NATIONAL GUIDELINE FOR
NURSING AND MIDWIFERY QUALITY CARE-METRICS
DATA MEASUREMENT IN

INTELLECTUAL DISABILITY SERVICES 2018

OFFICE OF THE
NURSING AND MIDWIFERY SERVICES DIRECTOR
HEALTH SERVICE EXECUTIVE

NURSING & MIDWIFERY
QUALITY
CARE-METRICS

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Office of the
Nursing & Midwifery
Services Director

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Is this document a:

Policy		Procedure		Protocol		Guideline	X

Office of the Nursing and Midwifery Services Director,
Clinical Strategy and Programmes Division

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1.1 Glossary of Terms and Definitions

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"The system through which healthcare teams are accountable for the quality, safety and satisfaction of patients in the care they have delivered. For healthcare staff, this means specifying the clinical standards you are going to deliver and showing everyone the measurements you have made to demonstrate that you have done what you set out to do." (HSE 2014)

Documented:

The process of writing or electronically generating information that describes the care or service provided to the service user. Through documentation, nurses communicate to other health care professionals their observations, decisions, actions and outcomes of care (HSE 2018).

Evidence Based Practice:

Evidence based practice is the integration of best research evidence with clinical expertise and patient values in order to improve healthcare outcomes (Steevens 2013).

Inter-rater Reliability:

Measurement of the extent to which data collectors (raters) assign the same score to the same variable (indicator) is called inter-rater reliability (McHugh 2012). [Two data collectors collect the same sample data independently and then compare scores].

Nursing Metrics:

Nursing metrics are agreed standards of measurement for nursing and midwifery care, where care can be monitored against agreed standards and benchmarks (Foulkes 2011).

Policy:

A policy is a written statement that clearly indicates the position and values of the organisation on a given subject (HSE 2016).

Procedure:

A procedure is a written set of instructions that describe the approved and recommended steps for a particular act or sequence of events (HSE 2016).

Quality Care-Metrics:

Quality Care-Metrics assist healthcare organisations to assess the extent to which nursing and midwifery interventions have an impact on patient safety, quality and professional work environments. Quality Care-Metrics provide a measurement of the quality of nursing and midwifery clinical care processes (HSE 2018).

Quality Care Process Metric:

Is a quantifiable measure that captures quality in terms of how (or to what extent) nursing care is being done in relation to an agreed standard (HSE 2018).

Quality Care Process Indicator:

Is a quantifiable measure that captures what nurses and midwives are doing to provide that care in relation to a specific tool or method (HSE 2018).

Quality Care-Metric Data Collectors:

Quality Care-Metric data collectors are individuals within the organisation who are responsible for collecting data and data entry on a monthly basis to Test Your Care HSE (TYC HSE) (HSE 2018).

1.2 Abbreviations

ASSIA	Applied Social Sciences Index and Abstracts
ADoN/ADoM	Assistant Director of Nursing/Assistant Director of Midwifery
CENTRAL	Cochrane Central Register of Controlled Trials
CINAHL	Cumulative Index to Nursing and Allied Health Literature
CNM/CMM	Clinical Nurse Manager/Clinical Midwife Manager
CDSR	Cochrane Database of Systematic Reviews
DARE	Database of Abstract of Reviews of Effects
DOB	Date of Birth
GP	General Practitioner
HEFT	Heart of England Foundation Trust
HIQA	Health Information and Quality Authority
HCRN	Healthcare Record Number
HSE	Health Service Executive
IT	Information Technology
MCN	Medical Council Number
NCEC	National Clinical Effectiveness Committee
NHS	National Health Service (United Kingdom)
NMBI	Nursing and Midwifery Board of Ireland
NMPDU	Nursing and Midwifery Planning and Development Unit
ONMSD	Office of the Nursing and Midwifery Services Director
PIN	Personal Identification Number
PPPG	Policies, Procedures, Protocols and Guidelines
QCM	Quality Care-Metrics
TYC HSE	Test Your Care Health Service Executive

1.3 Introduction

1.3.1 Patient safety is one of the most critical issues facing healthcare today. The delivery of care that is safe, patient-centred, compassionate, effective and efficient is the responsibility of all health care professionals. As nurses and midwives are at the centre of the care delivery continuum delivering clinical care around the clock, their contribution to influence high quality, safe care is immense. Research suggests that errors and patient harm are caused by system and process failures (Institute of Medicine 1999).

1.3.2 Nurses and midwives are a well-educated, highly skilled, experienced and a valuable resource to the health service and their contribution makes a significant impact to optimise patient care delivery and outcomes. Quality Care-Metrics provide nurses and midwives with a framework and a measurement tool to engage in continuous quality improvement at the point of care delivery in order to positively influence the care experience for patients, clients and families.

1.3.3 This National Guideline outlines the essential criteria that need to be in place by the health service provider in order to participate in Quality Care-Metrics and to ensure fidelity of data quality. The ONMSD is responsible for leading the national implementation of Nursing & Midwifery Quality Care-Metrics in Ireland. A suite of documents to support this initiative is available at the following link: : **www.hse.ie/eng/about/who/onmsd/safecare/qcm**

1.3.4 Clinical care processes delivered by nurses and midwives are based on scientific evidence, standards and/ or professional consensus. Measuring the degree to which nurses and midwives adhere to care processes plays an important role in assuring, sustaining and improving the safety and quality of care delivered to patient and clients.

1.3.5 Nursing and Midwifery Quality Care-Metrics present ways of measuring the quality of nursing and midwifery care utilising care process quality indicators, which provide a framework for how the fundamentals of nursing care can be measured (Foulkes 2011).

1.3.6 Measurements of clinical care and outcomes have, in the past, proved to be complex and were not always nurse or midwife specific. Many healthcare providers and organisations lack basic information on the quality of nursing and midwifery care. Anecdotal evidence was often used as an indicator of concerns in relation to care delivery. Feedback in a systematic way to the individual nurse or organisation was not always available.

1.3.7 Quality Care-Metrics aim to illuminate the contribution of nursing and midwifery to safe and effective care and provide the evidence and assurance to managers, governance structures and regulators that care quality is a priority for the professions of nursing and midwifery.

1.3.8 Nursing and Midwifery Quality Care-Metrics are fundamentally a continuous quality improvement journey highlighting areas of practice that require improvement and measuring for tangible evidence that improvement efforts are impacting in the delivery of care.

1.4 Background

1.4.1 The concept arose from work undertaken in the United Kingdom by the Heart of England NHS Foundation Trust (HEFT). The Chief Nurse at HEFT developed a web based tool entitled Test Your Care (TYC) to monitor patient safety and promote care quality following an increase in complaints, falls, pressure ulcers and medication management errors.

1.4.2 In 2011, through Nursing & Midwifery Planning Development Units (NMPDU), Quality Care-Metrics were developed and implemented in over 100 clinical areas across the North West, North East & Dublin North and endorsed by the Office of the Nursing & Midwifery Services Director (ONMSD) Health Service Executive (HSE).

1.4.3 In the Republic of Ireland, a small number of acute hospitals had also commenced measuring nursing and midwifery care processes. These sites either employed external agencies to develop a system to meet their single site requirements or used the Microsoft excel application.

1.4.4 In 2014, the ONMSD entered into a service level agreement with HEFT to provide access to the TYC nationally to HSE organisations across the Republic of Ireland. The online web based measurement system TYC HSE is now widely available to all Directors of Nursing/ Midwifery who wish to embed Quality Care-Metrics within their local quality governance frameworks.

1.5 What are Quality Care-Metrics?

1.5.1 Quality Care-Metrics are a measure of the quality of nursing and midwifery clinical care processes aligned to evidenced based standards and agreed through national consensus in healthcare settings in Ireland. The process of national consensus is achieved through care group work streams (HSE 2018).

1.5.2 The Donabedian (1966) conceptual framework (Figure 1) is one of the most commonly used measures to estimate care quality and broadly falls into the categories of structure, process and outcome. Healthcare quality as defined by Donabedian, has been universally accepted and is widely used in the empirical literature in the development of quality standards (Haj et al., 2013).

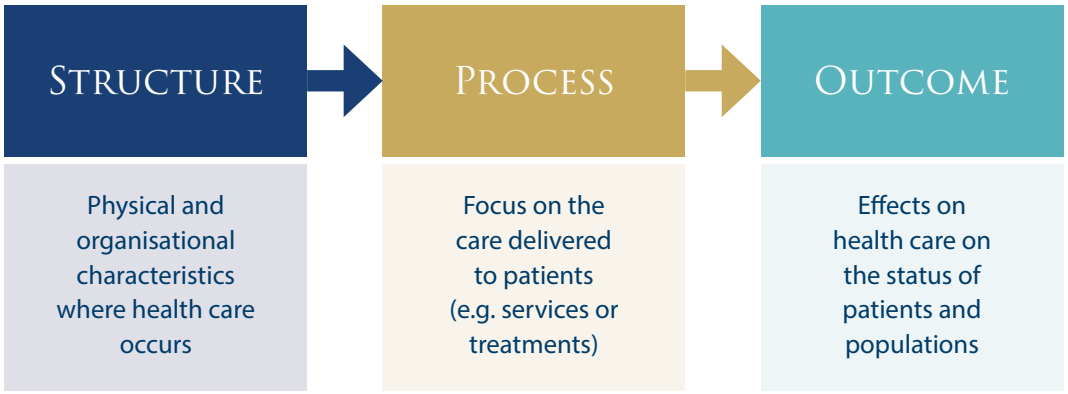


Figure 1: Donabedian's Conceptual Model for Evaluating Quality of Care (1966)

1.5.3 Structural indicators describe all the factors that affect the context in which care is delivered to include the physical facility, equipment, human resources as well as organisational characteristics such as staff training and qualifications.

1.5.4 Process indicators relate to the transactions between patients and care providers. It examines how care is provided in terms of its appropriateness, acceptability, completeness and competency. It includes dimensions such as communication, patient knowledge and the quality of the care intervention, the technical delivery of care and the interpersonal aspect of the clinician – patient relationship. Nursing and Midwifery Quality Care-Metrics examine indicators which measure the process components of care.

1.5.5 Outcome indicators refer to the end points of care such as improvement in function, recovery or survival and seek to capture whether the goals of care were achieved. They include measures such as immunisation rate, failure to rescue rate, falls incidence, hospital acquired pressure ulcers.

Work-streams

Nursing and Midwifery Quality Care-Metrics standardised across seven workstreams

Figure 2: Quality Care-Metrics Work Streams

1.5.6 Nursing and Midwifery Quality Care-Metrics currently consist of a core suite of quality indicators across seven care groups; Acute Care, Older Persons, Mental Health, Intellectual Disability, Midwifery, Public Health Nursing services and Children's services (Figure 2). Figure 3 demonstrates the updated metrics which are available for measurement and monitoring across the regions utilising Quality Care-Metrics TYC HSE system.

Nursing and Midwifery Quality Care-Metrics (2018)

Acute Care Services	Children's Services	Intellectual Disability Services	Older Persons Services	Mental Health Services	Public Health Nursing Services	Midwifery Services	Theatre
Patient Monitoring and Surveillance	Medicines Management	Nursing Documentation	Skin Integrity	Assessment	Pressure Ulcer Prevention and Management	Midwifery Plan of Care	Communication
Health Care Associated Infection Prevention and Control	Nursing Care Planning	Medication Management	Assessment and Management of Pressure Ulcers	Care Plan	Wound Care Management	Booking	Tissue Viability
Pain Assessment and Management	Healthcare Associated Infection Prevention	Environment	Optimizing Nutrition and Hydration	Management of Risk	Health Care Associated Infection Prevention & Control	Abdominal Examination (after 24 weeks gestation) on Current or Last Assessment	Pain Management
Nutrition and Hydration	Nutrition	Safeguarding	Pain Assessment and Management	Management of Violence and Aggression	Continence Assessment and Management	Intrapartum Fetal Wellbeing	Immediate Post-Operative Care
Continence Assessment and Management	Pain Assessment and Management	Person Centred Communication	Medicines Prescribing	Physical Health and Wellbeing	Client/Family/Carer Experience	Intrapartum Fetal Wellbeing Cardiotocography (CTG)	
Care Plan Development and Evaluation	Vital Signs Monitoring / PEWS	Physical health Assessments	Medicines Administration	Recovery Based Care	Health Promotion	Intrapartum Maternal Wellbeing	
Care Plan NMBI Guidance	Child and Adolescent Mental Health	Mental health Assessment	Infection Prevention and Control	Nursing Communication	Care Plan Development and Evaluation	Risk Assessment for Venous Thromboembolism (VTE) in Pregnancy & the Puerperium	
Medication Safety	Discharge Planning	Risk Assessment and Management	Activities of Daily Living	Medication Management	Medication Safety	Immediate Post Birth Care	
Medication Storage and Custody		Nursing Care Plan	Falls Risk	Service User Experience	Maternal Health	Communication (Clinical Midwifery Handover)	
Falls and Injury Management		Person Centred Planning	Falls Prevention		Infant Nutrition	Pain Management (other than labour)	
Delirium Prevention and Management		Positive Behaviour Support	Continence Assessment, Promotion and Management		Child Development Assessment	Infant Feeding	
Wound Care Management		End of Life/Palliative care	Frailty Nursing Assessment		Child and Family Health Needs Assessment	Postnatal Care (daily midwifery care processes)	
Pressure Ulcer Prevention and Management			End of Life and Palliative Care		Child Welfare and Protection	Post Birth Discharge Planning for Home	
			Psychological Nursing Assessment		Safeguarding Vulnerable Adult	Medication Administration	
			Responsive Behaviour Support			Medication, Storage and Custody (excluding MDAs)	
			Safeguarding Vulnerable Adults			MDA Scheduled Controlled Drugs	
			Social Assessment			Intravenous Fluid Therapy	
			Activities (Holistic)/Social Engagement			Clinical Record Keeping	
			Person Centred Care Planning			IMEWS Documentation Standards	
			MDA Medicines			IMEWS Parameters	
			Medicine Storage and Custody				
			Person Experience				

Figure 3: Nursing and Midwifery Quality Care-Metrics (2018)

1.6 Rationale for Measuring Nursing and Midwifery Care

1.6.1 The quality of healthcare is a national and international concern. Increasing reports of patient harm and poor quality care has created the requirement for healthcare professionals to question what is known about the quality of care being delivered in the clinical environment. In most organisations there is a wealth of data but no systematic means to collate, analyse and interpret data that will track the quality of care delivery.

1.6.2 For Nursing and Midwifery, Quality Care-Metrics provide a standardised system to measure the fundamentals of care where care can be monitored and improved against evidenced based standards and professional consensus. In a climate of greater fiscal controls on health budgets, focused attention is needed to maintain high-quality care delivery. There is an increased onus on healthcare providers to provide tangible evidence that they are assessing, monitoring and measuring the quality of care delivery.

1.6.3 Nursing and Midwifery Quality Care-Metrics provide a framework to identify gaps in care delivery, enabling action planning for quality improvement and provide the mechanism by which care providers can be accountable for the quality of their care delivery.

1.7 Clinical Governance

1.7.1 HSE (2014) defines clinical governance as: *"The system through which healthcare teams are accountable for the quality, safety and satisfaction of patients in the care they have delivered. For healthcare staff, this means specifying the clinical standards you are going to deliver and showing everyone the measurements you have made to demonstrate that you have done what you set out to do".*

1.7.2 Quality Care-Metrics supports Directors of Nursing/Midwifery to provide an accountability system that enables assessing, monitoring, reporting and feedback to teams about performance and identifies areas for improvement (HSE 2015; Donaldson et al 2005); using "real time" information regarding the quality of care patients/clients are receiving.

1.8 Benefits

1.8.1 Quality Care-Metrics provides a measuring system for individual nurses and midwives and their managers that:

- Monitors and assesses performance against evidenced based standards
- Quantifies trends and characteristics
- Highlights exceptional care and areas of risk which require immediate attention
- Provides a standardised system to track and benchmark the quality of care
- Offers direction on educational needs for healthcare staff
- Promotes staff engagement and accountability for the quality of care

1.8.2 In addition to providing real time information to nurses and midwives about how patients are benefiting from quality care delivery, metric data enables managers to monitor individual ward performance and organisational progress in delivering safer, quality focused patient care.

1.9 Purpose

1.9.1 The purpose of this guideline is to ensure a consistent approach to the implementation of Quality Care-Metrics by the Intellectual Disability services.

