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

MENTAL HEALTH 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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National Guideline for Nursing and Midwifery Quality Care-Metrics Data Measurement in Mental Health Services 2018

Is this document a:

Policy		Procedure		Protocol		Guideline	X

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

Title of Guideline Development Group:	**Office of Nursing and Midwifery Services Director Quality Care-Metrics Project Group**
Approved by:	**Ms Mary Wynne** Interim Nursing and Midwifery Services Director Office of the Nursing and Midwifery Services Director, Clinical Strategy and Programmes Division
Reference Number:	**ONMSD 2018 - 025**
Version Number:	**1**
Publication Date:	**2018**
Date for revision:	**2021**
Electronic Location:	**www.hse.ie/eng/about/who/onmsd/safecare/qcm/qcm-pppgs.html**

Version	Date Approved	List section numbers changed	Author

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PART A: Outline of Guideline Steps

1.0 INITIATION OF QUALITY CARE-METRICS AT SERVICE LEVEL

1.1 Glossary of Terms and Definitions

Clinical Governance:

"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 2018a).

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 and Midwifery Metrics:

Nursing and Midwifery metrics are agreed standards of measurement for nursing and midwifery care, where the 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 and midwifery 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

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
EMBASE	Exerpta Medica Database
GP	General Practitioner
HEFT	Heart of England Foundation Trust
HIQA	Health Information and Quality Authority
HCRN	Healthcare Record Number
HSE	Health Service Executive
IMEWS	Irish Maternity Early Warning Score
IT	Information Technology
MCN	Medical Council Number
MHC	Mental Health Commission
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
PEWS	Paediatric Early Warning Score
PIN	Personal Identification Number
PPPG	Policies, Procedures, Protocols and Guidelines
QCM	Quality Care-Metrics
TYC	Test Your Care
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 and experienced and a valuable resource to the health service, 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 and 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/midwife or organisation was not always available.

1.3.7 Nursing and Midwifery 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 System 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 the work stream working groups (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).

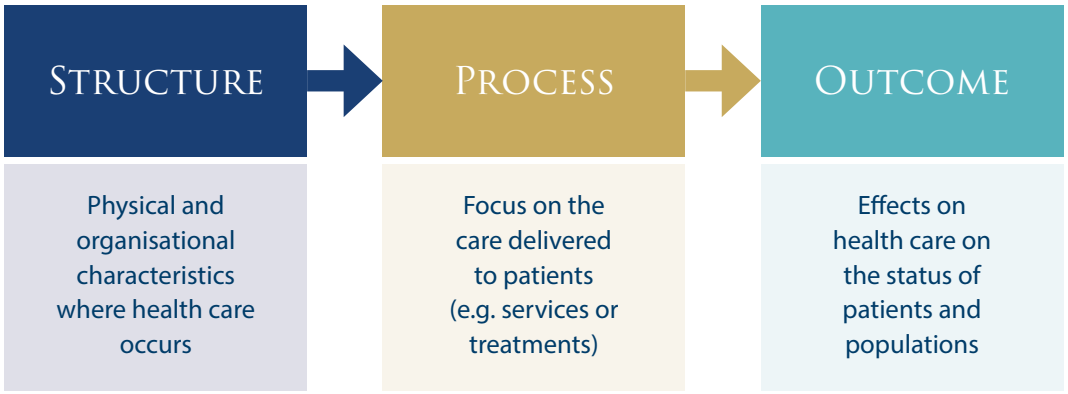


Figure 1: Donabedian's Conceptual Model for Evaluating Quality of Care (1966)

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

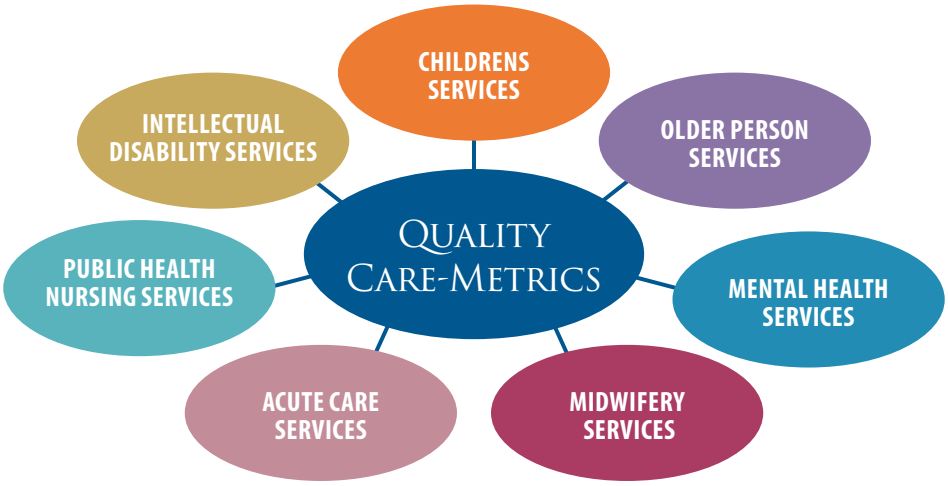


Figure 2: Quality Care-Metrics Work Streams

1.5.6 Nursing and Midwifery Quality Care-Metrics currently consist of a core suite of quality indicators across seven workstreams; Acute Care, Older Persons, Mental Health, Intellectual Disability, Midwifery, Public Health Nursing and Children's services (Figure 2). Figure 3 demonstrates the updated Quality Care-Metrics which are available nationally for measurement and monitoring across the regions utilising the 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 Nursing and Midwifery 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 2014; Donaldson et al 2005); using "real time" information regarding the quality of care patients/clients are receiving.

1.8 Benefits

1.8.1 Nursing and Midwifery Quality Care-Metrics provide 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, Quality Care-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 Mental Health services.

1.9.2 This guideline provides a standardised 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 Mental Health 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 Mental Health 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 Mental Health Research Report (HSE 2018).

