Midwifery Services Quality Care-Metrics

Midwifery Plan of Care Quality Care-Metric

	Midwifery Plan of Care	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
1	A midwife's plan of care is evident and reflects the woman's current condition including referral where appropriate										
2	Appropriate midwifery care based on the assessment and plan is recorded										
3	There is recorded evidence that a discussion has occurred with the woman about her care to include birth preferences										

Booking Quality Care-Metric

	Booking	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
1	The woman's name and healthcare record number (HCRN) are on each page/screen										
2	All previous pregnancies and outcomes are recorded										
3	Past medical/surgical/family/genetic/social/medication (as appropriate) histories are recorded										
4	The allergy status is recorded										
5	Infection status /alert is recorded										
6	The blood pressure, and gestation at booking is recorded										
7	There is evidence of assessment of antenatal risk factors recorded										
8	There is recorded evidence if a blood transfusion is acceptable to the woman										
9	There is evidence of assessment for mental health illnesses recorded										
10	There is evidence of routine inquiry for domestic violence recorded										
11	There is evidence that infant feeding has been discussed with the woman and recorded										

NURSING & MIDWIFERY QUALITY CARE-METRICS

12	There is evidence that health information relating to pregnancy has been given and recorded										

Abdominal Examination (after 24 weeks gestation) on Current or Last Assessment Quality Care-Metric

Abdominal Examination (after 24 weeks gestation) on Current or Last Assessment		**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
1	Abdominal inspection findings are recorded										
2	Palpation-Fundal height in cms (where appropriate) is recorded										
3	Palpation-Lie (where appropriate) is recorded										
4	Palpation-Presentation (where appropriate) is recorded										
5	Palpation-Position (where appropriate) is recorded										
6	Palpation-Engagement (where appropriate) is recorded										
7	Palpation-Fetal activity (if present) is recorded										
8	Auscultation-Fetal heart rates-Use of Pinard or hand held Doppler with a record of fetal heart rate in BPM										

Intrapartum Fetal Wellbeing Quality Care-Metric

Intrapartum Fetal Wellbeing		**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
1	There is recorded evidence of fetal heart monitoring with Pinard/Doppler on initial assessment										
2	When using intermittent auscultation, the fetal heart is recorded at least every 15 minutes in the 1st stage of labour and at least every 5 minutes in the 2nd stage of labour										
3	There is recorded evidence of date and time of infant's birth in the labour record										
4	Colour and volume of liquor are recorded										

Intrapartum Fetal Wellbeing Cardiotocography (CTG) Quality Care-Metric

Intrapartum Fetal Wellbeing Cardiotocography (CTG)		**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
1	There is recorded evidence of indication for cardiotocography (CTG)										

2	The date/time is validated and recorded at the start of CTG										
3	The woman's name and hospital number are recorded on the CTG by the midwife										
4	The maternal pulse is recorded on the CTG strip on commencement of the CTG tracing										
5	There is recorded evidence of systematic CTG interpretation occurring hourly (baseline, variability, accelerations, decelerations, uterine activity and plan of care)										
6	There is recorded evidence that CTGs of concern have been reviewed by the senior midwife and/or obstetrician										

Intrapartum Maternal Wellbeing Quality Care-Metric

Intrapartum Maternal Wellbeing		**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
1	There is recorded evidence of maternal vital signs during labour based on the woman's condition										
2	A narrative is recorded at least hourly, to provide a record of the woman's condition										
3	Indication for vaginal examination is recorded										
4	Consent to perform vaginal examination is recorded										
5	There is recorded evidence of abdominal examination prior to vaginal examination										
6	There is evidence of systematic record keeping of the findings of all vaginal examinations										
7	There is recorded evidence of contraction assessment at least every 30 minutes										
8	There is recorded evidence of date and time of onset of each stage of labour										
9	The name and designation of the person professionally requested to review the woman is recorded (as appropriate)										
10	Indication for amniotomy is recorded										
11	Consent for amniotomy is recorded										
12	Indication for administration of oxytocin is recorded										
13	Consent for administration of oxytocin is recorded										

14	There is recorded evidence that oxytocin infusion has been reduced or stopped when uterine tachystystole is present										
15	Where a CTG is of concern, there is recorded evidence that the oxytocin infusion was reduced or discontinued and a medical review was undertaken										
16	There is recorded evidence of findings of assessment for perineal trauma										
17	Where perineal repair was necessary and was performed by midwife, there is recorded evidence of repair										
18	There is recorded evidence of estimated blood loss at birth										
19	The date, time and method of birth are recorded										

Risk Assessment for Venous Thromboembolism (VTE) in Pregnancy & the Puerperium Quality Care-Metric

Risk Assessment for Venous Thromboembolism (VTE) in Pregnancy & the Puerperium		**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
1	There is recorded evidence of venous thromboembolism (VTE) assessment on admission										
2	There is recorded evidence of VTE assessment postnatally										

Immediate Post Birth Quality Care-Metric

Immediate Post Birth		**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
1	Maternal vital signs are recorded on the IMEWS chart, prior to transfer to the postnatal ward										
2	Maternal urinary output is recorded										
3	Skin to skin contact is recorded										
4	Breast feeding initiation time is recorded for a woman who chooses to breastfeed										
5	Neonatal condition at birth (live, neonatal death, fetal death) is recorded										
6	Findings of initial systematic examination of the newborn is recorded										