1.9.2 This guideline provides a standardized approach which will guide Quality Care-Metrics data collectors to interpret individual metric questions consistently thereby providing reliability and validity in the data collection process across all Intellectual Disability services nationally. The quality of data is very important as it may be used to inform the delivery of care. In this regard, it is vital that services know how reliable their data actually is.

1.10 Scope

1.10.1 This guideline applies to all registered nurses and midwives within Intellectual Disability services, who are engaged with Quality Care-Metrics in nursing and midwifery practice.

1.10.2 This guideline does not apply to other disciplines outside of nursing and midwifery.

1.10.3 Application of the guideline in individual HSE and HSE funded facilities is subject to local agreement, the development and application of a local supporting PPPG and the establishment of local governance structures.

1.10.4 The application of this guideline is aligned to the Quality Care-Metrics Intellectual Disability Research Report (HSE 2018).

1.10.5 All nurses and midwives within Intellectual Disability services, who are engaged with Quality Care-Metrics in nursing and midwifery practice, should complete Appendix I, Signature Sheet to indicate that they have read, understood and agree to the guideline. The completed signature sheet should be retained at service level.

1.11 Objective

1.11.1 The objective of this guideline is to enable nurses and midwives to engage with and implement Quality Care-Metrics using a consistent and standardised approach.

1.12 Outcomes

1.12.1 The guideline provides a framework to enable nurses and midwives to engage in care measurements for continuous quality improvement.

1.12.2 Application of this guideline will enable consistency in the reliability and validity of the data collection to support a standardised approach in Intellectual Disability services nationally.

1.12.3 Measurement of the quality of care delivered provides an assurance mechanism that captures the contribution and performance of nurses and midwives in a way that is transparent and focuses on improvement.

2.0METRICS, INDICATORS AND ADVICE FOR INTELLECTUAL DISABILITY SERVICES

The following Nursing Quality Care-Metrics are available for Intellectual Disability services as outlined in Figure 4.

Nursing Documentation	Medicines Management	Environment
Safeguarding	Person Centered Communication	Physical Health Assessment
Mental Health Assessment	Risk Assessment and Management	Nursing Care Plan
Person Centred Planning	Positive Behaviour Support	End of Life/ Palliative Care

Figure 4: Intellectual Disability Quality Care-Metrics

2.1 Nursing Documentation Quality Care-Metric

NURSING DOCUMENTATION **I** = Indicator, **A** = Data Collectors Advice, **N/A** = Not Applicable		
1	**I**	**Nursing written records are legible, in permanent ink and signed**
	A	Mark **Yes** if entries are all legible and all written in permanent black ink. Mark **Yes** if all entries have signature of nurse and that a signature bank is available for each signature corresponding to full name. Mark **No** if all elements are not adhered to.
2	**I**	**Documented alterations/corrections are as per NMBI Guidance**
	A	Mark **Yes** if entries are bracketed with a single line through them so the original entry is still visible. The alteration must be signed and dated with initials of person altering the record. Mark **No** if erasure fluid is used. Mark **No** if alterations do not follow this format. Mark **N/A** if no alterations have been made.

3	**I**	**Personal information is stored securely with access only to relevant persons in order to protect the privacy and confidentially of the individual's details**
	A	Mark **Yes** if all personal information is stored securely in a locked filing cabinet/room and the electronic system is encrypted with restrictive access to relevant personnel. Mark **No** if all personal information is not stored securely in a locked filing cabinet/room with restrictive access to relevant personnel. Mark **No** if the electronic system is not encrypted with restrictive access to relevant personnel.
4	**I**	**Documented entries are dated and timed (24 hour clock)**
	A	Check care plan and assessment documentation entries for the last 72hrs. Mark **Yes** if day/month/year is recorded for each 24hrs and time is listed in 24hr clock. Date is acceptable at beginning of each day. Mark **No** if date is not entered after 12mn for next day. Mark **No** if any time does not follow 24hr clock.
5	**I**	**Documented entries are in chronological order**
	A	Mark **Yes** if all entries in the nursing documentation are in chronological order for last 72 hours. Any variance from these needs to be documented. Mark **No** if not documented or not in order.
6	**I**	**Documented abbreviations/grading systems are from a national or local approved list/system**
	A	Mark **Yes** if abbreviations from the national abbreviations list are used. Mark **No** if abbreviations are not on this list. Mark **N/A** if no abbreviations have been made.
7	**I**	**All student nurse documented entries are countersigned by the supervising nurse**
	A	The standard of record keeping of those under supervision in the clinical area e.g. student nurses/midwives or nurses/midwives undertaking supervised clinical practice prior to registration, should be monitored by the nurse/midwife charged with responsibility for the supervision or her/his delegate. Mark **Yes** if all student entries are countersigned. (Check last 72 hours). Mark **No** if any student signature has not been countersigned. Mark **N/A** if there are no students nurses/midwives in the service area or no entries by a student nurse/midwife.

2.2 Medicines Management Quality Care-Metric

MEDICINES MANAGEMENT **I** = Indicator, **A** = Data Collectors Advice, **N/A** = Not Applicable		
1	**I**	**All medicinal products are stored in a locked cupboard/trolleys/room**
	A	Mark **Yes** if cupboard/trolley/room is locked or accessible by security code or pass key. Mark **No** if medicinal products are accessible in a cupboard/trolley/unlocked room. Fridge does not need to be locked if in a locked room. Mark **N/A** if medicinal products are not stored.

2	I	**Misuse of Drugs Act (MDA) are checked & signed at each shift changeover by registered nursing staff (member of day & night staff)**
	A	Mark **Yes** if MDA Scheduled Controlled Drugs Register has two signatures for members of day staff and night staff on shift changeover, checks back over last 72 hours. Where there is no night shift and MDA Scheduled Controlled Drugs are stored, Mark **Yes** if checked and signed at beginning and end of each day shift. Mark **No** if MDA Scheduled Controlled Drugs Register does not have two signatures for members of day staff and night staff. Mark **No** if not checked and signed at beginning and end of each day shift, if applicable. Mark **N/A** if unit does not store MDA Scheduled Controlled Drugs currently.
3	I	**Two signatures are entered in the MDA Drug Register for each administration of an MDA.**
	A	Mark **Yes** if MDA Scheduled Controlled Drugs Register has two signatures for last 72 hours. Mark **No** if there is not two signatures or if they were not on the same shift on the duty roster. Mark **N/A** if unit does not store MDAs currently.
4	I	**The MDA cupboard is locked and keys are held by the designated nurse**
	A	Mark **Yes** if the **MDA** drug cupboard is locked and the keys are held by a nurse/midwife on their person. Mark **No** if the **MDA** drug cupboard is not locked and the person holding the keys are not a registered nurse/midwife or if keys are not held by a person.
5	I	**MDA drug keys are kept separate from other medication keys**
	A	Mark **Yes** if keys are separate or detachable from other sets of keys as keys should not travel as one set. Mark **No** if MDA keys are not separable or detachable.
6	I	**The person's prescription documentation provides details of person's legible name, unique identifier and photo ID**
	A	Mark **Yes** if name and unique identifier are on each page. Where organisations do not use an unique identifier, Date of Birth (DOB) is a valid identifier. Mark **No** if all sheets do not have two identification details. Mark **No** if detachable prescription sheets do not have details. Mark **No** if name/unique identifier/DOB is not legible.
7	I	**The Allergy Status is clearly identifiable on the front page of the prescription chart**
	A	Mark **Yes** if allergy status is stated i.e. No known allergies. Mark **No** if left blank or it is not stated.
8	I	**Prescribed medicines not administered have an omission code entered and appropriate action taken**
	A	Mark **Yes** if omission codes are used and prescription sheet contains the initials of the nurse omitting the drug in last 72 hours. Mark **No** if no omission code is used or it is not initialled when a drug is not administered. Mark **N/A** if all drugs are administered and there is no requirement for an omission code.
9	I	**The prescription start date is recorded**
	A	Mark **Yes** if all drugs prescribed have a start date. This must include the Day/Month/Year. Mark **No** if all parts of date are not present.
10	I	**The correct legible dose of drug is recorded with correct use of abbreviations**
	A	Mark **Yes** if the correct dose is prescribed and legible. If decimals are used, check that a zero is written in front of the decimal point when there is no other figure (e.g. 0.5. 0.25). Mark **No** if unapproved abbreviations are used. *(International Units, Micrograms, Nanograms and units must not be abbreviated)*, check that quantities less than **1 gram** are written in **mgs** and quantities less than **1 mg** are written in **micrograms**.

11	I	**The route and/or site of administration is recorded**
	A	Mark **Yes** if the correct route is stated and if applicable that the site is identified. Mark **No** if route and site are not stated. Mark **N/A** if site is not applicable to prescribed drug.
12	I	**The frequency of medicines administration is as prescribed**
	A	Mark **Yes** if the frequency is listed and the appropriate times are either ticked or circled on the prescription chart at that time. Mark **No** if correct timings are not ticked /circled.
13	I	**The minimum dose interval and/or 24hr maximum dose is specified for all PRN medicines**
	A	Mark **Yes** if all drugs prescribed **"as required"** informs the nurse of the minimum dose interval for when medication can be administered. Mark **No** if this information is not provided. Mark **N/A** if drugs are not prescribed "as required".
14	I	**The prescription has the prescriber's signature (in ink) and Medical Council Number/ Nursing and Midwifery Board of Ireland personal identification number**
	A	The prescriber's signature can be identifiable if written clearly, if it contains an NMBI Personal Identification Number (PIN) or Medical Council Number (MCN) which is searchable online www.nmbi.ie or www.medicalcouncil.ie or there is an up to date local signature bank. Mark **Yes** if the signature includes NMBI PIN or MCN. Mark **Yes** if prescribers name and signature are identifiable from online signature bank, local signature bank or signature bank on the Drug Prescription Sheet. Mark **No** if PIN or MCN is not present or signature is not readily identifiable itself or from local signature bank. Mark **No** if signature is not written in ink.
15	I	**Discontinued medicines are crossed off dated and signed by person with prescriptive authority**
	A	Check for any discontinued drugs on prescription chart. Mark **Yes** if the drug is correctly crossed out and includes the full date (Day/Month/Year) it was discontinued and the signature of the prescriber who has discontinued the drug. Mark **No** if any element is not correct. Mark **No** if all discontinued drugs do not follow the standard. Mark **N/A** if there are no drugs discontinued.
16	I	**All medicines are reviewed in accordance with medication protocols**
	A	Mark **Yes** if there is documented evidence that medicines are reviewed in accordance with local protocols. Mark **No** if medicines are not reviewed.
17	I	**A current Drug Formulary is available at the point of administration**
	A	Mark **Yes** if a drug formulary MIMS/BNF etc. is available at the point of administration. It must be within two years of publication. It should be located at the point of administration to facilitate easy access for the nurse to reference drug details during drug administration. Mark **No** if unavailable or not within date.
18	I	**The generic name is used for each medicine unless the prescriber indicates a branded medicine and states "do not substitute"**
	A	Mark **Yes** if the generic name is used for drugs unless stated **"do not substitute"**. Mark **No** if generic name is not used for drugs unless stated **"do not substitute"**
19	I	**There is a support plan for self-administration of medication**
	A	Mark **Yes** if there is documented evidence of a support plan in the individuals care plan. Mark **No** if there is no evidence of a support plan in the individuals care plan. Mark **N/A** if the individual is not self-administrating.

20	**I**	**Self-administration of medicines is monitored for compliance and safety**
	A	Mark **Yes** if there is an audit process in place to monitor for compliance and safety. Mark **No** if there is no audit process in place to monitor for compliance and safety. Mark **N/A** if the individual is not self-administrating.

2.3 Environment Quality Care-Metric

ENVIRONMENT **I** = Indicator, **A** = Data Collectors Advice, **N/A** = Not Applicable		
1	**I**	**Policies, Procedures, Protocols and Guidelines (PPPGs) are current and signed by each registered nurse**
	A	Mark **Yes** if the PPPGs are current and are signed by the nursing staff. Mark **No** if the PPPGs are not current and are not signed by the nursing staff.
2	**I**	**There is evidence of an action plan based upon the most recent regulatory inspection**
	A	Mark **Yes** if an action plan is completed based upon the most recent regulatory inspection report. Mark **No** if no action plan is evident. Mark **N\A** if an action plan is not applicable.
3	**I**	**Environmental and infection control audits have been conducted and relevant action plans are in place**
	A	Mark **Yes** if an action plan is completed based on the completed environmental and infection control audit outcomes. Mark **No** if no action plan is evident. Mark **N/A** if the action plan is not applicable.

2.4 Safeguarding Quality Care-Metric

SAFEGUARDING **I** = Indicator, **A** = Data Collectors Advice, **N/A** = Not Applicable		
1	**I**	**Safeguarding policies are reviewed and up to date**
	A	Mark **Yes** if the safeguarding policies are current (within 3yrs) and are signed by the nursing staff. Mark **No** if the safeguarding policies are not current and are not signed by the nursing staff.
2	**I**	**Information is provided to the person regarding their rights (support to exercise their rights, advocacy, safeguarding/protection) in accessible formats**
	A	Mark **Yes** if there is evidence in the Personal Plan that information is provided to the person regarding their rights in accessible formats. Mark **No** if there is no evidence in the Personal Plan that information is provided to the person regarding their rights in an accessible format.

3	I	**Where there is evidence of a safeguarding concern there is documentation of registered nurses compliance with the safeguarding policy**
	A	Mark **Yes** if there is documented evidence that procedures in line with the safeguarding policies are followed. Mark **No** if there is no documented evidence that procedures in line with the safeguarding policies are followed. Mark **N/A** if there is no evidence of a safeguarding concern.
4	I	**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**
	A	Mark **Yes if** a personalised risk assessment has been completed in consultation with the person and relevant persons and is evident in the nursing care plans. Mark **No** if a personalised risk assessment has not been completed. Mark **No** if it has not been completed in consultation with the person and relevant persons. Mark **N/A** if a personalised risk assessment is not applicable.
5	I	**A plan is in place on the person's personal property, finances and possessions**
	A	Mark **Yes** if there is documented evidence in the Personal Plan, of a plan on the person's personal property, finances and possessions. Mark **No** if there no documented evidence of a plan on the person's personal property, finances and possessions in the Personal Plan.
6	I	**When assisting the person in the management of their finances, there is evidence that clear records are maintained, reconciled and subject to audit**
	A	Mark **Yes** if there is evidence that the records are reflective of the person's preferences with regard to their finances and are regularly reviewed and audited as per local policy. Mark **No** if there is no evidence that the records are reflective of the person's preferences with regard to their finances and are not regularly reviewed and audited as per local policy.

2.5 Person Centred Communication Quality Care-Metric

PERSON CENTRED COMMUNICATION **I** = Indicator, **A** = Data Collectors Advice, **N/A** = Not Applicable		
1	I	**A communication assessment has been conducted and a plan is documented**
	A	Mark **Yes** if a communication assessment has been completed with the person and a communication plan has been developed incorporating the communication skills and preferences of the person. Mark **No** if a communication assessment has not been completed with the person and a communication plan has not been developed incorporating the communication skills and preferences of the person. Mark **N/A** if not applicable.

2	I	**The person's choice is obtained, respected and documented**
	A	Mark **Yes** if there is evidence of the person participation in the development of the communication plan. Mark **No** if there is no evidence of the person participation in the development of the communication plan. Mark **N/A** if not applicable.
3	I	**Communication strategies are identified in the person's care plan**
	A	Mark **Yes** if there is evidence of augmentative and alternative communication strategies in the persons care plan. Mark **No** if there is no evidence of augmentative and alternative communication strategies documented in the persons care plan. Mark **N/A** if not applicable.
4	I	**The person's communication level and style are documented**
	A	Mark **Yes** if the person's communication level and style are documented. Mark **No** if the person's communication level and style are not documented.
5	I	**Non-verbal and atypical communication behavioural patterns are documented**
	A	Mark **Yes** if the person's non-verbal and atypical communication behavioural patterns are documented. Mark **No** if the person's non-verbal and atypical communication behavioural patterns are not documented. Mark **N/A** if non-verbal and atypical communication behavioural patterns are not present.
6	I	**There is documented evidence of a multidisciplinary team approach**
	A	Mark **Yes** if there is documented evidence of involvement of the multidisciplinary team in the assessment and communication plan. Mark **No** if there is no documented evidence of involvement of the multidisciplinary team in the assessment and communication plan. Mark **N/A** if involvement of the multidisciplinary team is not required.
7	I	**Information provided is in an accessible format for the individual**
	A	Mark **Yes** if the information provided to the person is as per the communication strategies in the communication plan. Mark **No** if the information provided to the person is not according to the communication strategies in the communication plan.
8	I	**Where non-engagement occurs, this is noted in the person's care plan**
	A	Mark **Yes** if there is documented evidence where non-engagement occurs. Mark **No** if is no documentation where non-engagement occurs. Mark **N/A** if non-engagement has not occurred.