1.10.5 All nurses and midwives within Mental Health 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 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 for 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 Mental Health 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 & ADVICE FOR MENTAL HEALTH SERVICES

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

Assessment	Management of Violence and Aggression	Nursing Communication
Care Plan	Physical Health and Wellbeing	Medication Management
Management of Risk	Recovery Based Care	Service User Experience

Figure 4: Mental Health Quality Care-Metrics

2.1 Assessment Quality Care-Metric

ASSESSMENT **I** = Indicator, **A** = Data Collectors Advice, **N/A** = Not Applicable		
1	**I**	**Presenting complaints/reasons for admission/attendance is recorded and the admission date and time are recorded**
	A	Mark **Yes** if current presenting complaints/reasons for admission/attendance and the admission date and time are recorded on the nursing assessment documentation. Mark **No** if presenting complaints/reasons for admission/attendance or if the admission date and time are not recorded on the nursing assessment documentation.
2	**I**	**The service user's name, date of birth and/or healthcare record number are on each page/screen**
	A	Mark **Yes** if the service user's name, DOB and/or HCRN are on each page/screen of the nursing documentation. Mark **No** if any one of the components are missing (service user's name, DOB and/or HCRN) from a page/screen.
3	**I**	**Initial assessment includes contact details for family member/carer**
	A	Mark **Yes** if the initial assessment of current admission/attendance includes the contact details for a family member/carer. Mark **No** if family member/carer contact details are not documented for this admission/attendance.

4	I	**There is a documented reason if the service user refuses to give family member/carer details**
	A	Mark **Yes** if the service user refuses to give a family member/carer details and there is a documented reason. Mark **No** if the service user refuses to give a family member/carer details and there is not a documented reason. Mark **N/A** if the service user has provided the contact details for a family member/carer.
5	I	**There is documented evidence of service user consent for family member/carer involvement in care and communication**
	A	Mark **Yes** if there is documented evidence that the service user has provided consent for family member/carer involvement in care and communication. Mark **No** if there is no documented evidence that the service user has provided consent for family member/carer involvement in care and communication. Mark **N/A** if there is documented evidence that no family member/carer has involvement in the service user care and communication.
6	I	**Documented evidence of discharge planning is recorded from admission**
	A	Mark **Yes** if there is documented evidence that discharge planning was commenced as soon as possible for community units and at least within 72 hours of an acute admission. Mark **Yes** if there is documented evidence that the service user has been communicated with, in regard to their long stay admission. Mark **No** if there is no documented evidence that discharge planning was commenced as soon as possible for community units and at least within 72 hours of an acute admission. Mark **N/A**, if individual has been admitted less than 72 hours for an acute admission.
7	I	**The service user is involved in all aspects of his/her assessments e.g. falls, risks, neglect etc. as per local policy**
	A	Mark **Yes** if there is documented evidence that the service user has been involved in all aspects of his/her assessments e.g. falls, risks, neglect etc. as per local policy. Mark **No** if there is no documented evidence that the service user has been involved in all aspects of his/her assessments e.g. falls, risks, neglect etc. as per local policy. If service user has cognition/confusion diagnosis, mark **Yes** if there is documented evidence that a family member /carer has been involved in all aspects of his/her assessments. **Note:** Each unit should have a list of all generic assessments as per local policy.
8	I	**It is documented that the Mental Health service, with the service user's informed consent has involved other named service providers in their assessment, if required**
	A	Mark **Yes** if there is documented evidence that the service user has provided informed consent for other named service providers involvement in their assessment. Mark **No** if there is no documented evidence that the service user has provided informed consent for other named service providers involvement in their assessment. Mark **No** if there is no documented evidence that the Mental Health service, has involved other named service providers in their assessment when required. Mark **N/A** if there is no involvement of other named service providers required in the service user's assessment.

2.2 Care Plan Quality Care-Metric

CARE PLAN **I** = Indicator, **A** = Data Collectors Advice, **N/A** = Not Applicable		
1	**I**	**There is documented evidence that the service user is involved in the co-production of their nursing care plan**
	A	This care plan should be reflective of the service users' current condition and have service user involvement. Mark **Yes** if there is documented evidence that the service user was involved in the co-production of their nursing care plan. Mark **No** if there is no evidence of service user involvement in the co-production of their care plan. Mark **No** if the care plan is not reflective of the service users' current condition.
2	**I**	**Nursing interventions are individualised and include nurse's signature, the date and time**
	A	Mark **Yes** if all nursing interventions are individualised to the service user, these should include the nurse's signature, be dated and timed. Mark **No** if all nursing interventions are not individualised to the service user and dated, timed and signed by the nurse. **Note:** Professional nursing status to be included in all integrated files (i.e. Student Nurse, Staff Nurse, Agency Nurse, CNM etc.) as per NMBI guidance. Good practice indicates that a local signature bank should include a signature, initials and professional status in all units.
3	**I**	**There is documented evidence that the nursing care plan has been reviewed on a regular basis, as defined by the individual clinical area**
	A	Mark **Yes** if evaluation of nursing care plan is undertaken in accordance with review date, as defined by the individual clinical area. Mark **No** if evaluation of nursing care plan is not evident or is not in line with review date. Mark **N/A** if the evaluation review date has not been reached.
4	**I**	**There is documented evidence that information has been provided to the service user on their care and treatment plan**
	A	Mark **Yes** if there is documented evidence that the service user has been provided with information on his/her care and treatment plan. Mark **No** if there is no documented evidence the service user has been provided with information on his/her care and treatment plan.
5	**I**	**There is documented evidence that the service user is involved in all aspects of his/her treatment and care**
	A	Mark **Yes** if there is documented evidence that the service user has been involved in all aspects of his/her assessment, treatment and care. Mark **Yes** if there is documented evidence that the service user is unable to be involved in all i.e. due to current condition. Mark **No** if there is no documented evidence the service user has been involved in all aspects of his/her assessment, treatment and care. Mark **No** if there is no documented evidence that the service user is unable to be involved in all aspects of their assessment, treatment and care.

