Mental Health Services Quality Care-Metrics

Assessment Quality Care-Metric

Assessment		**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
1	Presenting complaints/reasons for admission/attendance is recorded and the admission date and time are recorded										
2	The service user's name, date of birth, and/or healthcare record number are on each page/screen										
3	Initial assessment includes contact details for family member/carer										
4	There is a documented reason if the service user refuses to give family member/carer details										
5	There is documented evidence of service user consent for family member/carer involvement in care and communication										
6	Documented evidence of discharge planning is recorded from admission										
7	The service user is involved in all aspects of his/her assessments e.g. falls, risks, neglect etc. as per local policy										
8	It is documented that the mental health service, with the service user's informed consent has involved other named service providers in their assessment, if required										

Care Plan Quality Care-Metric

Care Plan		**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
1	There is documented evidence that the service user is involved in the co-production of their nursing care plan										
2	Nursing interventions are individualised and include nurse's signature, the date and time										
3	There is documented evidence that the nursing care plan has been reviewed on a regular basis, as defined by the individual clinical area										

NURSING & MIDWIFERY QUALITY CARE-METRICS

4	There is documented evidence that information has been provided to the service user on their care and treatment plan										
5	There is documented evidence that the service user is involved in all aspects of his/her treatment and care										
6	There is documented evidence in the nursing care plan that medication side effects are assessed by the nurse										
7	Any alterations in nursing documentation are as per NMBI guidelines										
8	All records are legible, in permanent black ink										
9	Student entries are countersigned by the supervising nurse										
10	All entries are in chronological order										
11	Any abbreviations/grading systems used are from a national or locally approved list/system										

Management of Risk Quality Care-Metric

Management of Risk		**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
1	There is documented evidence that the service user has been systematically assessed for clinical risks by a nurse or other named professional										
2	Where risk is identified there is documented evidence that a risk management plan is in place										
3	The nursing staff have documented and evaluated the actions taken in a response to any identified clinical risk										

Management of Violence and Aggression Quality Care-Metric

Management of Violence and Aggression		**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
1	There is documented evidence that incidents of violence and aggression are recorded										
2	There is documented evidence that timely and appropriate post-incident debriefing has occurred for service users										
3	There is documented evidence in the nursing care-plan of the nursing responses to violent and/or aggressive incidents										

Physical Health and Wellbeing Quality Care-Metric

Physical Health and Wellbeing		**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
1	There is documented evidence that the medical history is recorded in the service user's notes										
2	The allergy status is clearly identifiable on nursing documentation										
3	There is documented evidence of an ongoing physical health assessment from admission/referral										
4	There is documented evidence that identified physical health care needs are addressed in the nursing care plan										

Recovery Based Care Quality Care-Metric

Recovery Based Care		**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
1	The service user has been informed of/offered peer support to aid in their recovery										

2	The nurse has documented evidence that the service user has access to a recovery-based programme										
3	There is documented evidence that the service user is involved in all aspects of his/her recovery planning including discharge planning										
4	There is documented evidence in the nursing care plan that the nurse has provided information about voluntary services that may help service users in their recovery process										

Nursing Communication Quality Care-Metric

Nursing Communication		**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
1	There is evidence in the clinical notes that a nurse has communicated with the service user as per care plan										
2	The nurse has offered the service user information regarding their rights										
3	There is documented evidence in the nursing care plan that the nurse has offered the service user information on advocacy services and how to access them										
4	There is documented evidence to support the coordination of nursing care on transfer or discharge										
5	There is documented evidence that the service user's communication style and preferences are recorded in the nursing notes										

Medication Management Quality Care-Metric

Medication Management		**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 medicinal products are stored in a locked cupboard or locked room										
3	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										
4	A current drug formulary is available on all medication trolleys										
5	Misuse Drug Act (MDA) drugs are checked & signed at each changeover of shifts by nursing staff (member of day staff & night staff)										
6	Two signatures are entered in the MDA drug register for each administration of any MDA drug										
7	The MDA drug cupboard is locked and keys for MDA cupboard are held by designated nurse										
8	MDA drug keys are kept separate from the other medication keys										

Medication Management		**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
9	The individual's prescription documentation provides details of individual's legible name and health care record number										
10	The individual's identification band has correct and legible name and healthcare record number and/or photo ID if in use										
11	The allergy status is clearly identifiable on the front page of the prescription chart										
12	Prescribed medicines not administered have an omission code entered										
13	The generic name is used for each drug prescribed										

14	The date of commencement of the most recent prescription is recorded										
15	The prescription is written in block letters										
16	The correct legible dose of the medicine is recorded with correct use of abbreviations										
17	The route and/or site of administration is recorded										
18	The frequency of medicines administration is recorded and correct timings indicated										
19	The minimum dose interval and/or 24 hour maximum dose is specified for all "as required" or PRN medicines										
20	The prescription has an identifiable prescriber's signature (in ink)										
21	Discontinued medicines are crossed off, dated and signed by a person with prescriber authority										