2.6 Physical Health Assessment Quality Care-Metric

PHYSICAL HEALTH ASSESSMENT **I** = Indicator, **A** = Data Collectors Advice, **N/A** = Not Applicable		
1	**I**	**A comprehensive health assessment has been conducted**
	A	Mark **Yes** if a comprehensive health assessment has been completed. Mark **No** if a comprehensive health assessment has not been completed.
2	**I**	**Known associated health risk factors are identified within the care plan**
	A	Mark **Yes** if there is documented evidence of known associated health risk factors in the care plan. Mark **No** if there is no documented evidence of known associated health risk factors in the care plan. Mark **N/A** if not applicable.
3	**I**	**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**
	A	Mark **Yes** if there is evidence of use of recognised assessment tools as per local agreement appropriate to the person's needs. Mark **No** if there is no evidence of use of recognised assessment tools as per local agreement appropriate to the person's needs. Mark **N/A** if not applicable.
4	**I**	**The person has been supported to engage in health screening**
	A	Mark **Yes** if there is documented evidence in the Personal Plan that the person has been supported to engage in health screening. Mark **No** if there is no documented evidence in the Personal Plan that the person has been supported to engage in health screening.
5	**I**	**The health care plan demonstrates a systematic approach to nursing care, management and interventions**
	A	Mark **Yes** if there is evidence of a health care plan based on a recognised Model of Nursing. Mark **No** if there is no health care plan has been devised. Mark **No** if the health care plan is not based on a recognised Model of Nursing.
6	**I**	**Physical health checks are conducted at least annually**
	A	Mark **Yes** if there is documented evidence that a physical health check has been conducted within the last twelve months. Mark **No** if there is no documented evidence of an annual physical health check within the last twelve months.
7	**I**	**An individualised health passport has been developed in conjunction with the person**
	A	Mark **Yes** if an individualised health/hospital passport has been developed in conjunction with the person. Mark **No** if an individualised health passport has not been developed in conjunction with the person.

2.7 Mental Health Assessment Quality Care-Metric

MENTAL HEALTH ASSESSMENT **I** = Indicator, **A** = Data Collectors Advice, **N/A** = Not Applicable		
1	**I**	**A nursing mental health assessment has been conducted and documented**
	A	Mark **Yes** if a nursing mental health assessment has been completed and documented. Mark **No** if a mental health assessment has not been completed and documented. Mark **N/A** if not applicable.
2	**I**	**A diagnosis of mental health illness is documented**
	A	Mark **Yes** if a diagnosis of mental health illness exists and is documented in the personal plan. Mark **No** if a diagnosis of mental health illness exists and has not been documented in the personal plan. Mark **N/A** if a diagnosis of mental health illness does not exist.
3	**I**	**The individuals care plan demonstrates the nursing care, management and interventions to support the person's mental health and well-being**
	A	Mark **Yes** if there is an individualised mental health and well-being care plan supporting the persons identified needs. Mark **No** if there is no individualised mental health and well-being care plan supporting the persons identified needs.

2.8 Risk Assessment and Management Quality Care-Metric

RISK ASSESSMENT AND MANAGEMENT **I** = Indicator, **A** = Data Collectors Advice, **N/A** = Not Applicable		
1	**I**	**There is evidence of positive proactive risk assessment and an action plan for identified risks within the person's care plan**
	A	Mark **Yes** if a risk assessment has been completed and a risk management plan is in place in response to any identified risk in the person's care plan/personal plan. Mark **No** if a risk management plan has not been completed, where a risk has been identified. Mark **N/A** if the person has not been identified as at risk.
2	**I**	**Appropriate referral and resulting consultations have occurred to address identified risks and are documented**
	A	Mark **Yes** if there is documented evidence of referrals and consultations appropriate to the identified risk. Mark **No** if there is no documented evidence of referrals and consultations appropriate to the identified risk. Mark **N/A** if the person has not been identified as at risk.

3	**I**	**Incidents are documented within the care plan and reported/escalated as appropriate**
	A	Mark **Yes** if there is documented evidence of incidents, incident reporting and escalation as per local policy. Mark **No** if there is no documented evidence of incidents, incident reporting and escalation as per local policy. Mark **N/A** if not applicable.
4	**I**	**A risk re-assessment is conducted and documented**
	A	Mark **Yes** if a re-assessment has been completed and documented at least annually. Mark **No** if a re-assessment has been not been completed and documented at least annually. Mark **N/A** if not applicable.

2.9 Nursing Care Plan Quality Care-Metric

NURSING CARE PLAN **I** = Indicator, **A** = Data Collectors Advice, **N/A** = Not Applicable		
1	**I**	**The personal plan is based on a model of care (Nursing Care Plan is based on an identified model of care)**
	A	Mark **Yes** if an individualised personal plan is in place. This plan should include an identified nursing model of care. Mark **No** if an individualised personal plan is not devised or there is no identified nursing model of care.
2	**I**	**An assessment of need has been conducted and documented**
	A	Mark **Yes** if all aspects of the assessment of need have been completed. Mark **No** if all aspects of the assessment of need have not been completed.
3	**I**	**An individualised plan of care has been developed**
	A	Mark **Yes** if an individualised nursing plan of care has been completed which reflects the current nursing needs of the person. Mark **No** if an individualised nursing plan of care has not been completed or does not reflect the current nursing needs of the person.
4	**I**	**All documented nursing interventions are dated, timed and signed**
	A	Mark **Yes** if all nursing intervention entries are dated timed and signed as per NMBI guidance. Mark **No** if all nursing intervention entries are not dated timed and signed as per NMBI guidance.
5	**I**	**The care plan reflects the person's current health needs**
	A	Mark **Yes** if the care plan is reflective of the person's current health needs. Mark **No** if the care plan is not reflective of the person's current health needs

6	I	**There is evidence of regular review of the care plan, dated, timed and signed**
	A	Mark **Yes** if there is documented evidence of regular review of the care plan and it is dated timed and signed as per NMBI guidance. Mark **No** if there is no documented evidence of regular review of the care plan or it is not dated/timed/signed as per NMBI guidance.

2.10 Person Centred Planning Quality Care-Metric

PERSON CENTRED PLANNING **I** = Indicator, **A** = Data Collectors Advice, **N/A** = Not Applicable		
1	I	**A personal plan/assessment of all aspects of the person's life has been conducted**
	A	Mark **Yes** if there is documented evidence of a completed personal plan and use of appropriate assessment tools across all aspects of the person's life. Mark **No** if there is no documented evidence of a completed personal plan and use of appropriate assessment tools across all aspects of the person's life.
2	I	**Actions/interventions are devised to support the person within their personal plan**
	A	Mark **Yes** if there is documented evidence in the personal plan of planned actions and interventions that are outcome-focused to support the person. Mark **No** if there is no documented evidence in the personal plan of planned actions and interventions that are outcome-focused to support the person.
3	I	**There is evidence of the person's involvement in their Personal Plan**
	A	Mark **Yes** if their evidence of the person's involvement in their personal plan incorporating their lifestyle, skills, relationships, preferences, aspirations and other significant characteristics. Mark **No** if there is not any documented evidence of all of these.
4	I	**The person's level of need and preferences regarding the provision of intimate personal support are identified**
	A	Mark **Yes** if there is documented evidence that the person's choices and decisions with regard to their intimate personal needs are supported. Mark **No** if there is no evidence that the person's choices and decisions with regard to their intimate personal needs are supported.
5	I	**Self-advocacy/choices are recorded, respected and documented**
	A	Mark **Yes** if there is documented evidence that the person's decisions and choices are recorded and respected. Mark **No** if the person's decisions and choices are not recorded respected and documented.
6	I	**A transition plan exists across each life course stage**
	A	Mark **Yes** if a transition plan is completed and current and evident of sensitive, person-focused, planned, structured and accessible support of the person moving between activities, events, environments or other changes in their day to day lives. Mark **No** if a transition plan is not completed and current and evident of sensitive, person-focused, planned, structured and accessible support of the person moving between activities, events, environments or other changes in their day to day lives.

2.11 Positive Behaviour Support Quality Care-Metric

POSITIVE BEHAVIOUR SUPPORT **I** = Indicator, **A** = Data Collectors Advice, **N/A** = Not Applicable		
1	**I**	**An assessment of distress has been conducted**
	A	Mark **Yes** if there is evidence of a completed assessment of distress. Mark **No** if there is no evidence of a completed assessment of distress. Mark **N/A** if not applicable.
2	**I**	**A Personal Behavioural plan exists**
	A	Mark **Yes** if a personal behavioural plan exists and is reflective of the person's needs. Mark **No** if no personal behavioural plan exists or is not reflective of the person's needs. Mark **N/A** if a personal behavioural plan is not required.
3	**I**	**Proactive and Reactive Behavioural strategies are identified and evident**
	A	Mark **Yes** if there is documented evidence of proactive and reactive strategies identified and included in the Personal Behaviour plan. Mark **No** if proactive and reactive strategies are not identified or included in the Personal Behaviour plan. Mark **N/A** if not required.
4	**I**	**There is evidence that Positive Behavioural support strategies are reviewed by the multidisciplinary team**
	A	Mark **Yes** if there is evidence that Positive Behavioural support strategies are reviewed by the multidisciplinary team within the agreed timeframe in line with local policy. Mark **No** if there is evidence that Positive Behavioural support strategies are not reviewed by the multidisciplinary team within the agreed timeframe in line with local policy. Mark **N/A** if not required.

2.12 End of Life/Palliative Care Quality Care- Metric

END OF LIFE/PALLIATIVE CARE **I** = Indicator, **A** = Data Collectors Advice, **N/A** = Not Applicable		
1	**I**	**An end of life care plan is evident and documented**
	A	Mark Yes if an individualised end of life plan of nursing care has been completed which reflects the current nursing needs of the person. Mark No if an individualised end of life plan of nursing care has not been completed or does not reflect the current nursing needs of the person. Mark N/A if not applicable.
2	**I**	**The person has been supported to make end of life decisions and this process is evident within the personal care plan**
	A	Mark Yes if there is documented evidence that the plan of care has been developed in consultation with the person and or relevant others. Mark No if there is no documented evidence that the plan of care has been developed in consultation with the person and or relevant others. Mark N/A if not applicable.
3	**I**	**An ongoing assessment of changing health needs is evident and documented**
	A	Mark Yes if there is evidence of regular review of the persons changing health needs and assessments are completed timed and dated. Mark No if there is no evidence of regular review of the persons changing health needs and assessments are not completed timed and dated. Mark N/A if not applicable.
4	**I**	**A collaborative approach is in evidence across services**
	A	Mark Yes if there is documented evidence of regular communication between the person, relevant others and the multi-disciplinary team. Mark No if there is no documented evidence of regular communication between the person, relevant others and the multi-disciplinary team. Mark N/A if not applicable.
5	**I**	**There is evidence of ongoing information sharing with the individual regarding their end of life**
	A	Mark Yes if there is evidence that the person receives effective appropriate communication on their condition throughout this stage. Mark No if there is no evidence that the person receives effective appropriate communication on their condition throughout this stage. Mark N/A if not applicable.

Note: If safety concerns are present, highlighted by any of the above indicators, consider completing a Nursing Metrics Immediate Safety/Risk Form (Appendix II) to ensure appropriate action can be taken when required after the data collection has been completed.

3.0 IMPLEMENTATION FRAMEWORK

3.1 Purpose

The purpose of this implementation framework is to provide support and guidance to nursing and midwifery organisations within the HSE, who wish to implement the Nursing and Midwifery Quality Care-Metrics initiative. A standardised approach to implementation of Quality Care-Metrics across HSE and voluntary organisations will ensure consistency in the measurement of the standard of care across all services.

3.2 Foundations of the Framework

This framework was developed to support the implementation of Nursing & Midwifery Quality Care-Metrics to ensure a systematic, cohesive and sustainable approach. The framework is based on a clear vision statement, a set of core principles and a step-by-step guide (see Figure 5: Framework for Implementation).

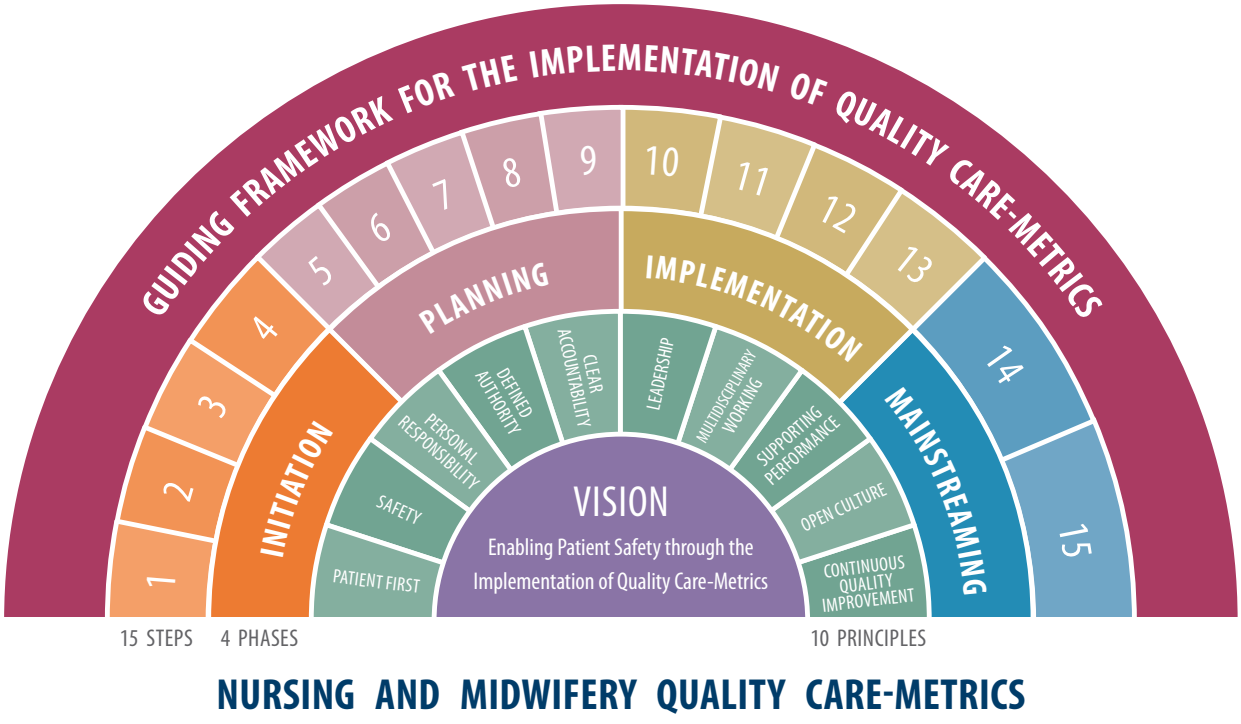


Figure 5: Framework for Implementation of Quality Care-Metrics

3.2.1 Vision Statement: The vision statement outlines the purpose and ambition in the introduction of Quality Care-Metrics to HSE and Voluntary healthcare organisations in Ireland.

3.2.2 Core Principles: The ten core principles in Figure 6 replicate the clinical governance principles developed by the HSE (2012) and provide the foundations for patient safety and quality improvement. A descriptor for each of the 10 Guiding Principles is provided (Figure 7), which outlines in more detail, information relating to the each of the principles and their relationship with clinical governance in order to improve patient outcomes.