6	I	**There is documented evidence in the nursing care plan that medication side effects are assessed by the nurse**
	A	Mark **Yes** if there is documented evidence in the nursing care plan that medication side effects have been assessed by the nurse. For acute care review the last 72 hours, for community care review current care plan. Mark **No** if there is no documented evidence in the nursing care plan that medication side effects have been assessed by the nurse. For acute care review the last 72 hours, for community care review current care plan. Mark **N/A** if the service user is not currently taking any medication or if the service user has had no medication side effects.
7	I	**Any alterations in nursing documentation are as per NMBI guidelines**
	A	Mark **Yes** if any alterations in nursing documentation are as per NMBI guidelines i.e. bracketed with a single line through them so the original entry is still visible. The alteration must be signed and dated by the nurse altering the record. For acute care review the last 72 hours, for community care review current care plan. Mark **No** if any alterations do not follow this format. Mark **N/A** if no alterations have been made.
8	I	**All records are legible, in permanent black ink**
	A	Mark **Yes** if all entries are legible and written in permanent black ink. For acute care review the last 72 hours, for community care review current care plan. Mark **No** if all entries are not legible, or not written in permanent black ink.
9	I	**Student entries are countersigned by the supervising nurse**
	A	Mark **Yes** if all student entries are countersigned by the supervising nurse. For acute care review the last 72 hours, for community care review current care plan. Mark **No** if any student entries are not countersigned. Mark **N/A** if there are no entries by a student nurse/midwife.
10	I	**All entries are in chronological order**
	A	Mark **Yes** if all entries in the nursing documentation are in chronological order or if the reason for any variance from this is documented. For acute care review the last 72 hours, for community care review current care plan. Mark **No** if any entries are not in chronological order. Mark **No** if any variances have not been documented.
11	I	**Any abbreviations/grading systems used are from a national or locally approved list/ system**
	A	Mark **Yes** if any abbreviations/grading systems used in entries are from a national or locally approved list/system. For acute care review the last 72 hours, for community care review current care plan. Mark **No** if abbreviations used in entries are not from a national or locally approved list/ system. Mark **N/A** if abbreviations are not used in any entries.

2.3 Management of Risk Quality Care-Metric

MANAGEMENT OF RISK **I** = Indicator, **A** = Data Collectors Advice, **N/A** = Not Applicable		
1	**I**	**There is documented evidence that the service user has been systematically assessed for clinical risks by a nurse or other named professional**
	A	Mark **Yes** if there is documented evidence that the service user has been systematically assessed for clinical risks (i.e. measuring risk of aggression, violence, suicide, self-harm, neglect & alcohol/drugs, as per local policy requirements) by a nurse or other named professional on admission. Mark **No** if there is no documented evidence that the service user has been systematically assessed for clinical risks (i.e. measuring risk of aggression, violence, suicide, self-harm, neglect & alcohol/drugs, as per local policy requirements) or if any clinical risk assessment has been omitted (as per local policy requirements) by a nurse or other named professional on admission.
2	**I**	**Where risk is identified there is documented evidence that a risk management plan is in place**
	A	Mark **Yes** if there is documented evidence in the care plan that a risk management plan is in place for the service user, in response to any identified risk. Mark **No** if there is no documented evidence in the care plan that a risk management plan is in place for the service user, in response to any identified risk. Mark **N/A** if the service user is not identified as at risk.
3	**I**	**The nursing staff have documented and evaluated the actions taken in a response to any identified clinical risk**
	A	Mark **Yes** if the nursing staff have documented in the care plan and evaluated the actions taken in response to any identified clinical risk, within the specified time frame as per local policy. Mark **No** if the nursing staff have not documented in the care plan the actions taken in response to any identified clinical risk within the specified time frame, as per local policy. Mark **No** if the nursing staff have not evaluated the actions taken in response to any clinical risk within the specified time frame, as per local policy. Mark **N/A** if the service user is not identified as at risk.

2.4 Management of Violence and Aggression Quality Care-Metric

MANAGEMENT OF VIOLENCE AND AGGRESSION **I** = Indicator, **A** = Data Collectors Advice, **N/A** = Not Applicable		
1	**I**	**There is documented evidence that incidents of violence and aggression are recorded**
	A	Mark **Yes** if any incident of violence and/or aggression has been documented. For acute care review the last 72 hours, for community care review current care plan. Mark **No** if any incident of violence and/or aggression has not been documented. Mark **N/A** if there were no incidents of violence and/or aggression.
2	**I**	**There is documented evidence that timely and appropriate post-incident debriefing has occurred for service users**
	A	Mark **Yes** if there is documented evidence that timely and appropriate post-incident debriefing has occurred for the service user. For acute care review the last 72 hours, for community care review current care plan. Mark **No** if there is no documented evidence that timely and appropriate post-incident debriefing has occurred for the service user. Mark **N/A** if post-incident debriefing does not apply to this service user.
3	**I**	**There is documented evidence in the nursing care-plan of the nursing responses to violent and/or aggressive incidents**
	A	Mark **Yes** if there is documented evidence in the nursing care-plan of the nursing responses to a violent and/or aggressive incident. For acute care review the last 72 hours, for community care review current care plan. Mark **No** if there is no documented evidence in the nursing care-plan of the nursing responses to a violent and/or aggressive incident. Mark **N/A** if there were no incidents of violence and/or aggression.

2.5 Physical Health and Wellbeing Quality Care-Metric

PHYSICAL HEALTH AND WELLBEING **I** = Indicator, **A** = Data Collectors Advice, **N/A** = Not Applicable		
1	**I**	**There is documented evidence that the medical history is recorded in the service users' notes**
	A	Mark **Yes** if there is documented evidence relevant to this admission, that the mental health and medical history is recorded in the service users' notes. Mark **No** if the mental health and medical history is not documented in the service users' notes.
2	**I**	**The allergy status is clearly identifiable on nursing documentation**
	A	Mark **Yes** if the allergy status is clearly identifiable on nursing documentation. Mark **No** if allergy status is not clearly identifiable on nursing documentation. Mark **No** if the allergy status is left blank.

