Intellectual Disability Services Quality Care-Metrics

Nursing Documentation Quality Care-Metric

Nursing Documentation		**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
1	Nursing written records are legible, in permanent ink and signed										
2	Documented alterations/corrections are as per NMBI Guidance										
3	Personal information is stored securely with access only to relevant persons in order to protect the privacy and confidentially of the individual's details										
4	Documented entries are dated and timed (24 hour clock)										
5	Documented entries are in chronological order										
6	Documented abbreviations/grading systems are from a national or local approved list/system										
7	All student nurse documented entries are countersigned by the supervising nurse										

Medication Management Quality Care-Metric

Medication Management		**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
1	All medicinal products are stored in a locked cupboard/trolleys/room										
2	Misuse of Drugs Act (MDA) drugs are checked & signed at each shift changeover by registered nursing staff (member of day & night staff)										
3	Two signatures are entered in the MDA Drug Register for each administration of an MDA										
4	The MDA drug cupboard is locked and keys are held by the designated nurse										
5	MDA drug keys are kept separate from other medication keys										
6	The person's prescription documentation provides details of person's legible name, unique identifier and photo ID										

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7	The Allergy Status is clearly identifiable on the front page of the prescription chart										
8	Prescribed medicines not administered have an omission code entered and appropriate action taken										
9	The prescription start date is recorded										
10	The correct legible dose of drug is recorded with correct use of abbreviations										
11	The route and/or site of administration is recorded										
12	The frequency of medicines administration is as prescribed										
13	The minimum dose interval and/or 24hr maximum dose is specified for all PRN medicines										
14	The prescription has the prescriber's signature (in ink) and Medical Council Number/Nursing Midwifery Board of Ireland personal identification number										
15	Discontinued medicines are crossed off dated and signed by person with prescriptive authority										
16	All medicines are reviewed in accordance with medication protocols										
17	A current Drug Formulary is available at the point of administration										
18	The generic name is used for each medicine unless the prescriber indicates a branded medicine and states "do not substitute"										
19	There is a support plan for self-administration of medication										
20	Self-administration of medicines is monitored for compliance and safety										

Environment Quality Care-Metric

Environment		**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
1	Policies, Procedures, Protocols and Guidelines (PPPGs) are current and signed by each registered nurse										

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2	There is evidence of an action plan based upon the most recent regulatory inspection										
3	Environmental and infection control audits have been conducted and relevant action plans are in place										

Safeguarding Quality Care-Metric

Safeguarding		**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
1	Safeguarding policies are reviewed and up to date										
2	Information is provided to the person regarding their rights (support to exercise their rights, advocacy, safeguarding/protection) in an accessible format										
3	Where there is evidence of a safeguarding concern there is documentation of registered nurses compliance with the safe guarding policy										
4	A personalised risk assessment has been carried out in consultation with the person and relevant persons (family, advocates and the multidisciplinary team) and evident in the nursing care plans										
5	A plan is in place on the person's personal property, finances and possessions										
6	When assisting the person in the management of their finances, there is evidence that clear records are maintained, reconciled and subject to audit										

Person Centred Communication Quality Care-Metric

Person Centred Communication		**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
1	A communication assessment has been conducted and a plan is documented										
2	The person's choice is obtained, respected and documented										
3	Communication strategies are identified in the person's care plan										

4	The person's communication level and style are documented										
5	Non-verbal and atypical communication behavioural patterns are documented										
6	There is documented evidence of a multidisciplinary team approach										
7	Information provided is in an accessible format for the individual										
8	Where non-engagement occurs, this is noted in the person's care plan										

Physical Health Assessment Quality Care-Metric

Physical Health Assessment		**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
1	A comprehensive health assessment has been conducted										
2	Known associated health risk factors are identified within the care plan										
3	A recognised assessment tool for persons with an intellectual disability has been used or appropriate tool adapted for specific areas e.g. pain, oral care, nutrition, hydration										
4	The person has been supported to engage in health screening										
5	The health care plan demonstrates a systematic approach to nursing care, management and interventions										
6	Physical health checks are conducted at least annually										
7	An individualised health passport has been developed in conjunction with the person										

Mental Health Assessment Quality Care-Metric

Mental Health Assessment		**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
1	A nursing mental health assessment has been conducted and documented										
2	A diagnosis of mental health illness is documented										

3	The individual's care plan demonstrates the nursing care, management and interventions to support the person’s mental health and well-being										

Risk Assessment and Management Quality Care-Metric

Risk Assessment and Management		**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
1	There is evidence of positive proactive risk assessment and an action plan for identified risks within the persons care plan										
2	Appropriate referral and resulting consultations have occurred to address identified risks and are documented										
3	Incidents are documented within the care plan and escalated/reported as appropriate										
4	A risk re-assessment is conducted and documented										

Nursing Care Plan Quality Care-Metric

Nursing Care Plan		**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
1	The personal plan is based on a model of care (Nursing Care Plan is based on an identified model of care)										
2	An assessment of need has been conducted and documented										
3	An individualised plan of care has been developed										
4	All documented nursing interventions are dated, timed and signed										
5	The care plan reflects the person's current health needs										
6	There is evidence of regular review of the care plan, dated, timed and signed										

Person Centred Planning Quality Care-Metric

Person Centred Planning		**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
1	A personal plan/assessment of all aspects of the person's life has been conducted										
2	Actions/interventions are devised to support the person within their personal plan										
3	There is evidence of the person's involvement in their Personal Plan										
4	The person's level of need and preferences regarding the provision of intimate personal support are identified										
5	Self-advocacy/choices are recorded, respected and documented										
6	A transition plan exists **across each life course stage**										

Positive Behaviour Support Quality Care-Metric

Positive Behaviour Support		**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
1	An assessment of distress has been conducted										
2	A personal behavioural plan exists										
3	Proactive and Reactive Behavioural strategies are identified and evident										
4	There is evidence that Positive Behavioural support strategies are reviewed by the multidisciplinary team										

End of Life/Palliative Quality Care-Metric

End of Life/Palliative		**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
1	An end of life care plan is evident and documented										
2	The person has been supported to make end of life decisions and this process is evident within the personal care plan										

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3	An ongoing assessment of changing health needs is evident and documented										
4	A collaborative approach is in evident across services										
5	There is evidence of ongoing information sharing with the individual regarding their end of life										