Communication (Clinical Midwifery Handover) Quality Care-Metric

Communication (Clinical Midwifery Handover)		**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
1	Mother- Identification of risk factors in handover is recorded										
2	Baby- Confirmation of identify band checking is recorded										
3	Baby- Gender of newborn is recorded										
4	Baby- Security tag is recorded as present and active										

Pain Management (other than labour) Quality Care-Metric

Pain Management (other than labour)		**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
1	Woman's response to actions taken to reduce pain are recorded										

Infant Feeding Quality Care-Metric

Infant Feeding		**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
1	Method of infant feeding is recorded										
2	Assessment of effectiveness of baby feeding is recorded										
3	The actions taken if feeding is ineffective are recorded										

Postnatal Care (Daily Midwifery Care Processes) Quality Care-Metric

Postnatal Care (Daily Midwifery Care Processes)		**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
1	There is recorded evidence of ongoing postnatal education being offered to the woman										
2	There is recorded evidence of daily assessment of the mother (as per national health care record/local policy)										
3	There is recorded evidence of how well the woman is coping postnatally										
4	There is recorded evidence of daily assessment of the neonate (as per national health care record/local policy)										

Post Birth Discharge Planning for Home Quality Care-Metric

Post Birth Discharge Planning for Home		**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
1	Discharge date and time are recorded										
2	The name of midwife completing discharge is recorded										
3	The destination of the woman is recorded on discharge										
4	Referral for professional skilled services (e.g. lactation consultant, physio, social work, speciality clinic, if required) is recorded										
5	There is recorded evidence of neonatal pulse oximetry screening having been performed (if appropriate)										
6	There is recorded evidence of discharge advice/discussion on health and wellbeing of self and baby										

Medication Administration Quality Care-Metric

Medication Administration		**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
1	The allergy status is clearly identifiable on the front page of the maternal medication record										
2	The individual's medication documentation provides details of individual's legible name and health care record number										
3	The individual's identification band (ID) has correct and legible name and healthcare record number										
4	Prescribed medication not administered has an omission code entered										
5	The individual's locker and bedside/ or surrounding environment are free of unsecured prescribed medicinal products										
6	The generic name is used for each medicine prescribed										
7	The medication record is written in block letters										

NURSING & MIDWIFERY QUALITY CARE-METRICS

8	The correct legible dose of the medicine is recorded and not abbreviated										
9	The Route and/or Site of administration is recorded										
10	The frequency of administration is recorded & correct timings indicated										
11	The minimum dose interval and or 24 hour maximum dose is specified for all "as required" or PRN drugs										
12	The prescription has a legible prescriber's signature (in ink)										
13	Discontinued medicine/s are crossed off, dated and signed by prescriber										

Medication, Storage and Custody (Excluding MDAs) Quality Care-Metric

Medication, Storage and Custody (Excluding MDAs)		**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
1	A registered midwife is in possession of the keys for medicinal product storage										
2	All medicinal products are stored in a locked cupboard or locked room										

MDA Scheduled Controlled Drugs Quality Care-Metric

MDA Scheduled Controlled Drugs		**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
1	Misuse Drugs Act (MDA) Drugs are checked & signed at each changeover of shifts by midwifery staff										
2	Two signatures are entered in the MDA drug register for each administration of any MDA drug										
3	The MDA drug cupboard is locked and keys for MDA Drug cupboard are held by designated midwife										
4	MDA drug keys are kept separate from other medication keys										

Intravenous Fluid Therapy Quality Care-Metric

Intravenous Fluid Therapy		**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
1	Fluid balance charts are completed accurately and totalled										

NURSING & MIDWIFERY QUALITY CARE-METRICS

Clinical Record Keeping Quality Care-Metric

Clinical Record Keeping		**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
1	All entries are dated and timed (using 24 hour clock)										
2	All written records are legible, in permanent ink and signed										
3	All entries are in chronological order										
4	All abbreviations/grading systems are from a national or local approved list/system										
5	Alterations/corrections are as per HSE standards and recommended practices for healthcare records management										
6	Recorded care provided by midwifery students is countersigned by a registered midwife										

IMEWS Documentation Standards Quality Care-Metric

IMEWS Documentation Standards		**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
1	The addressograph (or details) are recorded on both sides of the IMEWS chart										
2	The booking blood pressure, gestation at booking, booking BMI and large Blood Pressure cuff are recorded										
3	Date and time of the observations are recorded										
4	Time is recorded using the 24 hour clock										
5	Each entry is initialled										
6	The ISBAR tool was used to document the escalation of care										

IMEWS Parameters Quality Care-Metric

IMEWS Parameters		**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
1	Respiratory rate is documented numerically										
2	Respiratory rate is documented in the appropriate box										
3	SpO2 (if applicable) is documented numerically										

NURSING & MIDWIFERY QUALITY CARE-METRICS

4	SpO2 (if applicable) is documented in the appropriate box										
5	Temperature is documented numerically										
6	Temperature is documented in the appropriate box										
7	Maternal heart rate is documented numerically										
8	Maternal heart rate is documented in the appropriate box										
9	Systolic Blood Pressure is documented numerically										
10	Systolic Blood Pressure is documented in the appropriate box										
11	Diastolic Blood Pressure is documented numerically										
12	Diastolic Blood Pressure is documented in the appropriate box										
13	Urinalysis is documented										
14	Pain score is documented										
15	AVPU is recorded										
16	Total Yellow Zone is correct on every entry										
17	Total Pink Zone is correct on every entry										