Figure 6: Guiding Principles for Clinical Governance (HSE 2012)

GUIDING PRINCIPLES DESCRIPTOR *(Source: HSE (2012a) Quality and Patient Safety, Clinical Governance Information Leaflet)*	
PATIENT FIRST	Based on a partnership of care between patients, families, carers and healthcare providers in achieving safe, easily accessible, timely and high quality service across the continuum of care.
SAFETY	Identification and control of risks to achieve effective, efficient and positive outcomes for patients and staff.
PERSONAL RESPONSIBILITY	Where individuals, whether members of healthcare teams, patients or members of the public, take responsibility for their own and others healthcare needs.
DEFINED AUTHORITY	The scope given to staff at each level of the organisation to carry out their responsibilities. The individual's authority to act, the resources available and the boundaries of the role are confirmed by their direct line manager.
CLEAR ACCOUNTABILITY	A system whereby individuals, functions or committees agree accountability to a single individual.
LEADERSHIP	Motivating people towards a common goal and driving sustainable change to ensure safe high quality delivery of clinical and social care.
INTER-DISCIPLINARY WORKING	Work processes that respect and support the unique contribution of each individual member of a team in the provision of clinical and social care. Interdisciplinary working focuses on the interdependence between individuals and groups in delivering services. This requires proactive collaboration between all members.
SUPPORTING PERFORMANCE	In a continuous process, managing performance in a supportive way, taking account of clinical professionalism and autonomy in the organisational setting. Supporting a director/manager in managing the service thereby contributing to the capability and the capacity of the individual and organisation. Measurement of the patients and staff experience being central in performance measurement (as set out in the National Charter 2010).
OPEN CULTURE	A culture of trust, openness, respect and caring where achievements are recognised. Open discussion of adverse events are embedded in everyday practice and communicated openly to patients. Staff willingly report adverse events and errors, so there can be a focus on learning, research, improvement, and appropriate action taken where there have been failings in the delivery of care.
CONTINUOUS QUALITY IMPROVEMENT	A learning environment and a system that seeks to improve the provision of services with an emphasis on maintaining quality in the future and not just controlling processes. Once specific expectations and the means to measure them have been established, implementation aims at preventing future failures and involves setting goals, education and the measurement of results so that improvement is on-going.

Figure 7: Guiding Principles Descriptor

3.2.3 Implementation Phases

The introduction of Nursing & Midwifery Quality Care-Metrics is based on the four stages of the project management lifecycle which are:

- Initiation
- Planning
- Implementation
- Mainstreaming

The steps to support implementation are outlined in Figure 8.

Figure 8: 15 Steps to Support Implementation of Quality Care-Metrics

INITIATION	STEP 01	NMPDU invite expressions of interest from services	→	Services contact their regional NMPD
	STEP 02	NMPDU provide information sessions	→	Services are invited to send key managers and staff
	STEP 03	Services prepare, complete and submit State of Readiness Checklist to NMPDU	→	Services need to have systems and processes in place to implement Quality Care-Metrics
	STEP 04	Director of Nursing/Midwifery enables an appropriate Governance structure to oversee the implementation and maintenance of the Quality Care-Metrics Initiative	→	This involves identification of: service lead and data collectors, agreement on set of monthly metrics and establishment of membership of governance group with terms of reference
PLANNING	STEP 05	Director of Nursing/Midwifery informs NMPDU of Service Lead	→	Local implementation plan is developed
	STEP 06	Director of Nursing/Midwifery agrees the number of sites, data sharing and order of priority	→	Service lead informs NMPDU Quality Care-Metrics Project Officer of site names & prefix for TYC HSE
	STEP 07	Sites go live on TYC HSE	→	NMPDU Quality Care-Metrics Project Officer arranges site set up on TYC HSE
	STEP 08	Director of Nursing/Midwifery agrees and identifies data collectors to undertake Quality Care-Metrics monthly	→	Service Lead requests usernames and passwords from NMPDU Quality Care-Metrics Project Officer for all authorised staff to access TYC HSE
	STEP 09	Data collectors, managers and staff undertake Quality Care-Metrics education session	→	NMPDU Quality Care-Metrics Project Officer provides initial education session to relevant staff followed by Train the Trainer approach thereafter
IMPLEMENTATION	STEP 10	Data collectors undertake collection of Quality Care-Metrics in agreed sites monthly as per implementation plan	→	Immediate Risk/Safety Forms and brief feedback are provided to Clinical Nurse/Midwife Manager (CNM/CMM) onsite. Data is entered onto TYC HSE
	STEP 11	CNM/CMM or designate views results and prints same for team	→	CNM/CMM enables team discussion on achieving quality standards
	STEP 12	CNM/CMM or designate draws up action plans for any amber or red indicators	→	Service Lead and CNM/CMM liaise re action plans each month
	STEP 13	Results, action plans and interventions presented at relevant governance and management meetings	→	Service lead provides reports and findings at appropriate governance meetings
MAINSTREAMING	STEP 14	Communicate and disseminate results and findings	→	Choose dissemination routes
	STEP 15	Monitor, review and evaluate local implementation plan at set intervals	→	Update local implementation plan, Introduce further sites Provide training for new members of staff

3.3 Governance

3.3.1 The ONMSD provides the overarching national governance that enables the development of a robust system and infrastructure for the introduction of Quality Care-Metrics in clinical organisations.

3.3.2 The initiative is managed and co-ordinated by a national lead and is supported by Project Officers from each NMPDU.

3.3.3 In addition, the ONMSD provides the leadership to enable the development of a suite of Quality Care-Metrics that are sensitive to nursing and midwifery care processes. The development of new nurse/midwife-sensitive quality care-metrics were organised through seven work-streams (see Figure 9).

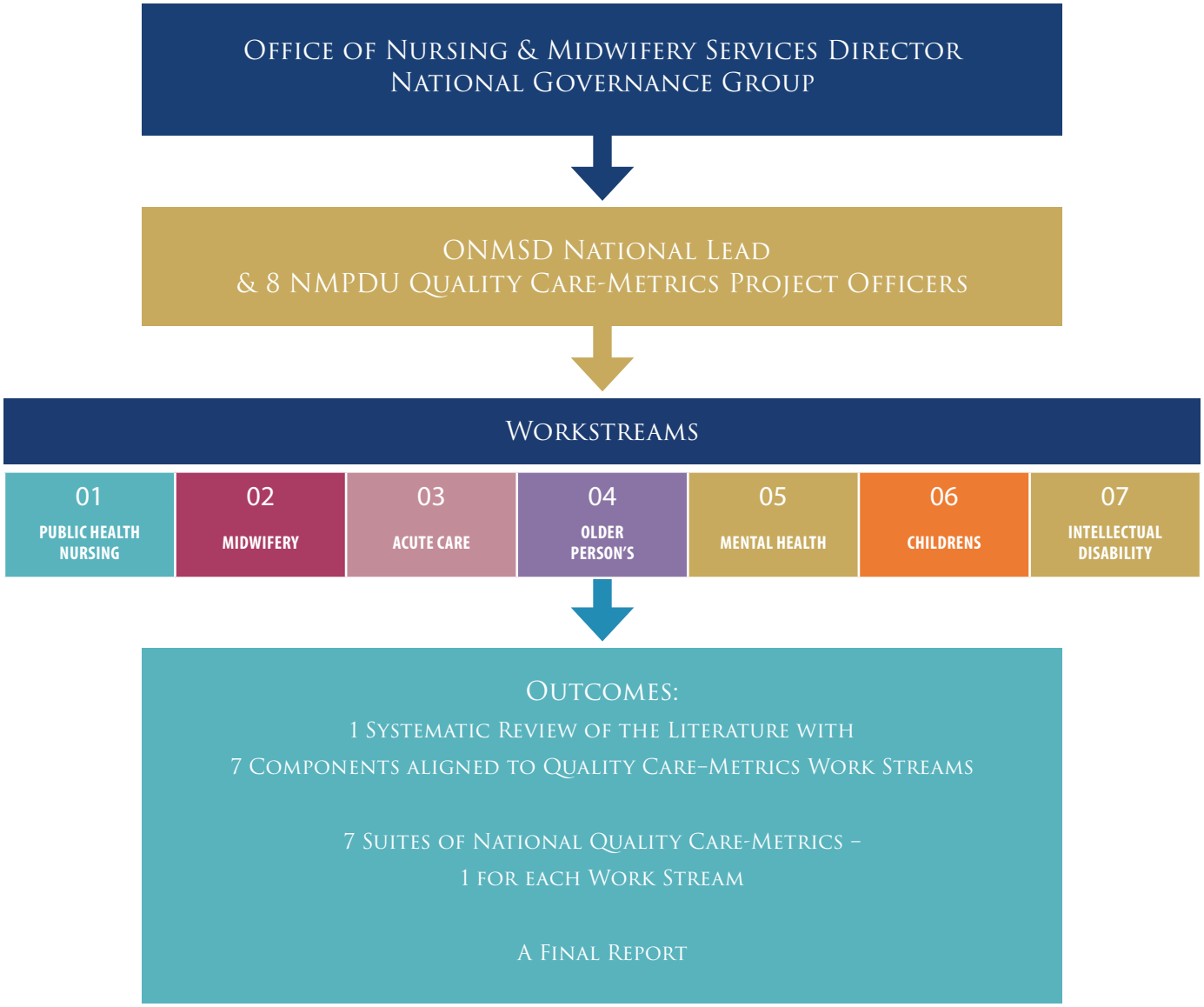


Figure 9: Nursing and Midwifery Quality Care-Metrics Governance Flow Chart

3.3.4 The ONMSD is not responsible for the data and evidence generated from the data collection system on **http://www.testyourcarehse.com**. Directors of Nursing & Midwifery are the accountable officers for all data generated on the TYC HSE system.

3.3.5 NMPDU Directors play a key role in supporting and advising on the implementation and management of Quality Care-Metrics in clinical organisations.

3.3.6 Each NMPDU Director has identified a Project Officer to support nominated service leads, to establish and embed Quality Care-Metrics in practice.

3.3.7 Governance for the implementation of Quality Care-Metrics in clinical organisations is the responsibility of Directors of Nursing & Midwifery.

3.3.8 Directors of Nursing & Midwifery are accountable for the quality of nursing and midwifery care delivery and to ensure appropriate governance and leadership structures are in place to assess, monitor and review care standards to include

- Development of a plan for the monitoring, audit and evaluation of Quality Care-Metrics including timelines and identification of the lead person(s) responsible for these processes
- Identification of the specific outcomes which the implementation of Quality Care-Metrics aims to achieve and processes to measure these outcomes
- Development of a communication plan to disseminate the Quality Care-Metrics results/findings to the relevant stakeholders (as appropriate) at ward/unit or management level
- Implementation of processes to support continuous improvement in the development, implementation, monitoring, auditing and evaluation of Nursing and Midwifery Quality Care-Metrics Data Measurement in Intellectual Disability Services such as PPPG Development Groups, project sponsors or appropriate governance group, quality and safety groups/committees etc.

3.4 State of Readiness and Capacity Checklist

3.4.1 If a nursing or midwifery service has interest in implementing Quality Care-Metrics, this service can self-assess their organisation in relation to key factors on how ready they are to begin the implementation process using the State of Readiness and Capacity Checklist as outlined in Figure 10.

Rate your organisation from the perspectives of capacity and readiness to implement the Quality Care-Metrics	**READINESS** *How would you rate your organisation's readiness?*			**CAPACITY** *How would you rate your organisation's capacity?*		
Areas for Consideration	High	Medium	Low	High	Medium	Low
The Management team are fully supportive of the implementation of Nursing and Midwifery Quality Care-Metrics						
There is a level of shared understanding among nursing and midwifery staff with regards to Quality Care-Metrics.						
A Quality Care-Metrics Implementation and Governance Plan is in place or in development e.g. phased roll-out, selection of specific metrics to be collected						
There is a level of resources available to support the Quality Care-Metrics implementation. Consider:						
• A Quality Care-Metrics Project Lead/Champion with allocated time & responsibility						
• Identified Quality Care-Metrics Data Collectors						
• ICT resources and support e.g. Laptops, printers, tablets etc						
• Internet and Wi-fi availability: online or offline collection will both be possible						
There is a defined reporting process to feedback and disseminate findings from the Quality Care-Metrics e.g. ward communication boards, monthly staff meetings						
There is an action plan review process and governance system to escalate and action on any risks or poor performance identified in Quality Care-Metrics measurement.						
There is a Whole Systems Approach on how findings can be disseminated and utilised in conjunction with key nursing and midwifery data to improve care delivery						

Figure 10: State of Readiness and Capacity Checklist

3.4.2 Providing this information assists the Quality Care-Metrics Project Leads in developing a regional and national plan for implementation. It also assists the service in identifying what is required in order to increase their organisation's readiness to successfully implement the Nursing and Midwifery Quality Care-Metrics.

4.0 IMPLEMENTATION AT SERVICE LEVEL

4.1 Implementation Plan

4.1.1 The implementation framework as set out in Figure 5 should be used at local level to support the implementation of Quality Care-Metrics in order to support a systematic, cohesive and sustainable approach to the implementation process.

4.1.2 As part of the development of an implementation plan, due consideration should be given to the identification of required actions, facilitators and the determined timelines for implementation in addition to any possible barriers which may impede the implementation process.

4.1.3 To determine the readiness of the organisation to commence the implementation process, the State of Readiness and Capacity Checklist (Figure 10) must be completed and submitted to the Quality Care-Metrics Project Officer prior to commencement of the implementation process.

4.2 Education/Training Plans for Implementation

4.2.1 Education/training plans should be developed by the nominated service lead at service level to meet local requirements. This can be completed in collaboration with the relevant NMPDU Quality Care-Metrics Project Officer who may provide information/education sessions to individual healthcare organisations with a view to the services undertaking a Train the Trainer approach for on-going education.

4.2.2 The Quality Care-Metrics hub on HSELanD is also available to support education/training plans as it is an online resource that provides relevant information and learning resources on Quality Care-Metrics for nurses and midwives.

4.3 Identification of Lead Person(s) Responsible for Implementation

4.3.1 As part of the governance structure at service level to support the implementation of Quality Care-Metrics, the Director of Nursing and Midwifery is required to nominate a Service Lead who will co-ordinate the implementation process through the development of local implementation plan.

4.4 Specific Roles and Responsibilities

4.4.1 Nursing & Midwifery Planning and Development Unit Director

- Advise and support the development and implementation of Quality Care-Metrics in healthcare organisations within their region
- Provide resources to implement Quality Care-Metrics
- Establish, monitor and evaluate progress aligned to NMPDU regional implementation plans
- Contribute to the development of new nurse/midwife-sensitive Quality Care-Metrics by the provision of an NMPDU Director as chairperson to each of the work-streams
- Ensure that development of new nurse/midwife-sensitive Quality Care-Metrics is based on national standardised criteria
- Facilitate the review of metrics as new evidence presents within defined timelines
- Make recommendations as required to the National Lead

4.4.2 NMPDU Quality Care-Metrics Project Officer

- Each NMPDU has identified a Project Officer within their region to enable implementation at local and regional level and to support the development of new Quality Care-Metrics in the established work-streams. Additional responsibilities include:
- Work collaboratively under the direction of the National Lead in order to ensure consistency of approach and that the goals and targets agreed on behalf of the ONMSD are achieved
- Contribute to local implementation plans developed and agreed with their respective NMPDU Director
- Lead on the development of new metrics through the established work streams
- Work collaboratively with Quality Care-Metrics Service Leads in individual healthcare organisations to support implementation of agreed Quality Care-Metrics
- Provide information/education sessions to individual healthcare organisations with a view to the services undertaking a Train the Trainer approach for on-going education

- Arrange the issue of usernames and passwords to new users on the TYC HSE system
- Liaise with Nominated Service Lead in relation to new site setup on the TYC HSE system and any technical issues experienced by users which may require escalation to the TYC HSE IT support person
- Monitor and track the uptake and usage of Quality Care-Metrics within clinical services
- Participate in Nursing and Midwifery Quality Care-Metrics National Group meetings
- Support the National Lead in the promotion, marketing and evaluation of Quality Care-Metrics, to include conference presentations and journal publications

4.4.3 Director of Nursing and Midwifery

- Liaise with Regional NMPDU Director and/or Regional NMPDU Quality Care-Metrics Project Officer in order to introduce Quality Care-Metrics within their organisation
- Approve the implementation of Quality Care-Metrics within their organisation
- Nominate a Quality Care-Metrics Service Lead and delegate responsibility for implementation in agreed locations
- Agree the governance structure for the management of Quality Care-Metrics data internally to include data collection methods, monitoring of results, action planning and follow-up
- Create a vision for how Quality Care-Metrics data contribute to the hospital and/or services quality governance framework

4.4.4 Nominated Service Lead

- Coordinate and manage the implementation of Quality Care-Metrics within the organisation
- Agree Quality Care-Metrics for implementation with the Director of Nursing/ Midwifery
- Facilitate training sessions for nursing/midwifery Quality Care-Metrics data collectors on the TYC HSE system and establish a train the trainer approach for future education
- Participate in the Quality Care-Metrics local governance committee
- In conjunction with the Director of Nursing/Midwifery, identify data collectors with senior nurse/midwifery management experience
- Establish a monthly process for data collection
- Liaise with CNM on action plans where performance improvement is required at ward/unit level
- In conjunction with CNM and Nurse Practice Development Coordinator, contribute to practice issues highlighted as part of this process and take remedial action as appropriate

- Attend required meetings with Director of Nursing/Midwifery to report on Quality Care-Metrics data results
- Liaise with NMPDU Quality Care-Metrics Project Officer on Quality Care-Metrics data collected and reports as required
- Escalate risk incidents identified during Quality Care-Metrics data collection as appropriate see (Appendix II)

4.4.5 Clinical Nurse Manager

- Liaise and support the Quality Care-Metrics data collectors to undertake data collection in their area of responsibility
- Receive and act on feedback from Quality Care-Metrics data collectors
- Review online reports on the TYC HSE System
- Devise responsive action plans consistent with Quality Care-Metrics results as required in consultation with line manager
- Provide feedback to ward/unit healthcare staff on Quality Care-Metric results, acknowledging the achievement of standards and leading on improvement action plans as required
- Display and share Quality Care-Metrics reports on unit/ward notice board
- Present evidence of Quality Care-Metric results to appropriate nursing/midwifery governance structures

4.4.6 Quality Care-Metrics Data Collector

The Quality Care-Metrics Data collector should not be directly employed within the collection area. He/she should:

- Have a working knowledge of the guideline as appropriate to each metric, to ensure accuracy, standardisation and consistency in the interpretation of the metric
- Attend the required training session(s) on Quality Care-Metrics
- Have a working knowledge of the TYC HSE system prior to conducting data collection
- Liaise with CNM to arrange suitable time for data collection
- Undertake data collection on a monthly basis and enter into the TYC HSE system using allocated username and password
- Provide feedback as appropriate to CNM
- Provide information to CNMs and takes appropriate action where areas of risk are identified

5.0 PROCESS FOR QUALITY CARE-METRICS DATA COLLECTION

5.1 PROCESS

5.1.1 The process for data collection should ensure that collection is peer to peer and that staff nurses /CNMs do not collect in the area in which they are working. Including procedures such as *"inter-rater reliability"* checks will support data quality.

