express their feelings in whatever way they can, to spend time with their baby, to draw upon the support of family, and help is given to plan a bereavement service.
Special bereavement services are arranged for families in the maternity oratory, during this service a booklet prepared by the nursing staff and including a photograph of the baby and personal details, as well as a remembrance blessing, is given to the parents.
Each year we co-operate with staff in organising a remembrance service for bereaved parents and families.
We as pastoral care department value the help and co-operation we receive from the maternity staff in providing this holistic care.

Sister Gabriel Ashe,
Medical Missionaries of Mary

Glossary of Terms

ANC	Antenatal Clinic
APH	Antepartum Haemorrhage
ARM	Artificial Rupture of Membranes
BNA	Borderline Nuclear Abnormality
BSO	Bilateral Salpingo-oophorectomy
CANC	Combined antenatal care
CIN	Cervical Intraepithelial Neoplasia
CTG	Cardiotocograph
DNA	Did not attend
ERPC	Evacuation of Retained Products of Conception
GTT	Glucose Tolerance Test
LFTs	Liver Function Tests
LLETZ	Large Loop Excision of Transformation Zone
LSCS	Lower Segment Caesarean Section
NCHD	Nonconsultant Hospital Doctor
Para	Previous baby
PET	Pre-eclamptic Toxaemia
PHN	Public Health Nurse
PKU	Phenylketonuria test
PPH	Post Partum Haemorrhage
PPROM	Preterm Prolonged Ruptured Membranes
SROM	Spontaneous Rupture of Membranes
SVD	Spontaneous Vaginal Delivery
STI	Sexually Transmited Infections
TAH	Total Abdominal Hysterectomy
TL	Tubal Ligation
TORCH	Test for viral diseases

This report was facilitated by the kind assistance of Brigid Russell, Medical Records Officer.

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