3	**I**	**There is documented evidence of an on-going physical health assessment from admission/referral**
	A	Mark **Yes** if there is documented evidence of an on-going physical health assessment reflective of the service user's current condition relating to this admission/referral. Mark **No** if there is no documented evidence of an on-going physical health assessment reflective of the service user's current condition relating to this admission/referral. Mark **N/A** if physical health care needs are being addressed by GP in the community.
4	**I**	**There is documented evidence that identified physical health care needs are addressed in the nursing care plan**
	A	Mark **Yes** if there is documented evidence that all current identified physical health care needs are addressed in the nursing care plan. Mark **No** if there is no documented evidence that all current identified physical health care needs are addressed in the nursing care plan. Mark **No** if there is a current identified physical health care need not addressed in the nursing care plan. Mark **N/A** if there are no identified physical health care needs.

2.6 Recovery Based Care Quality Care-Metric

RECOVERY BASED CARE **I** = Indicator, **A** = Data Collectors Advice, **N/A** = Not Applicable		
1	**I**	**The service user has been informed of / offered peer support to aid in their recovery**
	A	Mark **Yes** if there is documented evidence that the service user has been informed of / offered peer support to aid in their recovery. Mark **No** if there is no documented evidence that the service user has been informed of / or offered peer support to aid in their recovery. Mark **N/A** if there is documented evidence that the service user declined this information/ offer of peer support or if a there is a valid documented reason why this information / support was not offered.
2	**I**	**The nurse has documented evidence that the service user has access to a recovery-based programme**
	A	Mark **Yes** if the nurse has documented evidence in the treatment plan/care plan that the service user has access to a recovery-based programme. Mark **No** if there is no documented evidence in the treatment plan/care plan by a nurse that the service user has access to a recovery-based programme. **Note:** A recovery approach aims to "support an individual in their own personal development, building self-esteem, identify and finding a meaningful role in society" (Allott and Loganathan, 2003 cited in MHC, 2008)

3	**I**	**There is documented evidence that the service user is involved in all aspects of his/her recovery planning including discharge planning**
	A	Mark **Yes** if there is documented evidence that the service user is involved in all aspects of his/her recovery planning including discharge planning. Mark **Yes** if there is documented evidence that the long stay/community service user is involved in all aspects of his/her recovery planning. Mark **Yes** if there is documented evidence that the service user is unable to be involved in all aspects of his/her recovery planning including discharge planning. Mark **No** if there is no documented evidence that the service user is involved in all aspects of his/her recovery planning including discharge planning. Mark **N/A**, if individual has been admitted less than 72 hours for an acute admission.
4	**I**	**There is documented evidence in the nursing care plan that the nurse has provided information about voluntary services that may help service users in their recovery process**
	A	Mark **Yes** if there is documented evidence in the nursing care plan that the nurse has provided information about voluntary services that may help service users in their recovery process. Mark **No** if there is no documented evidence that the nurse has provided information about voluntary services that may help service users in their recovery process. Mark **N/A** if there is documented evidence that the service user declined this information or if a valid reason why information on voluntary services was not given.

2.7 Nursing Communication Quality Care-Metric

NURSING COMMUNICATION **I** = Indicator, **A** = Data Collectors Advice, **N/A** = Not Applicable		
1	**I**	**There is evidence in the clinical notes that a nurse has communicated with the service user as per care plan**
	A	Mark **Yes** if there is documented evidence that the service user received information that reflects their input regarding their care. Mark **No** if there is no documented evidence that the service user received information that reflects their input regarding their care. Mark **N/A** if it is documented that the service user declined to communicate with the nurse regarding their care.
2	**I**	**The nurse has offered the service user information regarding their rights**
	A	Mark **Yes** if there is documented evidence that the nurse has offered the service user information regarding their rights. Mark **No** if there is no documented evidence that the service user has been offered information regarding their rights.
3	**I**	**There is documented evidence in the nursing care plan that the nurse has offered the service user information on advocacy services and how to access them**
	A	Mark **Yes** if there is documented evidence in the nursing care plan that a nurse has offered the service user information on advocacy services and how to access them. Mark **No** if there is no documented evidence in the nursing care plan that a nurse has offered the service user information on advocacy services and how to access them.

4	I	**There is documented evidence to support the coordination of nursing care on transfer or discharge**
	A	Mark **Yes** if there is documented pre-discharge/transfer evidence to support the coordination of nursing care for transfer or discharge. Mark **No** if there is no documented pre-discharge/transfer evidence to support the coordination of nursing care for transfer or discharge. Mark **N/A** if the service user does not require transfer or discharge.
5	I	**There is documented evidence that the service user's communication style and preferences are recorded in the nursing notes**
	A	Mark **Yes** if there is documented evidence that the service user's communication style and preferences are recorded in the nursing notes/care plan. Mark **No** if there is no documented evidence of the service user's communication style and preferences recorded in the nursing notes/care plan.

2.8 Medication Management Quality Care-Metric

MEDICATION MANAGEMENT **I** = Indicator, **A** = Data Collectors Advice, **N/A** = Not Applicable		
1	I	**A registered nurse is in possession of the keys for medicinal product storage**
	A	Mark **Yes** if keys are held by a nurse on their person. Mark **No** if a registered nurse is not holding the keys. Mark **N/A** if medicinal products are not stored in the ward/unit.
2	I	**All medicinal products are stored in a locked cupboard or locked room**
	A	Mark **Yes** if cupboard and fridge is locked or the room is locked. Mark **No** if medicinal products are accessible in an unlocked cupboard, fridge or room. Mark **N/A** if medication products are not stored in the ward/unit. **Note:** All presses/trolleys/fridges containing medication MUST be locked. As numerous staff may have passkeys to access clinical rooms but should not have access to medication once in that room.
3	I	**All medication trolleys are locked and secured as per local organisational policy and open shelves on the medication trolley are free of medicinal products when not in use**
	A	Mark **Yes** if all medication trolleys are locked and secured as per local organisational policy and open shelves on the medication trolley are free of medicinal products when not in use. Mark **No** if all medication trolleys are not locked, when not in use. Mark **No** if the medication trolleys are not in a locked room and/or are not secured with chain and lock to wall, when not in use. Mark **No** if there are medicinal products left accessible (unlocked) on end/side of trolley. Mark **N/A** if a medication trolley is not used in the ward/unit.

