Theatre Services Quality Care-Metrics (QCM)

Theatre Communication

Theatre Communication QCM	1	2	3	4	5	6	7	8	9	10
1. The patient's name, hospital number, date and operation details are on the appropriate documentation										
2. The allergy status of the individual is clearly identified on the front page of the prescription chart										
3. Safe site surgery check list is completed										
4. Relevant traceability stickers are in current health care record										
5. Pre and Post swab count tallies are documented (and countersigned)										
6. There are two documented signatures on transfer/handover sheet for patient transfer pre operatively										
7. There are two documented signatures on transfer/handover sheet for patient transfer post-operatively										

Tissue Viability in Theatre

Theatre Tissue Viability QCM	1	2	3	4	5	6	7	8	9	10
1. Pressure area risk assessment is documented pre operatively										
2. There is documented evidence of use of pressure relieving devices for high risk patients intra operatively										
3. Diathermy site was observed and recorded pre-operatively/Postoperatively										
4. For mayor surgery, both the recovery nurse/midwife and receiving ward staff member document, pressure areas checked on transfer to ward										

NURSING & MIDWIFERY QUALITY CARE-METRICS

Pain Management

Theatre Pain Management QCM	1	2	3	4	5	6	7	8	9	10
1. Pain status of the patient is assessed on admission to recovery area, using a pain scoring system										
2. Analgesia administration and efficacy is recorded										
3. There is evidence that pain was under control (pain score), before the patient was discharged to the ward										

Immediate Post Operative Care

Theatre Immediate Post Operative Care QCM	1	2	3	4	5	6	7	8	9	10
1. Airway management was documented										
2. Level of consciousness was documented										
3. Blood Pressure, temperature, pulse, respiratory rate and SPo2 were recorded post operatively										
4. Blood pressure, temperature, pulse, respirations and SPo2 were recorded on the INEWS/EWS chart prior to transfer to ward										
5. There is documented evidence that the wound site has been checked and recorded										
6. There is documented evidence that vaginal loss has been checked (Midwifery Related only)										
7. Intravenous therapy/fluid management is documented										
8. Urinary output is recorded for all major surgery										
9. For patients requiring regional block; the level of block is checked prior to transfer to ward										
10. Discharge criteria check list is completed										