5.1.2 Data collectors are selected within each organisation by their Director of Nursing/ Midwifery. Authorisation is given to enter data on the TYC HSE System using an individualised username and password.

5.1.3 The data collector is required to confirm that they have a working knowledge of the guideline as appropriate to each metric, to ensure accuracy, standardisation and consistency in the interpretation of the metric – as outlined in **Section 2 Part A**.

5.1.4 Data collectors should be mindful of the clinical area/unit they are attending, following protocols for that service, to include: obtaining permission as required entering the clinical area, dress code as per policy and adherence to infection prevention and control procedures in the clinical area/unit.

5.1.5 At all times, individuals should be treated with respect and dignity and afforded the necessary confidentiality and anonymity.

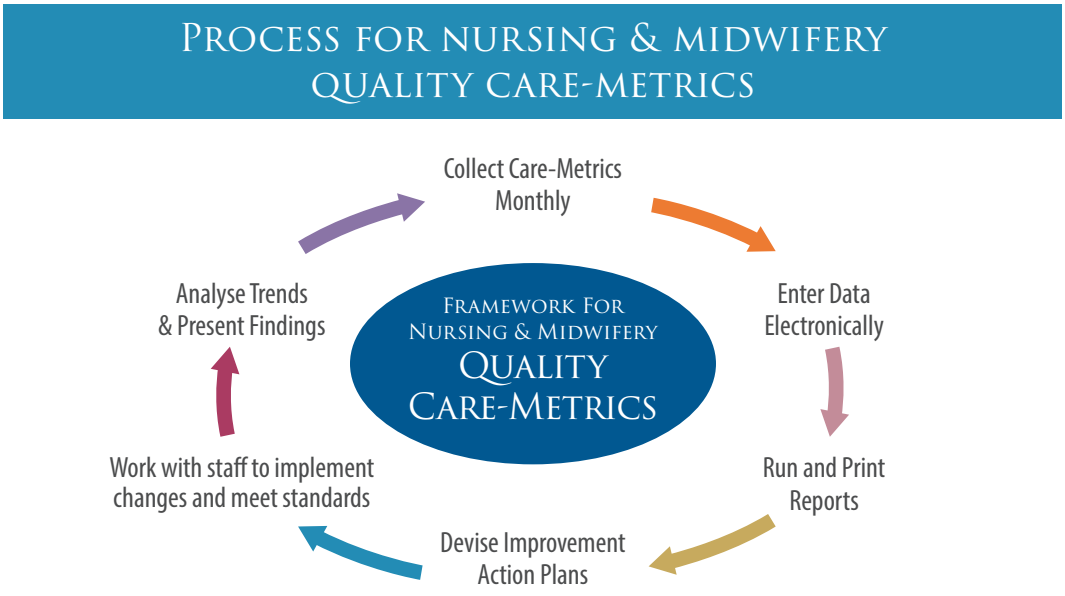


Figure 11: Undertaking Quality Care-Metrics at Service Level

5.2 Sample Size

5.2.1 Sample Size Selection in Ward/Unit Based Areas

- Based on total bed capacity, samples of 25% of patient/service user records are randomly selected per month from each ward/unit/location/network. Following guidance from the HSE Quality Improvement Division, it is recommended that a minimum of 5 data collections per month for each ward/unit/location/network are conducted.
- Where the bed capacity or occupancy for a particular ward/unit/location/network is fewer than 5, it is recommended that Quality Care-Metrics data is collected from all patient/service user records per month.
- Where a sample of 25% of patients/service users exceeds 10, it is recommended that the number of data collections per month should equal 10.

5.2.2 Sample Size Selection in Caseload Based Services

- In services such as operating theatres, procedure areas, labour suites or day service areas the monthly sample recommended is 10 cases per month. Similarly in Public Health Nursing Areas, the sample caseload should be 10 cases per network each month.

5.3 Timing of Monthly Data Collections

5.3.1 Data may be collected anytime between the first and the last day of each month. Data entered will automatically be entered in the current month.

5.3.2 Best practice requires that all data is entered on the day of measurement which will give immediate and efficient access to the results.

5.3.3 Data collectors are only required to examine the care records for the 72 hours preceding data collection.

5.4 Accessing Test Your Care HSE (TYC HSE) System

5.4.1 The TYC HSE System is available nationally to agreed services implementing Nursing and Midwifery Quality Care-Metrics. The level of access users will have to the TYC HSE system is authorised by the Quality Care-Metrics Service Lead within organisations. Names of individuals who may access the data entry field and the reporting fields are determined by the Nominated Service Lead and supplied to the Quality Care-Metrics Project Officer who arranges the issuing of passwords.

Figure 12: TYC HSE System

5.4.2 To access the TYC HSE System, users log on to the Internet browser and open the website **http://www.testyourcarehse.com**. Users enter a username and password and click the login button. The TYC HSE system disseminates the initial username and password to the user via two emails. Passwords can then be changed by the user by going to Settings on the TYC toolbar and entering a password of choice. Username and passwords should not be shared as they are unique to users and allow access to either data entry or reporting or both. The home page of the TYC HSE System is illustrated in Figure 12.

5.4.3 Users will only have access to the locations in their own hospital/service or as agreed by the relevant Director of Nursing/Midwifery. Options available on the system are:

- **Collect:** Data Entry (To enter the Care-Metric responses for each location area
- **Report:** Reporting on the results of the Care-Metric responses per location area
- **Action Plans:** This section gives access to an online action plan to address scores under 100% as deemed appropriate by each manager
- **Documents:** This section contains supporting documentation including the National Guidelines for each Quality Care-Metric and the templates for data collection

5.4.4 Access to Collecting: Nurses are given permission for collecting at 2 levels within TYC HSE and access should be given for the required level only:

- Collect only
- Collect and Report

If the user only has access to reporting, the data entry option will not be accessible. The screen will automatically open in the Data Entry section if the user has both data entry and reporting entitlements.

5.5 Data Entry

5.5.1 The TYC HSE System will open automatically on the data entry screen (Collect). If this does not occur, the data collector/user should click the **Collect** link in the middle of the toolbar on the top right of screen.

5.5.2 A drop down menu (Figure 13) is utilised to select the questionnaire of choice and also the location where it is being undertaken. To undertake data entry:

- Select the relevant questionnaire
- Select the relevant location
- Select **"Begin"**; once selected, the number of times data has been accessed and saved **this month** will be displayed

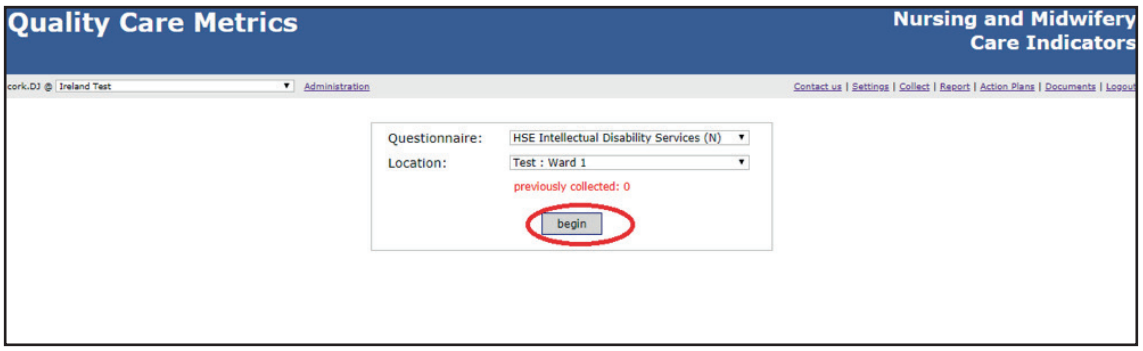


Figure 13: Data Entry: TYC HSE System

5.5.3 Data entry occurs through the selection of the predetermined answers 'Yes/No/Not Applicable' (Figure 14 and 15)

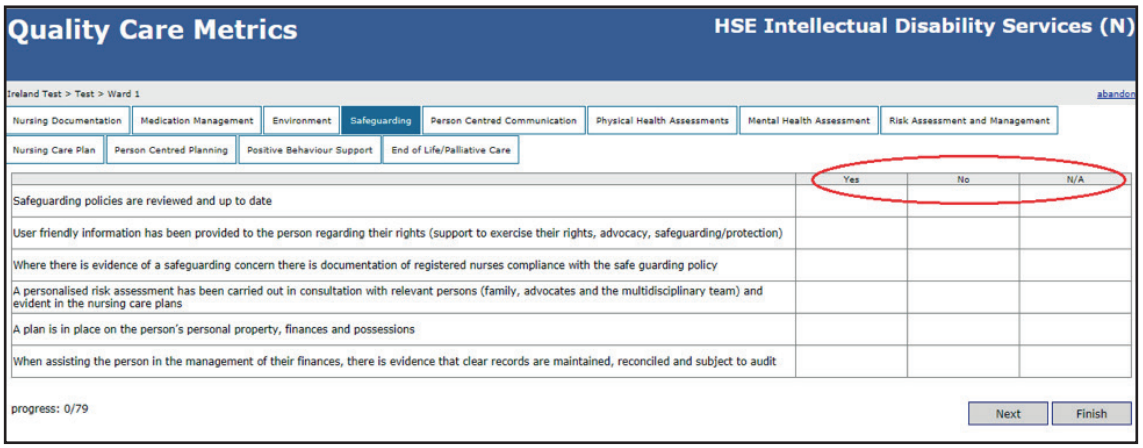


Figure 14: Data Entry: TYC HSE System (1)

- Select the appropriate response for each question, on completing a section the user should click the **Next** button
- **Yes** answer has a score of 10/10
- **No** answer has a score of 0/10
- **N/A** answer does not have a score and doesn't affect the overall result
- Once all questions have been answered, click the **Finish** button to **save** and the data entered for that patient/service user will be uploaded to the server
- At any time the user can **abandon** the current collection; however abandoned collections are not saved or included in the reports

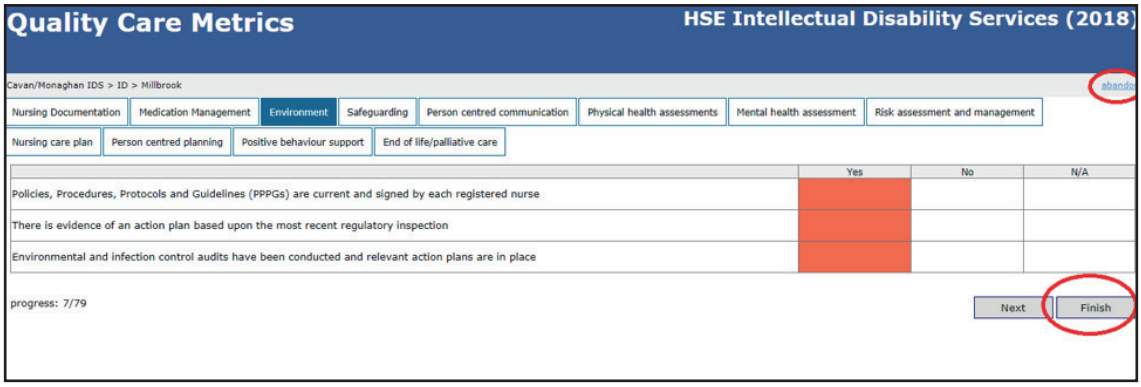


Figure 15: Data Entry: TYC HSE System (2)

6.0QUALITY CARE-METRICS DATA ANALYSIS

6.1 Scoring System

6.1.1 Scores are illustrated easily using a Traffic Lights Scoring System which highlights areas of improvement, areas of risk and areas of excellence (Figure 16). Areas of good practice are demonstrated using green lights. Areas requiring some improvement are displayed with amber lights and areas requiring immediate attention and action plans are shown using red lights.

90% - 100%	=	Green
80% - 89%	=	Amber
79% - 0%	=	Red

Figure 16: Traffic Light Scoring System

6.1.2 The highlighted score will be colour coded as illustrated in Figure 16. The arrows will be coloured according to the score achieved and so could be any of the 3 colours green, amber or red Figure 17 is for arrow direction illustration only.

	Across Arrow	This shows that the results remain unchanged from the previous month
	Down Arrow	This show that the results have decreased from the previous month
	Up Arrow	This show that the results have increased/improved from the previous month

Figure 17: Scoring System

6.2 Reporting

6.2.1 Reports are created to assist in the systematic measuring of quality of Nursing and Midwifery clinical care processes. Reports identify and acknowledge services that are delivering safe, quality care and agreed standards and identify opportunity for quality improvements.

6.2.2 Reporting in TYC HSE provides a visual **real-time** summary of Care Indicator or Patient Experience collections.

6.2.3 When new services are being configured, it is important 'Location Groupings' are discussed with the Nominated Service Lead. This option facilitates collective reporting for senior managers if required, however, individual locations may be adequate for reporting requirements.

6.2.4 To access reporting click the **Report** tab in the top right hand corner (Figure 18)

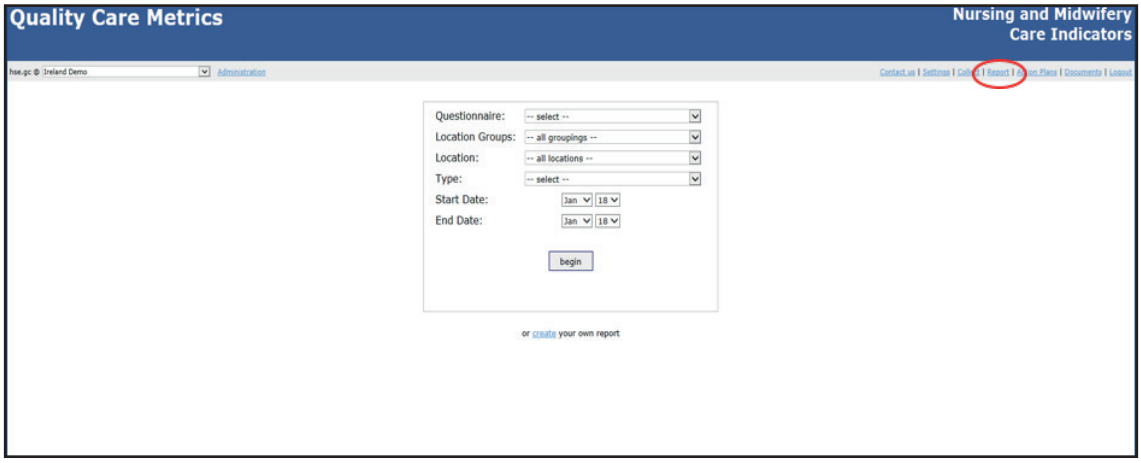


Figure 18: Accessing Reports from TYC HSE

6.2.5 Summary Report: A common report is the 'Summary Report' which gives an overall score for each metric and the results can be exported into excel/word etc. if needed. This report can also provide details on the specific metrics by drilling into the relevant month in addition to identifying trends.