4	I	**A current drug formulary is available on all medication trolleys**
	A	Mark **Yes** if a drug formulary (MIMS/BNF/ etc.) is available on all medication trolleys/ cabinets, as per local organisational policy. Mark **No** if a drug formulary (MIMS/BNF etc.) is unavailable or not within date. **Note:** The drug formulary /resource (MIMS/BNF etc.) must be within two years of publication. It should be located on the ward/unit to facilitate easy access for the nurse to reference drug details during drug administration.
5	I	**Misuse Drug Act (MDA) drugs are checked & signed at each changeover of shifts by nursing staff (member of day staff & 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, check 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.
6	I	**Two signatures are entered in the MDA drug register for each administration of an MDA drug**
	A	Mark **Yes** if MDA Scheduled Controlled Drugs register has two signatures for each MDA Scheduled Controlled Drug administered within the last 72 hours. Mark **No** if MDA Scheduled Controlled Drugs register does not have two signatures for each MDA Scheduled Controlled Drug administered within the last 72 hours. Mark **N/A** if unit does not store MDA Scheduled Controlled Drugs currently. Mark **N/A** if there has been no MDA Scheduled Controlled Drugs administered within the last 72 hours.
7	I	**The MDA drug cupboard is locked and keys for MDA cupboard are held by designated nurse**
	A	Mark **Yes** if the MDA Scheduled Controlled Drugs cupboard is locked and the keys are held by the CNM or a nurse designated by the nurse in charge. Mark **No** if MDA Scheduled Controlled Drugs cupboard is not locked. Mark **No** if CNM/or nurse designee does not know who has the MDA Scheduled Controlled Drugs keys. Mark **N/A** if there are no MDA Scheduled Controlled Drugs stored.
8	I	**MDA drug keys are kept separate from the other medication keys**
	A	Mark **Yes** if MDA Scheduled Controlled Drugs keys are separate from other sets of keys, as MDA Scheduled Controlled Drugs and other drug cupboard/trolley keys should not travel as one set. Mark **No** if MDA Scheduled Controlled Drugs keys are not separate. Mark **N/A** if there are no MDA Scheduled Controlled Drugs stored.

9	I	**The individual's prescription documentation provides details of individual's legible name and health care record number**
	A	Mark **Yes** if service users' legible name and health care record number (HCRN) are on each page of the prescription documentation. Where organisations do not use HCRN, date of birth (DOB) is a valid second identifier. Mark **No** if each page of the service user prescription documentation does not have two identifiers. Mark **No** if detachable prescription sheets do not have two identifiers. Mark **No** if name/HCRN or DOB are not legible. Mark **N/A** if no prescription documentation is required.
10	I	**The individuals' identification band has correct and legible name and healthcare record number and/or photo ID if in use**
	A	Mark **Yes** if the service user's name and health care record number (HCRN) are on ID Band and are legible or photo ID is in use. **Note:** Where organisations do not use HCRN or ID Band, date of birth (DOB) and Full Name (1st Name and Surname) is used as the identifier. Mark **No** if the service user's ID band has incorrect or illegible name and healthcare record number. Mark **No** if a service user does not consent to ID Band or Photo ID, or cannot provide their DOB and Full Name (this must be documented).
11	I	**The allergy status is clearly identifiable on the front page of the prescription chart**
	A	Mark **Yes** if the allergy status is clearly identifiable on the front page of the prescription chart. Mark **No** if the allergy status is not stated or if it is left blank. Mark **N/A** if no prescription documentation is utilised.
12	I	**Prescribed medicines not administered have an omission code entered**
	A	Mark **Yes** if omission codes are used and prescription sheet contains the initials of the nurse omitting the drug, check within last 72 hours. Mark **No** if no omission code is used for drugs not administered in the last 72 hours. Mark **No** if omission code is not initialled by the nurse when a drug is not administered. Mark **N/A** if all drugs are administered and there is no requirement for an omission code in the last 72 hours. Mark **N/A** if no prescription documentation is utilised.
13	I	**The generic name is used for each drug prescribed**
	A	Mark **Yes** if the generic name is used for drugs with the following exceptions: combination products or narrow therapeutic index drugs. Mark **Yes** if brand name is used for - combination products, narrow therapeutic index drugs where brand should not be changed - e.g. theophylline MR, lithium preparations, anti-epileptic medication, immunosuppressant drugs (e.g. ciclosporin, tacrolimus, mycophenolate), modified release preparations, controlled drug oral opiates, insulins. Mark **No** if generic name is not used for drugs other than combination products or narrow therapeutic index drugs. Mark **N/A** if no prescription documentation is utilised.
14	I	**The date of commencement of the most recent prescription is recorded**
	A	Mark **Yes** if all drugs prescribed have a start date. This must include the Day/Month/Year. Mark **No** if all components of commencement date are not present on the prescription. Mark **N/A** if no prescription documentation is utilised.

