Acute Care Quality Care-Metrics

Patient Monitoring and Surveillance Quality Care-Metric

Patient Monitoring and Surveillance		**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
1	The patient's baseline physiological observations were assessed and recorded on admission/transfer using the National Early Warning System (NEWS)										
2	The patient's physiological observations have been reassessed and recorded using the NEWS at the appropriate frequency										
3	There is documented evidence of an increased frequency of monitoring and recording of vital signs in response to any deterioration in the patient's condition										
4	In the event of any deterioration there is documented evidence of escalation of care as per NEWS Escalation protocol										
5	The ISBAR tool was used to document the escalation of care										
6	The nursing care provided to manage a deterioration in the patient's condition has been recorded										
7	If infection is suspected to be the cause of the patient's deterioration, care is escalated using the sepsis screening form in accordance with the NEWS Escalation Protocol										

Health Care Associated Infection Prevention and Control Quality Care-Metric

Health Care Associated Infection Prevention and Control		**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
1	The patient's infection status has been documented										
2	The patient's infection status has been communicated to the multi-disciplinary team										
3	The patient's infection status has been communicated to the patient										
4	A care bundle has been completed for each invasive device in use										

Pain Assessment and Management Quality Care-Metric

Pain Assessment and Management		**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
1	Pain is assessed and documented within 24 hours of admission/transfer using a validated tool that is consistent with the patient's age, condition and ability to understand										
2	Pain is reassessed and documented using a validated tool at least every 12 hours										
3	Pain is assessed and documented using a validated tool *before* a pain relieving intervention										
4	Pain is assessed and documented using a validated tool *within 1 hour after* a pain relieving intervention										
5	An adverse drug reaction associated with administered pain treatments is communicated with the medical team/prescriber										
6	Communicated with the medical team/prescriber when there is an identified need for patient pain review										

7	Pain-related education is provided to the patient and/or family on pain management on admission										
8	Pain-related education is provided to the patient and/or family on pain management prior to discharge										

Nutrition and Hydration Quality Care-Metric

Nutrition and Hydration		**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
1	The patient's risk of malnutrition has been screened on admission/transfer										
2	A plan of care has been developed based on the patient's risk of malnutrition										
3	The patient's risk of malnutrition has been re-screened										
4	The patient’s oral health status assessment has been completed										
5	The nursing care provided for the patient's oral health has been documented										
6	*Changes* in the patient's bowel pattern has been assessed, recorded and managed										

Continence Assessment and Management Quality Care-Metric

Continence Assessment and Management		**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
1	A continence assessment has been recorded on admission / transfer if applicable										
2	Fluid balance monitoring has been recorded in full and there is evidence that it is being totalled and managed										
3	*Changes* in the patient's urinary continence pattern have been assessed, recorded and managed										

Care Plan Development and Evaluation Quality Care-Metric

Care Plan Development and Evaluation		**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
1	The care plan has been developed with the patient and reflects the patient's current condition and goals										

2	The patient's self-care activities have been assessed										
3	The nursing interventions/supports given to the patient to improve their self-care activities have been documented										
4	The *progress* made by the patient to improve their self-care activities has been documented in the care plan										
5	The patient's care plan has been reassessed in accordance with the local PPPGs										
6	There is evidence of a discharge plan that reflects the patient's current condition/progress										
7	The patient's discharge plan has been discussed with the patient and documented										
8	A care plan for End of Life has been completed which incorporates a holistic needs assessment and symptom management plan										
9	If an individual is identified as a vulnerable person, concerns regarding neglect and abuse have been documented										
10	If an individual is identified as a vulnerable person, concerns have been reported to the appropriate authorities according to national and local policy										

Care Plan NMBI Guidance Quality Care-Metric

Care Plan NMBI Guidance		**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
1	The patient's name and healthcare record number (HCRN) is on every page of the nursing record										
2	All nursing entries include the nurse's signature, the date and time										
3	Any alterations in nursing documentation are as per NMBI guidelines										
4	All records are legible, in permanent black ink										
5	Student entries are countersigned by the supervising nurse										
6	All entries are in chronological order										
7	Any abbreviations/grading systems used are from a national or locally approved list/system										

Medication Safety Quality Care-Metric

Medication Safety		**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
1	The patient's weight and date of weight are recorded on the front page of the medication record										
2	The patient's *identification wristband* is on the patient and details are legible and correct										
3	Patient identification is legible and correct on the *medication record*										
4	The allergy status is clearly identifiable on the front page of the medication record										
5	The prescription is legible with correct use of abbreviations										
6	An up-to-date medicines formulary/resource is available and accessible										
7	All medicines were administered at the prescribed frequency										
8	The minimum dose interval and/or 24 hour maximum dose is specified for all "as required" or *PRN* medicines										
9	Prescribed medicines not administered have an omission code entered										
10	Prescribed medicines not administered have had appropriate action taken										
11	Independent verification of medication preparation and administration has taken place										
12	Appropriate action has been taken in response to any adverse *reactions* the patient has to any medication										
13	If a medication *error* has occurred there is evidence of appropriate monitoring and intervention in accordance with medication PPPGs										
14	Medication-related education is provided by the nurse to the patient and/or family										

NURSING & MIDWIFERY QUALITY CARE-METRICS

Medication Storage and custody Quality Care-Metric

Medication Storage and custody		**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
1	A registered nurse is in possession of the keys for medicinal product storage										
2	All medication trolleys are locked and secured as per local organisational policy and open shelves on the medication trolley are free of medicinal products when not in use										
3	MDA drugs are checked & signed at each changeover of shift by nursing staff (member of day staff & night staff)										
4	The MDA drugs cupboard is locked										
5	The MDA drugs keys are held by the CNM or senior nurse designee										
6	The MDA drugs keys are held separate or detached from all other sets of keys										
7	The patient bed space is free of any unsecured prescribed medicinal products										

Falls and Injury Management Quality Care-Metric

Falls and Injury Management		**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
1	A falls risk assessment was recorded on admission / transfer if applicable										
2	If the patient is identified as at risk of falling, nursing interventions are in place to minimise the risk of falling										
3	The patient, if identified at risk of falling, has been offered information about falls										
4	If a patient has fallen, the relevant post falls documentation have been completed										

Delirium Prevention and Management Quality Care-Metric

Delirium Prevention and Management		**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
1	A delirium assessment has been completed										

2	If a patient has delirium, a care plan has been developed										
3	There is documented evidence that a care plan for the patient with delirium has been evaluated										

Wound Care Management Quality Care-Metric

Wound Care Management		**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
1	A comprehensive wound assessment has been completed										
2	The wound care plan has been re-evaluated										

Pressure Ulcer Prevention and Management Quality Care-Metric

Pressure Ulcer Prevention and Management		**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
1	A pressure ulcer risk assessment was recorded using a validated tool within 6 hours of admission or transfer										
2	If a patient is identified as at risk, daily skin inspections have been recorded										
3	The *pressure ulcer risk* was reassessed in response to any changes in the patient's condition										
4	The *pressure ulcer risk* was reassessed weekly										
5	If a pressure ulcer is present, the category/stage has been recorded										
6	Reassessment and evaluation of the *pressure ulcer* have been completed										
7	The frequency of patient repositioning is recorded										
8	The use of pressure redistributing devices is recorded										