- **Questionnaire** – Select the relevant questionnaire e.g. Intellectual Disability
- **Location Groups** – Select groupings such as units, housing groups, or if a particular group is not required, select all
- **Location** – Select the name of the ward, unit or all locations to get an overall hospital /care facility/network score
- **Type** –Select Summary

6.2.6 Collection Summary Report: A common report is the 'Collection Summary Report' which gives an overall view of collections and the results can be exported into excel/word etc. if needed. This report can also provide details on the specific metrics by drilling into either the number of collections or the relevant month.

- **Questionnaire** – Select the relevant questionnaire e.g. Intellectual Disability
- **Location Groups** – Select groupings such as units, housing groups, or if a particular group is not required, select all
- **Location** – Select the name of the ward, unit or all locations to get an overall hospital /care facility/network score
- **Type** –Select Summary

6.2.7 Create your own Report (1): if a more detailed report is required to ascertain precisely which indicators within a metric scored low, the 'Create your own report' option may be used (Figure 19 and 20).

- Once in Report tab click on **Create your own report**
- **Questionnaire** – Select the relevant questionnaire e.g. Intellectual Disability
- Select the **start** and **end date**
- **Location** –Select ward from the list
- **Column Heading** –select 'month'(this puts the month(s) across the top of the page for viewing)
- **Row Heading** – select **Section and question** to show results for each question (indicator) within a metric
- Click **submit** button
- A print friendly version of the report is available by clicking the 'print'

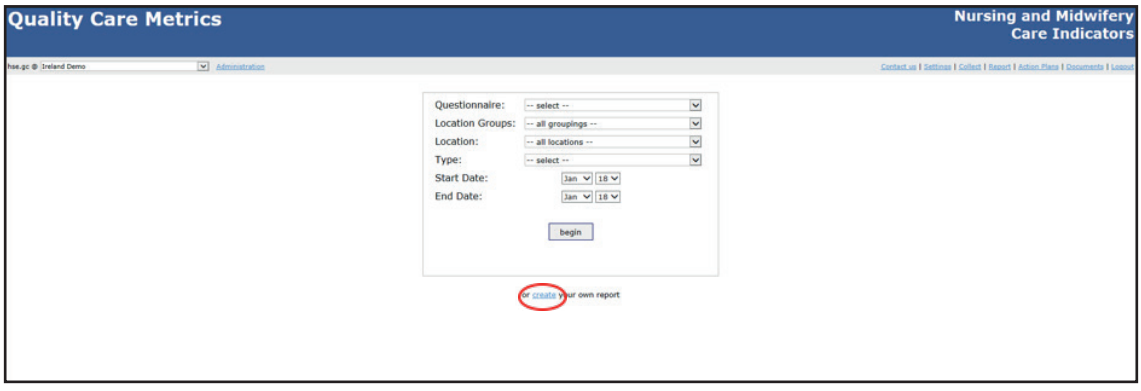


Figure 19: Create your own Report

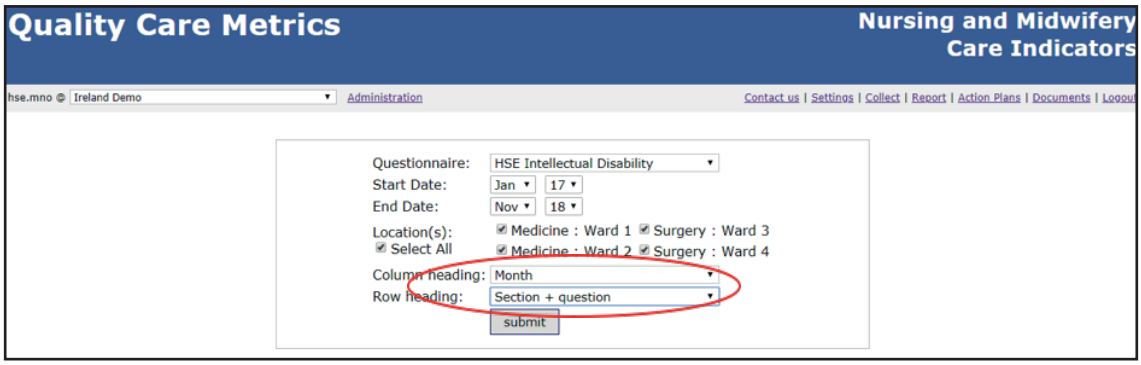


Figure 20: Create your own Report; Column Heading: Month and Row Heading: Section and Question

- This selection, **'Column heading: Month and Row Heading: Section and Question'** supports the CNM to investigate what areas of good practice require recognition and what areas need improvements (Figure 21).

	Jan 2018	Mar 2018	Jun 2018
Medication Storage and Custody : RGN/RNM holds keys	100%	100%	100%
Medication Storage and Custody : Meds in locked room/cupboard	100%	100%	100%
Medication Storage and Custody : Trolleys locked, no open meds		100%	100%
Medication Storage and Custody : Drug Formulary available	100%	100%	100%
MDA Drugs : MDAs checked am & pm	100%	100%	100%
MDA Drugs : Two Signatures in Drug Register	100%	100%	100%
MDA Drugs : MDA Cupboard Locked & Keys	100%	100%	100%
MDA Drugs : MDA Keys Separate	100%	100%	100%
Medication Administration : Name and HCRN	0%	60%	100%

Figure 21: Create your own Report; Results; Column Heading: Month and Row Heading: Section and Question

6.2.8 Create your own Report (2): if a more detailed report is required to compare locations (wards / units) across a service the 'Create your own report' option may also be used (Figure 19 and 22).

- Once in Report tab click on **Create your own report**
- **Questionnaire** – Select the relevant questionnaire for the relevant service
- Select the **start** and **end date**
- **Location** –Select ward from the list
- **Column Heading** –select 'location' or 'location grouping'(this puts the location (s) or the location grouping (s) across the top of the page for viewing)
- **Row Heading** – select **Section and question** to show results for each question (indicator) within a metric
- Click **submit** button
- A print friendly version of the report is available by clicking the 'print'

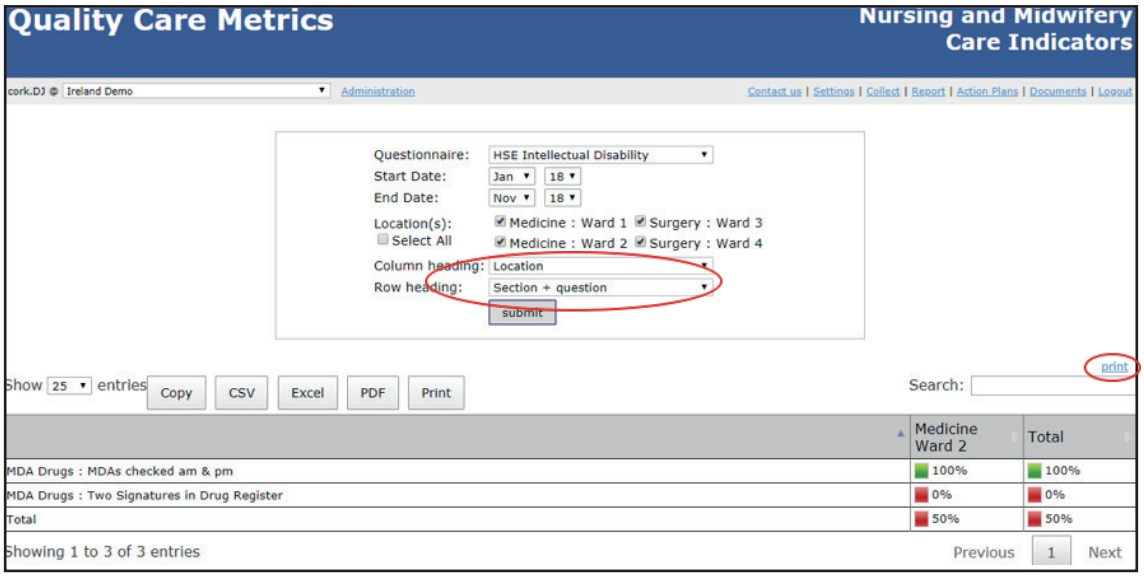


Figure 22: Create your own Report; Results; Column Heading: Location and Row Heading: Section and Question

- This selection, **'Column heading: Location and Row Heading: Section and Question'** supports the CNM to compare indicators in each area for shared learning (Figure 22).

6.2.9 Create your own Report (3): if a more detailed report is required the 'Create your own report' option may be used (Figure 19 and 23).

- Once in Report tab click on **Create your own report**
- **Questionnaire** – Select the relevant questionnaire e.g. Intellectual Disability
- Select the **start** and **end date**
- **Location** –Select **ward** or **select all** from the list
- **Column Heading** –select **month** (this puts the month (s) across the top of the page for viewing)
- **Row Heading** – select **location grouping** to show overall results for location grouping
- Click **submit** button
- A print friendly version of the report is available by clicking the 'print'

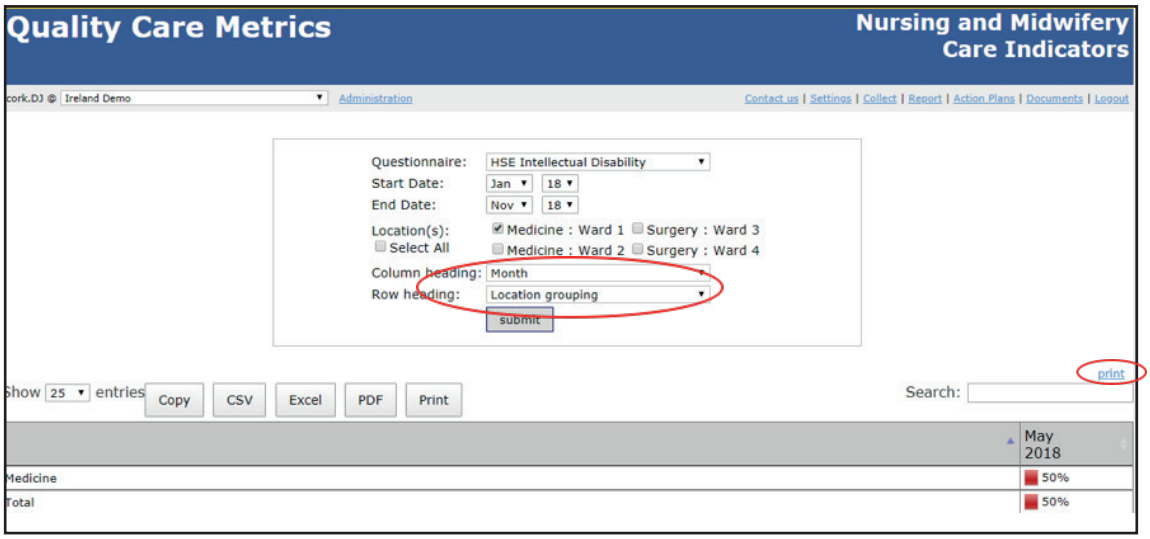


Figure 23: Create your own Report; Results; Column Heading: Month and Row Heading: Location Grouping

- This selection, **'Column Heading: Month and Row Heading: Location Grouping'** supports the ADoN/ADoM to compare groupings/divisions per month if set up (Figure 23).

Alternatively, for more detail in relation to each metric, select **section** in the **Column Heading** – (this puts the metrics across the top of the page for viewing) (Figure 24).

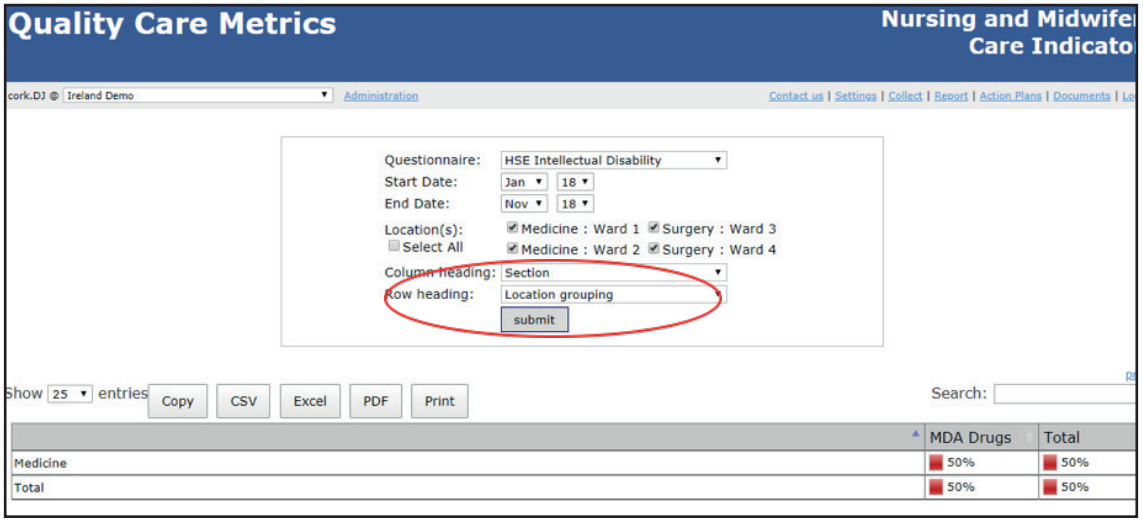


Figure 24: Results; Column Heading: Section and Row Heading: Location Grouping

7.0 QUALITY CARE-METRICS ACTION PLANNING

7.1 ACCESSING ACTION PLANNING ON TEST YOUR CARE HSE

7.1.1 Action Plan Reporting is available for each location to keep an electronic record of action plans arising from measurement of the metrics. Action plans are completed by going to the top right hand corner and selecting the Action Plans Link. Click "Action Plans" and complete the data fields as per example below in Figure 25.

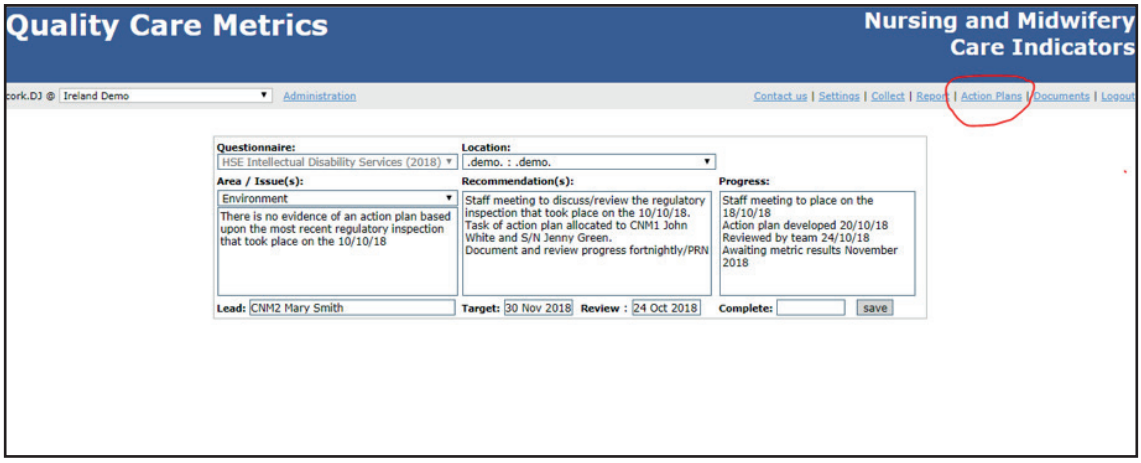


Figure 25: Accessing Action Planning on Test Your Care HSE

7.1.2 Users can also generate or print an "Action Plan" Report through the Report option and then by selecting Action Plan from the drop down menu. This report is available to managers in order to oversee, highlight issues, or provide recommendations on the actions arising from the Quality Care-Metrics measurement.