15	I	**The prescription is written in block letters**
	A	Mark **Yes** if the prescription is clear, legible and written un-joined lowercase letters or block capitals. Mark **No** if prescription is not clear or legible and is not written in either un-joined lower case letters or block capitals. Mark **N/A** if no prescription documentation is utilised. Complete a Safety/Risk Form if safety concerns are present so that the prescription can be corrected (Appendix II).
16	I	**The correct legible dose of the medicine is recorded with correct use of abbreviations**
	A	Mark **Yes** if the correct dose is prescribed and is legible and abbreviations used are approved. 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 the correct legible dose of the medicine is not recorded, or if unapproved abbreviations are used. Mark **N/A** if no prescription documentation is utilised. *(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**. In cases where the dose of a drug is related to weight, ensure the weight is recorded in order to calculate correct dose.
17	I	**The route and/or site of administration is recorded**
	A	Mark **Yes** if the correct route is recorded and if applicable that the site is identified. Mark **No** if route and/ or site are not recorded. Mark **N/A** if no prescription documentation is utilised.
18	I	**The frequency of medicines administration is recorded and correct timings indicated**
	A	Mark **Yes** if the frequency is recorded and the appropriate times are either ticked or circled on the prescription chart at that time. Mark **No** if frequency is not record. Mark **No** if correct timings are not ticked/circled. Mark **N/A** if no prescription documentation is utilised.
19	I	**The minimum dose interval and/or 24 hour maximum dose is specified for all "as required" or PRN medicines**
	A	Mark **Yes** if all medicines prescribed **"as required"** states the minimum dose interval and/or the maximum 24 hour dose. Mark **No** if all medicines prescribed **"as required"** do not state the minimum dose interval and/or the maximum 24 hour dose. Mark **N/A** if medicines are not prescribed **"as required".** Mark **N/A** if no prescription documentation is utilised.

20	I	**The prescription has an identifiable prescriber's signature (in ink)**
	A	Mark **Yes** if prescribers name and signature are identifiable from online signature bank/local signature bank or signature bank on the medication prescription sheet. Mark **Yes** if the signature includes NMBI Personal Identification Number (PIN)/Medical Council Number (MCN). Mark **No** if signature is not written in permanent ink. Mark **No** if PIN/MCN is not present or signature is not readily identifiable itself or from local signature bank. **Note:** 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.
21	I	**Discontinued medicines are crossed off, dated and signed by a person with prescriber authority**
	A	Mark **Yes** if the drug is correctly crossed out and includes the full date (Day/Month/Year) it was discontinued and the signature of a 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.

2.9 Service User Experience Quality Care-Metric

The following Mental Health Service User Experience Quality Care-Metric is available for collection monthly. It is recommended to collect a sample size of 25% (approximately 5/10 service users) of the overall unit/ward, monthly. **Staff can print a Service User Experience Sheet for completion by randomly selected service users with returns to the nurse/data collector or to an anonymous collection point.** The Data collector may read out the options to the service user and select the appropriate answer based on their responses or can offer the service user the use of a smart device (if available) to select the answers anonymously themselves.

SERVICE USER EXPERIENCE	
1	**Were you provided with information about this service?**
2	**Were you introduced to the nurse or nurses responsible for your care?**
3	**Do you know the names of your nursing team?**
4	**Have you received information from your responsible nurse on how to manage symptoms of your illness?**
5	**Has your medication and any potential benefits/side effects been explained to you by your responsible nurse?**
6	**Have you got the relevant information on who to contact in times of a crisis?**
7	**Were you involved in developing your nursing care plan?**
8	**Were you offered a copy of your care plan?**
9	**Have you been offered the opportunity to have your family member/carer involved in your care?**
10	**Are you offered 1:1 nursing time as indicated in your care plan?**
11	**Has information been offered on organised activities/groups in your area?**
12	**Do the activities/groups offered support you in your recovery process?**
13	**Is there the opportunity for access to outside space?**
14	**Can you access fresh drinking water?**

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 and 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 of Quality Care-Metrics).

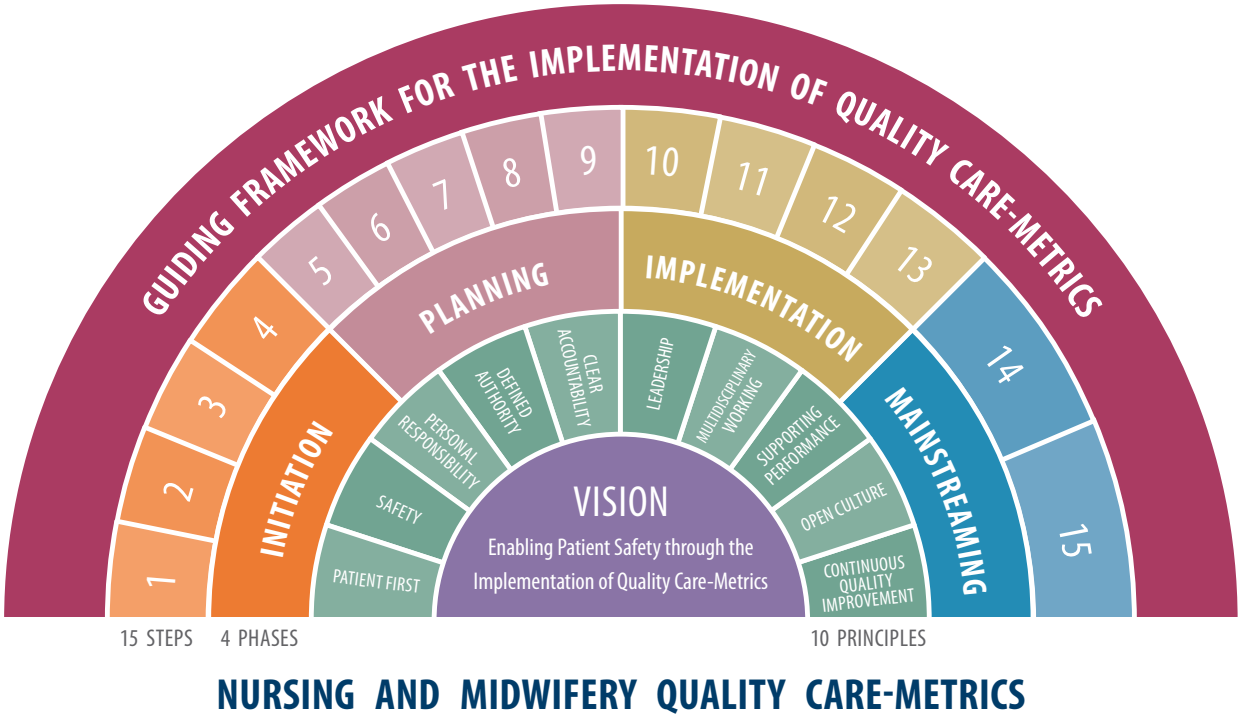


Figure 5: Framework for Implementation of Quality Care-Metrics

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 NMPDU
	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 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).

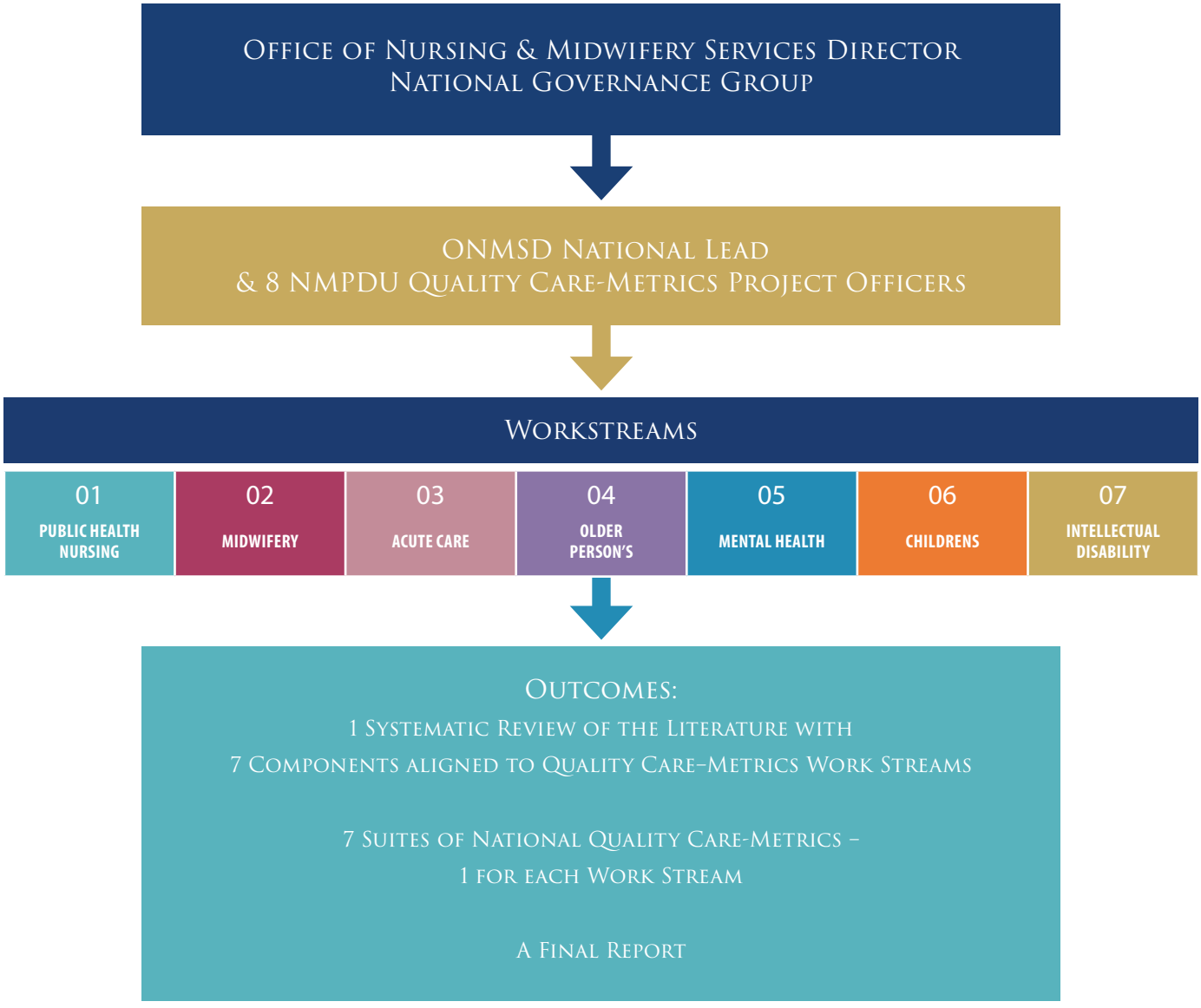


Figure 9: Nursing and Midwifery Quality Care-Metrics Governance Flow Chart

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 for dissemination of 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 Mental Health services such as PPPG development groups, project sponsors or appropriate governance groups, 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 Officers 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 Nursing and Midwifery 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 Nursing and Midwifery 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.
- 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 workstreams.
- 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 workstreams.
- 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/CMM on Action Plans where performance improvement is required at ward/unit level.
- In conjunction with CNM/CMM and Nurse/Midwife 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 (Appendix II) identified during Quality Care-Metrics data collection as appropriate.

4.4.5 Clinical Nurse/Midwife 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's/CMM's 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's/CMM's.
- Provide information to CNM's/CMM's and take 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 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.

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

Figure 11 outlines the process for undertaking Nursing and Midwifery Quality Care-Metrics

PROCESS FOR NURSING & MIDWIFERY QUALITY CARE-METRICS

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 healthcare records for the 72 hours preceding data collection.

5.4 Accessing Test Your Care 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 the Settings options on the TYC HSE 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 Quality Care-Metric responses for each clinical area)
- Report: Reporting on the results of the Quality Care-Metric responses per clinical 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/Midwives 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

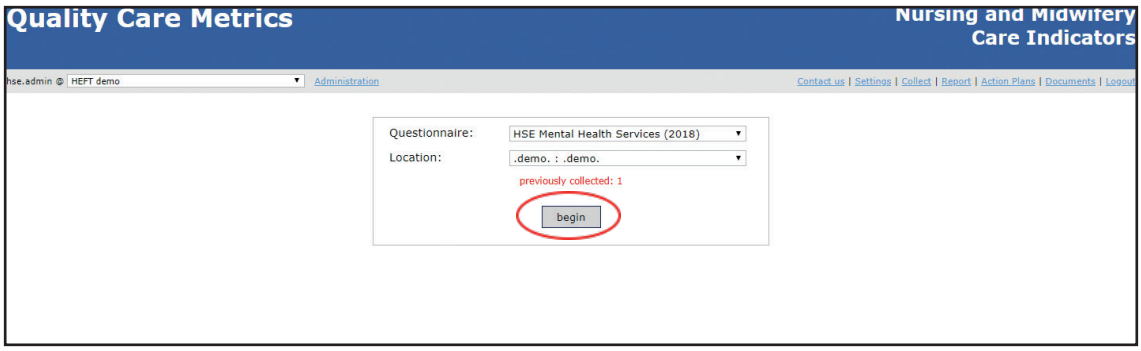


Figure 13: Data Entry: TYC HSE System

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

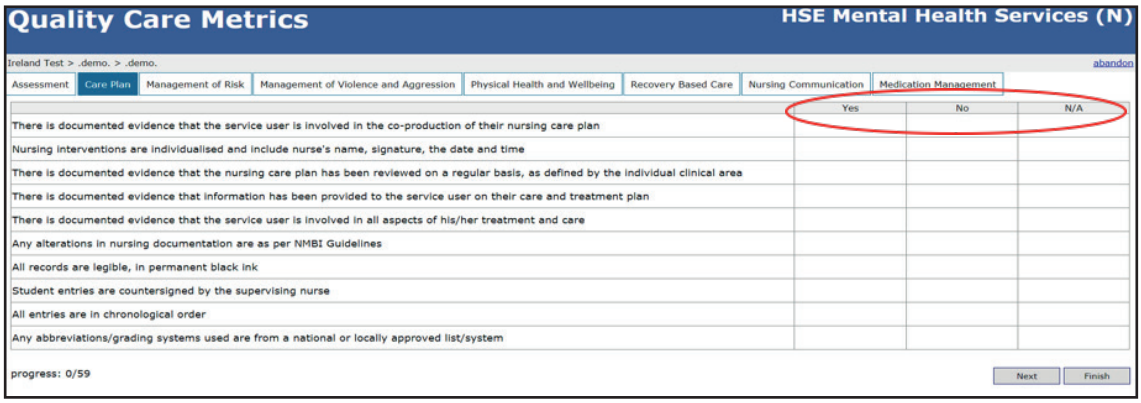


Figure 14: Data Entry: TYC HSE System (1)

- 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

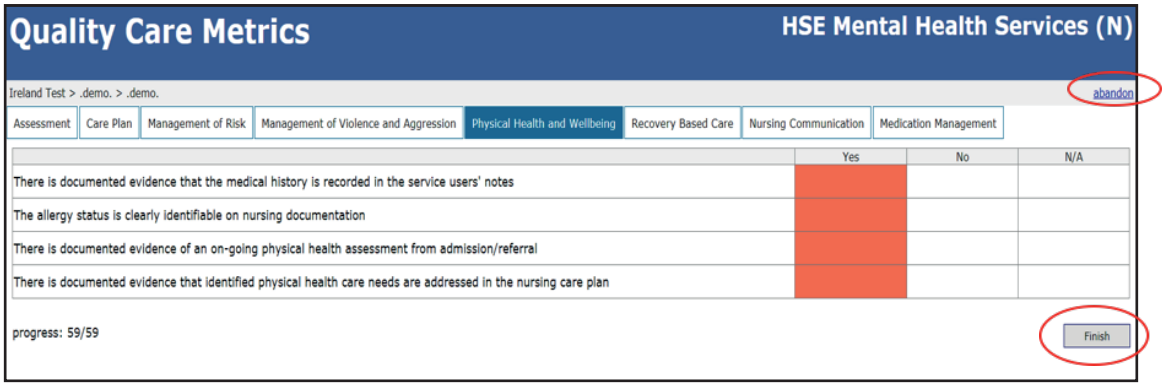


Figure 15: Data Entry: TYC HSE System (2)

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)

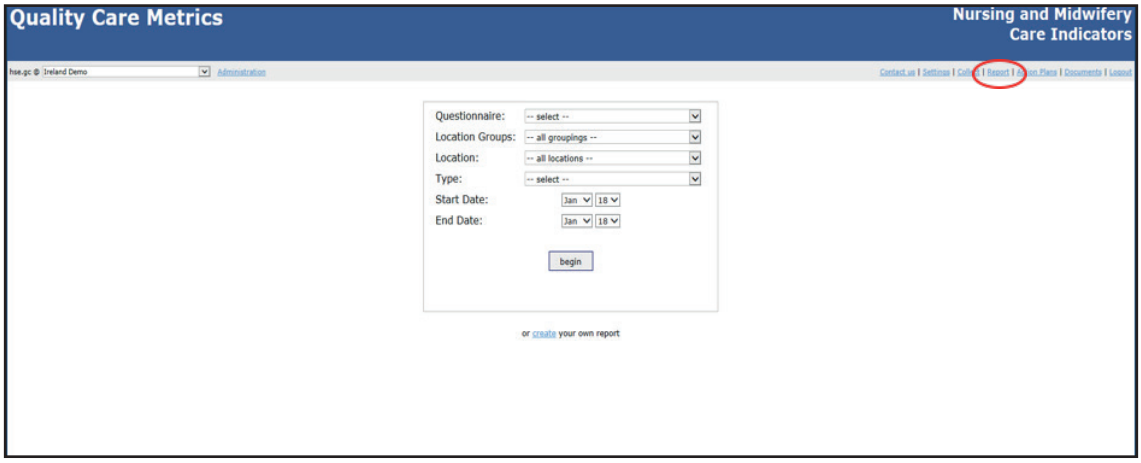


Figure 18: Accessing Reports from TYC HSE

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. Mental Health, Acute, Theatre, Children's, Public Health
- **Location Groups** – Select groupings such as Acute, Community, CAMHS or if a particular group is not required, select all
- **Location** – Select the name of the ward, unit or theatre 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. Mental Health, Acute, Theatre, Children's, Public Health
- **Location Groups** – Select groupings such as Acute, Community, CAMHS or if a particular group is not required, select all
- **Location** – Select the name of the ward, unit or theatre 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. Mental Health, Acute, Theatre, