Children's Services Quality Care-Metrics

Medication Management Quality Care-Metric

Medication Management		1	2	3	4	5	6	7	8	9	10
1	Security for the storage of medicinal products is managed by the registered nurse										
2	All medicinal products are stored in a locked cupboard/locked fridge or within a locked room										
3	Where medication trolleys are in use, they 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										
4	High alert medicine is identified and stored appropriately, as per local policy										
5	There is easy access to an up-to-date drug formulary										
6	Misuse of Drugs Act (MDA) drugs register is checked and signed at each changeover of shifts by registered nursing staff (member of day staff & night staff)										
7	Two signatures are entered in the MDA drug register for each administration of an MDA drug										
8	The MDA drug cupboard is locked and security around access to the MDA cupboard is held by a registered nurse										
9	Security for the storage of MDA drugs is kept separate to security for other medication										
10	The child's prescription documentation includes their legible name and healthcare record number										

NURSING & MIDWIFERY QUALITY CARE-METRICS

Medication Management		1	2	3	4	5	6	7	8	9	10
11	The child's identification band has correct and legible name and healthcare record number/unique identifier										
12	The child's allergy status is clearly identifiable on the front page of the prescription chart										
13	The child's weight and date of weight are recorded on the front page of the prescription chart										
14	The child's locker and bedside/surrounding environment are free of unsecured prescribed medicinal products										
15	The generic name is used as appropriate for each medicine prescribed										
16	The date of commencement of the most recent prescription is recorded										
17	The prescription is written in un-joined letters										
18	The decimal point is clearly marked										
19	The correct legible dose of the medication is recorded with correct use of abbreviations										
20	The route of medication administration is recorded										
21	Prescribed medication not administered have an omission code entered and appropriate action taken										
22	The time of medication administrations is as prescribed										
23	The minimum dose interval and/or 24 hour maximum dose is specified for all pro re nata (PRN) medication										
24	The prescription has an identifiable prescriber's signature										
25	Discontinued medications are crossed off, dated and signed by a person who has prescriptive authority										

Nursing Care Planning Quality Care-Metric

Nursing Care Planning		1	2	3	4	5	6	7	8	9	10
1	The child's name, date of birth and healthcare record number/unique identifier are on each page/ screen										
2	The child's admission date and time are recorded										
3	The child's presenting complaints/reason for admission/ attendance is recorded										
4	The child's next of kin/family support details are recorded										
5	The child's past medical/surgical history is recorded										
6	The child's allergy status is clearly identifiable on relevant nursing documentation										
7	All sections of the nursing admission assessment documentation are completed within 24 hours of admission										
8	Nursing care plans are evident and reflect the child's current condition										
9	Nursing interventions are individualised, dated, timed (using 24 hr clock) and signed										
10	Evaluation of the nursing care plan is evident and has been updated accordingly										
11	All nursing records are legible and identifiable										
12	All nursing entries are in chronological order										
13	All abbreviations/grading systems used in the nursing record are from a national or approved list/system										
14	All alterations/corrections to the nursing record are as per NMBI guidance										
15	Student entries are countersigned by a registered nurse										
16	There is evidence of promotion of child and family enablement documented in a communication care plan										

17	The reason for the application of clinical holding is documented										
18	Evidence for alternatives to clinical holding were explored										

Healthcare Associated Infection Prevention Quality Care-Metric

Healthcare Associated Infection Prevention		**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
1	The child's infection status/alert is recorded										
2	Infection Prevention and Control guidelines are available and accessible										
3	There is evidence of appropriate nursing action in the event of a Healthcare-Associated Infection										
4	The child's infection status and any associated risk is communicated to the family and multidisciplinary team										
5	There is evidence that a care bundle has been completed for each invasive medical device in use										

Nutrition Quality Care-Metric

Nutrition		**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
1	There is evidence of ongoing monitoring of the child's weight										
2	There is evidence that the child's fluid balance has been assessed and managed										
3	Information and support is made available for breastfeeding mothers										

Pain Assessment and Management Quality Care-Metric

	Pain Assessment and Management	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
1	The child's pain is assessed and recorded using a developmentally appropriate pain scoring tool										
2	There is evidence that a pain care plan was initiated										
3	There is evidence that the child's pain management is recorded in nursing documentation										
4	Re-evaluation of pain scores are recorded before and after a pain relieving intervention										

Vital Signs Monitoring / PEWS Quality Care-Metric

	Vital Signs Monitoring / PEWS	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
1	The child's baseline physiological observations were assessed on admission, calculated and recorded using the age-appropriate national PEWS system										
2	The child's physiological observations have been reassessed, calculated and recorded using the age-appropriate PEWS system										
3	Any deterioration in the child's condition is documented and there is evidence of adherence to the minimum observation frequency as per age-appropriate national PEWS guidelines										
4	In the event of a deterioration, there is documented evidence of escalation of the child's care and communication to the medical team using the ISBAR as per the age-appropriate national PEWS escalation protocol										
5	There is documentation of the nursing care that has been provided to manage a deterioration in the child's condition (management plan)										
6	In the event of infection/sepsis, there is documented evidence of escalation as per national PEWS sepsis/infection protocol										

NURSING & MIDWIFERY QUALITY CARE-METRICS

Child and Adolescent Mental Health Quality Care-Metric

Child and Adolescent Mental Health		**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
1	A child and adolescent mental health care plan has been initiated where appropriate										
2	There is documentation within the nursing record/care plan when a mental health referral has been made for the child/adolescent										
3	The child/adolescent and family have been given contact details for advice/follow up with the relevant child and adolescent mental health team/service										

Discharge Planning Quality Care-Metric

Discharge Planning		**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
1	There is documented evidence of discharge planning										
2	There is evidence of involvement of the child and family in the discharge plan										
3	There is evidence of the provision of post discharge advice to the child/family										