7.2 SEVEN STEPS OF ACTION PLANNING

- Understanding Quality Care-Metrics results
- Communicating and discussing Quality Care-Metrics results
- Developing focused Action Plans in response to Quality Care-Metrics results
- Communicating Action Plans and deliverables
- Implementing Action Plans
- Accessing progress and evaluating the impact
- Sharing what works

7.2.1 Step 1; Understanding Quality Care-Metrics Results

- Review Quality Care-Metrics results and interpret them before developing the action plan. Need a detailed report? –'Create Your Own Report' on TYC HSE
- Identify and prioritise with the team a manageable number of areas for improvement
- Use clinical judgement – choose the indicators/questions which require the most urgent action to keep the patient safe

7.2.2 Step 2; Communicating and Discussing Results - Holding Team Meeting/Huddle

- Bring the *detailed report* to the team meeting/huddle
- *Choose* what to tackle first - There may be several questions/indicators that require attention, however the team will need to determine priority areas first
- *Be specific* - Identify specific tasks and activities that are required to address the area requiring improvement
- *Extra resources* – Identify external resources (outside my unit) required to tackle this e.g. expertise, education, equipment
- *Timeframes:* Assign realistic timeframes to each specific task or activity
- *Be collaborative* – ask staff to highlight issues which may be causing low scores /poor care on this issue. Ask - What makes it difficult for staff to do it this way/ carry out this check…?
- *Lead person* -Identify who on the team will be responsible for leading on the Action Plan and encouraging the team
- What might block this plan?-*Identify* potential obstacles that may be encountered when trying to implement change and try to understand resistance

7.2.3 Step 3; Writing the Action Plan

- Having identified what areas (metric/indicator) to tackle - be SMART as guided by Figure 26
- Use plain English
- Address one issue per Action Plan otherwise the Action Plan can become unfocussed and confusing to follow
- State clearly what the team is expected to do - the identified actions should be precise in what needs to be done and the changes that need to be made
- Write a plan that relates directly to the individual workplace and that is under the team's area of influence
- Be realistic with identified target dates

Figure 26: SMART Goals

7.2.4 Step 4; Communicate the Action Plan

- Make sure the nursing team are informed about the Action Plan
- Print off current Action Plans and display on notice board or communication board or Quality Improvement board
- Discuss after all hand-overs one day per week (…each Tuesday discuss what Action Plans are on-going – 5 minutes) to keep it on the ward/unit agenda

7.2.5 Step 5; Implement the Action Plan

- Vital - taking *action* makes the real difference.
- Changes do not have to be major or require significant resources
- Make Action Plans small and manageable

7.2.6 Step 6; Assess your Progress

- Ask staff how they are getting on with this change
- Don't wait for the next metric result …. Keep an eye to see if the change is being carried out
- Fill in the progress part of the Action Plan
- If the change has worked, tell staff
- If the change has not worked – ask why?
- Were the changes outlined in the Action Plan not carried out?
- Were the 'wrong changes' planned - was there something different that could have done?

7.2.7 Step 7; Share what Works

- Share with CNM/ADoN colleagues at meetings
- Be honest about the parts that were hard/didn't work
- Get ideas from Action Plans from other areas already completed

8.0QUALITY CARE-METRICS HUB

8.1 The Quality Care-Metrics hub on HSELanD is located within the ONMSD Nursing and Midwifery Hub at **http://qcmhub.hseland.ie/using-tyc/**

8.2 The aim of the hub is to create an online resource that provides relevant information and learning resources on Quality Care-Metrics for nurses and midwives.

8.3 The hub guides 'Test Your Care' users and potential users through

- 'QCM Explained'
- 'Implementing QCM'
- Using 'Test Your Care'
- 'Improving Practice' section focused on action planning
- 'News' to keep users and those with an interest in QCM up to date in QCM project developments
- 'Help and Resources' to support implementation processes

Testimony from expert users from around the country is also featured to encourage those starting their journey

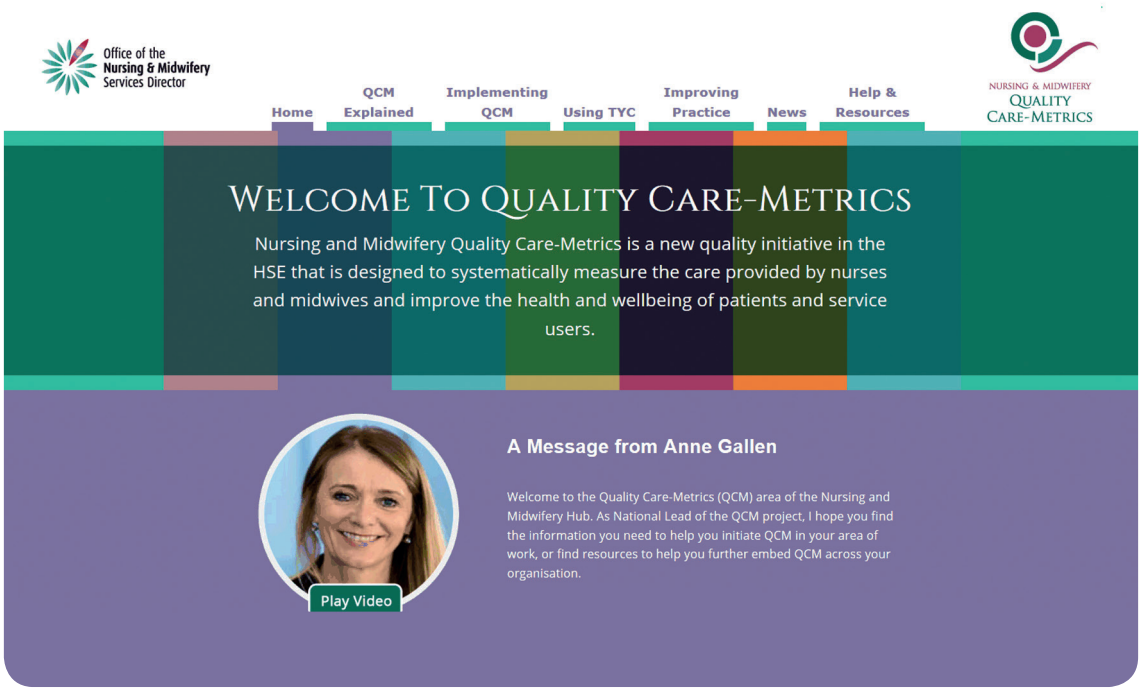


Figure 27: Quality Care-Metrics Hub

8.4 To access the Quality Care-Metrics hub on HSELanD:

- Log in to www.HSELanD.ie
- Go to - All hubs
- Go to - Nursing and Midwifery
- Go to - Quality Improvement
- Go to - Quality Care-Metrics

PART B:
Guideline Development Cycle

1.0 INITIATION

1.1 Purpose

Please refer to Part A, 1.9

1.2 Scope

Please refer to Part A, 1.10

1.3 Objective

Please refer to Part A, 1.11

1.4 Outcomes

Please refer to Part A, 1.12

1.5 Guideline Development Group

1.5.1 This guideline has been developed by the National Quality Care-Metrics Project Lead and team (NMPDU Quality Care-Metrics Project Officers) under the guidance of the ONMSD. Refer to Appendix III for Membership of the Guideline Development Group.

1.5.2 Guideline Conflict of Interest Declaration Forms as per Appendix IV have been completed by each member of the Guideline Development Group as per Appendix III and are retained with the master copy of this guideline.

1.5.3 Additional contributors and reviewers of this guideline are identified within Appendix V

1.6 Guideline Governance Group

1.6.1 The ONMSD Governance Group has provided governance for the project and guideline development. Refer to Appendix VI for Membership of the Guideline Approval Governance Group.

1.7 Supporting Evidence

1.7.1 Legislation and regulation publications, which are relevant to the Intellectual Disability Quality Care- Metrics development were reviewed and are incorporated in the development of this guideline and are listed below. In addition, existing policy and standards were reviewed and incorporated into the development of the guideline.

NMBI Guidance	
Relevant literature	Chang et al 2015 Chin et al 2011 Chow et al 2015 Data Protection – It's Everyone's Responsibility An Introductory Guide for Health Service Staff ND Guideline to be followed by staff working in HSE DML Intellectual Disability Services when supporting an individual with Epilepsy 2015 No author 2015 Nurses' Own Recordkeeping No author 2011 The National Database of Nursing Quality Indicators at work.
Standard	HIQA 2016

Medication	
Relevant literature	Chin et al 2011 Procedure for the use of Restrictive Interventions for Adult Intellectual Disability Services HSE DML Laois/ Offaly/ Longford/ Westmeath 2015
Standard	CALNOC Collaborative Alliance for Nursing Outcomes 2015 Guidance to Nurses and Midwives on Medication Management 2007 HIQA 2016 Practice Standards and Guidelines for Nurses and Midwives with Prescriptive Authority 2010 Standards for Medicines Management for Nurses and Midwives 2015

Environment	
Relevant literature	Cappucciati et al 2013 Chang et al 2015 Dreesen et al 2014 Guideline on Infection Prevention and Control for Community Intellectual Disability Services 2016
Standard	HIQA 2016

Safeguarding	
Relevant literature	Chin et al 2011 Currie 2008 No author 2009. The National Database of Nursing Quality Indicators® Reaches 1500 Hospitals Procedure for the use of Restrictive Interventions for Adult Intellectual Disability Services HSE DML Laois/ Offaly/ Longford/ Westmeath 2015 Guideline to be followed by staff working in HSE DML Guideline on Advocacy 2016 Guideline on Privacy for Individuals with an Intellectual Disability within Residential, Respite or Day Services in Laois/Offaly/Longford/Westmeath 2015
Standard	NA

Person centred communication	
Relevant literature	Dreesen et al 2014 Guideline on Person Centred Planning for Adult Intellectual Disability Services HSE Midlands Region 2016
Standard	NA

Physical health assessments	
Relevant literature	Bergquist-Beringer et al. 2009 Brown 2009 Burfield et al. 2012 Chang et al 2015 Chaboyer et al 2016 Chin et al 2011 Dreesen et al 2014 Guideline to be followed by staff working in HSE Midland Area Intellectual Disability Services when supporting individuals during their Mealtime (Protected Mealtimes) 2016 Guideline on Management of Enteral Tube Feeding for Patients/Service Users in Primary/Social Care Settings 2015 No author 2011 Applicability of palliative quality measures to end-of-life care in ICUs. Nursing Assessment and Treatment of Hypoglycaemia in Residents/ Service Users with Diabetes 2015 Promotion of Continence and the Management of Incontinence Guidelines 2015 Provision of Nutritionally Balanced Meals in Residential Care for Older People & Intellectual Disabilities 2015 Recording Residents/ Service Users Daily Fluid Balance in HSE Dublin Mid-Leinster Older Person and Intellectual Disability Day and Residential Services Laois /Offaly Longford Westmeath Area 2013
Standard	HIQA 2016 US Nursing Home Quality Measures US Nursing Home Standards US Nursing Home Compare

Mental health	
Relevant literature	Chang et al 2015 Chin et al 2011 Dreesen et al 2014
Standard	NA

Nursing care plan	
Relevant literature	Bergquist-Beringer et al. 2009 Chaboyer et al 2016 Chin et al 2011 Chow et al 2015 Dreesen et al 2014 Guideline on the use of Standardised Abbreviation List for the HSE DML Intellectual Disability Services Laois/Offaly/Longford/Westmeath 2015 No author 2009. The National Database of Nursing Quality Indicators® Reaches 1500 Hospitals No author 2015 Record Retention Periods Health Service Policy 2013 Guideline on Intimate Physical Care to HSE Adult Intellectual Disability Residential service in Laois/Offaly/Longford/Westmeath 2016 Promotion of Continence and the Management of Incontinence Guidelines 2015
Standard	NA

Person centred planning	
Relevant literature	Chow et al 2015 Dreesen et al 2014 Guideline on the use of Standardised Abbreviation List for the HSE DML Intellectual Disability Services Laois/Offaly/Longford/Westmeath 2015 No author 2015 Nurses' Own Recordkeeping. Record Retention Periods Health Service Policy 2013 Guideline on Person Centred Planning for Adult Intellectual Disability Services HSE Midlands Region 2016 Guideline on Referral, Admission, Transfer and Discharge procedure for adults with an intellectual disability to a HSE Intellectual Disability Residential Service Laois/ Offaly/Longford/ Westmeath 2015
Standard	NA

Positive behaviour support	
Relevant literature	Bone Health Policy and Guidelines 2015 Cappucciati et al 2013 Chang et al 2015 Dreesen et al 2014 Procedure for Listening and Responding to Individuals who demonstrate Behaviours of Concern 2015
Standard	HIQA 2016

End of life/palliative care	
Relevant literature	End- of -Life care in local HSE Intellectual Disability Service in Laois/Offaly/ Longford/ Westmeath 2015 No author 2011 Applicability of palliative quality measures to end-of-life care in ICUs
Standard	HIQA 2016

1.7.2 PPPGs being replaced by this PPPG:

- *Guiding Framework for the implementation of Nursing and Midwifery Quality Care-Metrics in the Health Service Executive Ireland.* (HSE 2015)
- *Standard Operating Procedure for Nursing and Midwifery QCM Data Collection in Intellectual Disability Services.* (HSE 2015a)

1.7.3 Related PPPGs:

- *National Guideline for Nursing and Midwifery Quality Care-Metrics Data Measurement in Acute Health Services.* (HSE 2018a)
- *National Guideline for Nursing and Midwifery Quality Care-Metrics Data Measurement in Midwifery Services.* (HSE 2018b)
- *National Guideline for Nursing and Midwifery Quality Care-Metrics Data Measurement in Mental Health services.* (HSE 2018c)
- *National Guideline for Nursing and Midwifery Quality Care-Metrics Data Measurement in Public Health Nursing Services.* (HSE 2018d)
- *National Guideline for Nursing and Midwifery Quality Care-Metrics Data Measurement in Older Person Services.* (HSE 2018e)
- *National Guideline for Nursing and Midwifery Quality Care-Metrics Data Measurement in Children's Services.* (HSE 2018f)

1.8 Glossary of Terms and Definitions

Please refer to Part A, 1.1

1.9 Abbreviations

Please refer to Part A, 1.2

2.0 DEVELOPMENT OF GUIDELINE

2.1 Development

2.1.1 The development of this guideline is to support implementation of the Intellectual Disability Services Quality Care-Metrics (2018g)

2.1.2 This guideline has been developed following a robust research project which aimed to (a) critically review the scope of existing Nursing and Midwifery Quality Care Process Metrics and relative indicators and (b) identify additional metrics and indicators relevant to the Intellectual Disability Services. This was undertaken through the completion of a systematic review and consensus methodology.

2.1.3 The development and content of this document has been informed in part by the Quality Care-Metrics Intellectual Disability Research Report (HSE 2018). This report outlines the research process undertaken as a collaborative between the ONMSD National Quality Care-Metrics Project Team and the University of Limerick. It includes the final suite of *Intellectual Disability Nursing Process Metrics and Indicators* developed from the research.

2.1.4 The *Intellectual Disability Nursing Process Metrics and Indicators* are adapted from national and international evidence based practice including PPPGs and reflect what intellectual disability nurses nationally felt was important to measure.

2.1.5 Evidence of the sources for Quality Care-Metrics generated from this robust research is available in the Quality Care-Metrics Intellectual Disability Research Report (HSE 2018) and as listed in 1.7 above.

2.2 Research Design

The study design had four phases as follows:

Phase 1: A systematic literature review to identify metrics that have been used in the respective fields and the indicators for same.

Phase 2: A two-round online Delphi survey of intellectual disability nurses to develop consensus on metrics to be measured.

Phase 3: A two-round online Delphi survey of intellectual disability nurses to develop consensus on indicators for prioritised metrics.

Phase 4: A face-to-face consensus interviews with key stakeholders to review the findings and build consensus on metrics and indicators.

2.3 Literature Search Strategy

2.3.1 Aim: To identify quality care **process** metrics and associated indicators for nursing and midwifery.

2.3.2 Databases Searched: Eight databases were systematically searched including: PyscINFO, Embase, Pubmed, ASSIA, Cumulative Index to Nursing and Allied Health Literature (CINAHL), Cochrane Database of Systematic Reviews (CDSR), Cochrane Central Register of Controlled Trials (CENTRAL), and Database of Abstract of Reviews of Effects (DARE).

2.3.3 Study Selection: Studies were included if participants were registered nurses/ midwives, as well as education programmes using nursing and midwifery metrics systems in acute, children, intellectual disability, mental health, midwifery, older persons, or public health or where participants were persons in receipt of nursing or midwifery care and services. Included studies made a clear reference to nursing or midwifery care processes and identified a specific quality process in use or proposed use. Studies were screened for work stream relevance initially with data extracted from included eligible studies. Figure 28 outlines the complete process flow diagram for the systematic literature review.

2.4 Method of Evidence Appraisal

2.4.1 Data Extraction: A data extraction form was designed and studies were critically appraised. After several rounds of paper review, appraisal and data extraction by the four members of the Intellectual Disability academic team.

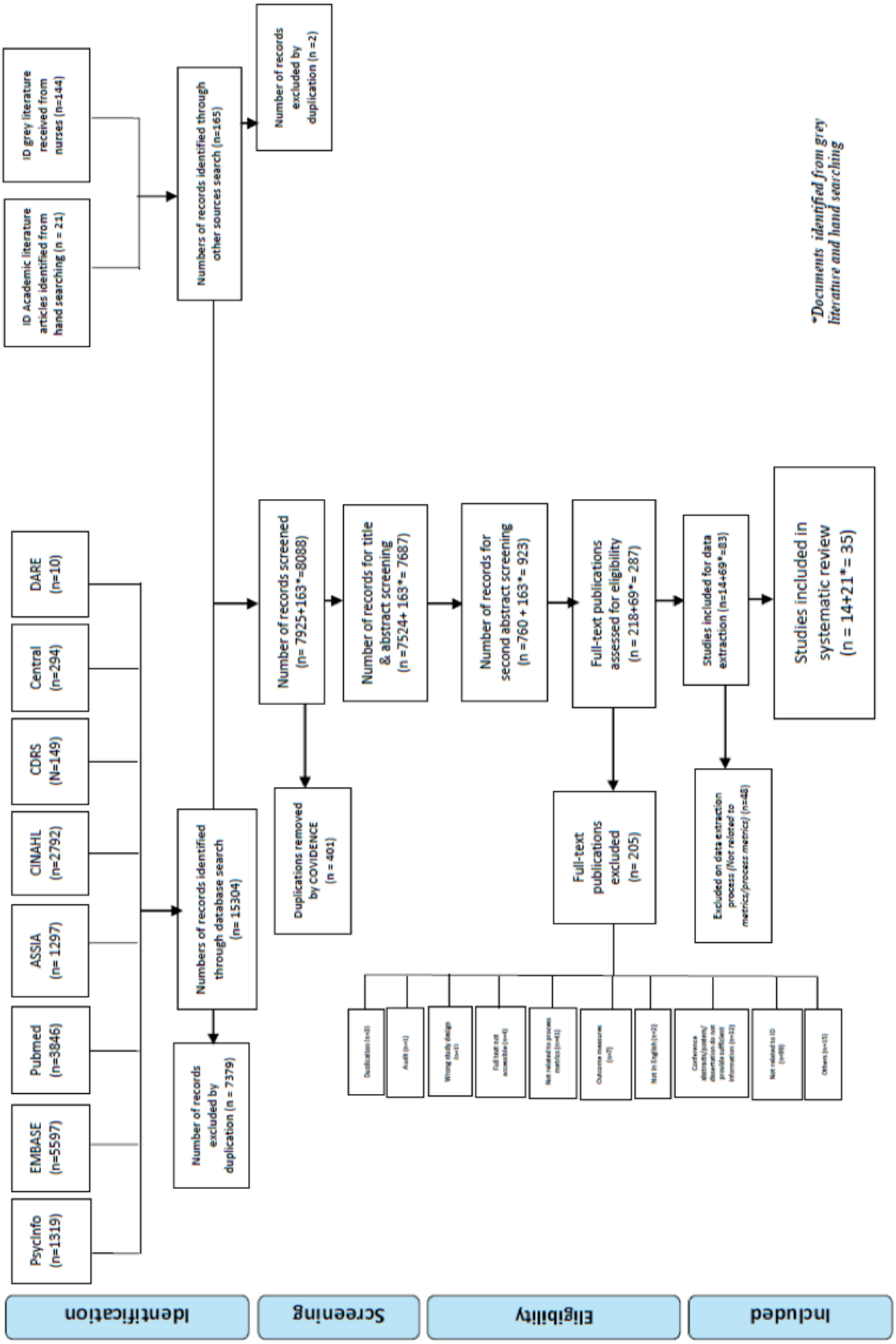
2.4.2 Results: The search conducted across the eight databases resulted in **15, 304** citations. Following removal of duplicates, **7,524** unique references were identified and independently screened for selection. Following title and abstract screening, **218** citations were retained for full-text screening. Following full text screening, **112** articles were included upon the basis that they met the study's inclusion criteria. These articles were then tagged depending on their relevance to acute, mental health, public health nursing, children, midwifery, older person, and intellectual disability services. From this initial search, no articles were identified which were directly relevant to Intellectual Disability, however, **14** articles were drawn upon the generic nursing literature.

Additional searches included grey literature relevant to Intellectual Disability and publications identified from hand searching. From this search, **21** documents from grey literature were identified as relevant and included in the review.

2.5 Summary of the Evidence from the Literature

2.5.1 The Systematic Literature Review for Intellectual Disability resulted in **35** studies out of **7689** included after full text screening. **36** Intellectual Disability metrics were identified. **Twenty** of the identified metrics were existing metrics with **16** new metrics identified. These new metrics were: *Developing and maintaining positive relationships to meet client needs, Person centred communication provided appropriate to their communication needs, Positive behaviour support, Providing support for making choices and plans, Action plan in place, Infection prevention, Relevant health needs assessments have been carried out, Relevant individual health action plans, Appropriate screening plan, Health promotion, Pain assessment, monitoring and observing for verbal and non-verbal signals, Pain management, End of life and palliative care, Person centred plan to meet identified social needs e.g. family contact, Social skills e.g. skills for education, work and independent living, Mental health screening and action plan in place.* The supporting evidence from the literature for the guideline is derived, guided and referenced in the Quality Care-Metrics Intellectual Disability Research Report (HSE 2018).

Figure 28 Study Selection Process Flow Diagram for Intellectual Disability Workstream



2.6 Consensus Process

2.6.1 This stage consisted of a four-round online Delphi survey to develop consensus on prioritised metrics and indicators. At the end of the first two rounds, the metrics were identified and at the end of Round 3 and 4, the indicators for those metrics were identified.

2.6.2 Consensus Meeting: Following the Delphi survey rounds, the next phase of the Delphi process consisted of a face-to-face meeting with key stakeholders to review the findings from the Delphi surveys and build consensus on the final suite of metrics and respective indicators. Prior to this was a Pre-consensus meeting of the work-stream in which there was a rigorous appraisal of each indicator with particular reference to relevance and wording.

The final Intellectual Disability work-stream consensus meeting was held on the 29th of November 2017 in Dublin. Participants at this meeting were representatives of the work stream key stakeholders with consideration to grade and geographical representation. There were a total of 20 participants. Sixteen members performed voting who were nurses from different levels and four of them were invited as experts for the consensus meeting. The purpose of the meeting was that through face to face discussion, each metric and indicator would be voted on resulting in a final suite of metrics and indicators for Intellectual Disability.

Attention was paid to identifying the optimum way to run this consensus meeting. A systematic review of the literature was conducted prior to the meeting to identify good guidelines. Following this, guidance was provided to the participants including ground rules (Gagnier et al 2013, McMillan et al 2016, Nair et al 2011, Van Ganzewinkel et al 2011) (HSE 2018 p44). An electronic voting system was planned to be used to ensure anonymity of the voting process. Due to technical issues, a paper based voting was performed by asking members to raise hands to vote for metrics and indicators. A judgement framework tool adapted from Flenady et al. (2016)was use as a guide in determining if the process metric/ indicator was appropriate for inclusion in the final suite of metrics (figure 29).

NURSING AND MIDWIFERY QUALITY CARE METRICS/ INDICATORS EVALUATION TOOL	
01	**PROCESS FOCUSED** The metrics/ indicator contributes clearly to the measurement of nursing care processes.
02	**IMPORTANT** The data generated by the metric/indicator will likely make an important contribution to improving nursing care processes.
03	**OPERATIONAL** Reference standards are developed for each metric or it is feasible to do so. The indicators for the respective metric can be measured.
04	**FEASIBLE** It is feasible to collect and report data for the metric/indicator in the relevant setting.

Modified from: eRegistries indicator evaluation tool (Flenady et al. 2016)

Figure 29: Nursing and Midwifery Quality Care-Metrics Judgement Framework Tool

2.6.3 Consensus Findings: Following the Intellectual Disability Quality Care-Metrics consensus meeting, 12 process metrics and 79 indicators were agreed upon for the new suite of Intellectual Disability Quality Care-Metrics as included in Part A 2.0.

2.7 Resources Necessary to Implement the Guideline Recommendations

2.7.1 The resources required for the implementation of the guideline recommendations e.g. Quality Care-Metrics at service level, are outlined within 3.2.3 *Implementation Phases; 15 Steps to Support Implementation* and 3.4, *State of Readiness and Capacity Checklist*.

2.7.2 Consideration of each Implementation Phase and Completion of the State of Readiness and Capacity Checklist will provide services with the opportunity to identify what resources may be required locally.

2.7.3 Directors of Nursing and Midwifery should be cognisant of local structures and/or requirements when completing the *State of Readiness and Capacity Checklist*.

2.8 Outline of Guideline Steps/ Recommendations

Refer to Part A

3.0 GOVERNANCE AND APPROVAL

3.1 Formal Governance Arrangements

3.1.1 The National Nursing and Midwifery Quality Care-Metrics Approval Governance Group (Appendix VI) provided formal governance for the project, the Director of the ONMSD is the designated chairperson for this group.

3.1.2 The National Nursing and Midwifery Quality Care-Metrics Approval Governance Group worked to an agreed scope and terms of reference. Roles and responsibilities of this advisory group membership along with the process of meeting were clearly outlined and agreed.

3.1.3 The National Nursing and Midwifery Quality Care-Metrics Project Lead reported to the National Nursing and Midwifery Quality Care-Metrics Approval Governance Group and the ONMSD. The national project plan and work of the National Nursing and Midwifery Quality Care-Metrics Project Officer Group was presented by the National Project Lead at all governance meetings.

3.2 Guideline Development Standards

3.2.1 The guideline was developed within the HSE National Framework for Developing PPPGs (2016) and has adhered to the NCEC standards as set out within.

3.3 Copyright/Permission Sought

3.3.1 Not required.

3.4 Guideline Checklist

3.4.1 The approved checklist has been completed as per Section 4 of the HSE National Framework for developing PPPGs (2016) and is retained with the master copy of this guideline.

4.0 COMMUNICATION AND DISSEMINATION

4.1 Staff will be made aware of this guideline through HSE Directorate communication mechanisms, nursing forums and the ONMSD communication process. This guideline will be available on **http://www.hse.ie/eng/about/Who/ONMSD/**

5.0 IMPLEMENTATION

5.1 Implementation Plan: Refer to Part A, 4.1
5.2 Education/Training plans required for Implementation: Refer to Part A, 4.2
5.3 Identification of Lead Person(s) responsible for Implementation: Refer to Part A, 4.3
5.4 Specific Roles and Responsibilities: Refer to Part A, 4.4

6.0 MONITORING, AUDIT AND EVALUATION

6.1 The ONMSD provides the overarching governance and leadership to support structures for monitoring, audit and evaluation of PPPGs related to Quality Care-Metrics through the ONMSD Governance Group.

6.2 The National Quality Care-Metrics Project team is responsible for the development and dissemination of this guideline to support services in the implementation process for Nursing and Midwifery Quality Care-Metrics Data Measurement within the Intellectual Disability Services.

7.0 REVISION/UPDATE

7.1 This guideline will be due for revision three years from approval. The procedure for this revision will be in alignment with the HSE National Framework for developing PPPGs (2016).

7.2 In the event of new evidence emerging which relates directly to this guideline, a working group will be convened to revise and amend the guideline if warranted.

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9.0 APPENDICES

Appendix I
Signature Sheet

Appendix II
Immediate Safety/Risk Identification Form for Nursing and Midwifery Metrics

Appendix III
Membership of the Guideline Development Group

Appendix IV
Conflict of Interest Declaration Form Template

Appendix V
Additional Guideline Contributors and Reviewers

Appendix VI
Membership of the Guideline Approval Governance

Appendix I
Signature Sheet

I have read, understand and agree to adhere to this Guideline:

Print Name	Signature	Area of Work	Date

Appendix II
Immediate Safety/Risk Identification Form for Nursing and Midwifery Metrics

The data collector has identified the following immediate safety or risk issues (Example Safety Issue Identified: cupboard unsecured) which requires attention by the clinical nurse/midwife manager or nurse/midwife in charge on the day of the metric being undertaken.

This Immediate Safety/Risk Identification Form is to highlight an issue that may need to be addressed immediately by the clinical nurse/midwife manager or nurse/midwife in charge prior to the formal report findings of the Metric. It is the responsibility of the clinical nurse/midwife manager or nurse/midwife in charge to act immediately on the issues outlined in line with the safety/risk identified. It is their responsibility to inform their relevant Clinical Nurse Manager 3/ ADoN of the issue in a timely fashion and outline to the CNM3/ADoN the action they took to alleviate or eliminate safety/risk identified.

During the conduction of metrics in the ward today, the following safety/risk concerns are identified.

To be Completed by the data collector undertaking Metric	
Name of Hospital/Service Location:	
Name of Ward:	
Name of Auditor:	
Metric Title:	
Date:	
Safety/Risk Issue Identified:	
Name of CNM or Nurse/Midwife in charge informed of Safety/Risk Issue:	

To be completed by CNM or Nurse in Charge		
Name of Unit Nursing Officer/ ADoN informed of Safety/Risk Issue		
Please sign to confirm the relevant CNM3/ADoN has been informed and record date informed.	**Date:**	**Signature of CNM/ Nurse in Charge** .....

Please retain this Form for reference on your ward for a period of one year

Appendix III
Membership of the Guideline Development Group (National Quality Care-Metrics Project Team)

Chairperson: **Dr Anne Gallen** National Lead for Nursing & Midwifery Quality Care-Metrics
Angela Killeen NMPDU Quality Care-Metrics Project Officer, NMPD HSE North West
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Appendix IV
Conflict of Interest Declaration

A Conflict of Interest Declaration Form has been completed by each member of the Guideline Development Group (National Quality Care-Metrics Project Team) and is retained with the master copy of the guideline.

Appendix V
Additional Contributors/Guideline Reviewers

Judy Ryan	DIRECTOR NURSING MIDWIFERY PLANNING & DEVELOPMENT UNIT
Nora Fitzgerald	CNM2

Appendix VI
Membership of the Approval Governance Group (ONMSD Governance Group)

Chairperson: **Ms Mary Wynne** Director of the Office of the Nursing and Midwifery Services Director	SIGNATURE: Mary Wynne DATE: 5TH DECEMBER 2018

Dr Anne Gallen (NMPDU) ONMSD National Lead QCM
Professor Laserina O'Connor (UCD) QCM Academic Group Rep
Ms Gillian Conway (NMPDU) QCM NMPD Project Officers Rep
Hospital Group Chief Nurse Reps / IADNAM DON/M Reps:
Ms Julie Nohilly Acute Care
Ms Mary Brosnan Midwifery
Ms Suzanne Dempsey Children's Nursing
Ms Georgina Bassett Older Persons Care
Ms Catherine Adams Area Director of Mental Health Nursing Rep
Ms Mary B Finn-Gilbride Director of Public Health Nursing
Ms Theresa O'Loughlin Director of Nursing Intellectual Disability
Dr Jennifer Martin HSE Quality Improvement Division Rep
Mr Pat Kelly HSE ICT Rep
Ms Martina Harkin-Kelly INMO Rep
Ms Aisling Culhane PNA Rep
Ms Aideen Carberry SIPTU Rep
Ms Anne Harris Patient Voice
Ms Anita Gallagher Secretary to the Group

NURSING & MIDWIFERY

QUALITY CARE-METRICS

DECEMBER 2018

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Clinical Strategy and Programmes Division

Health Service Executive
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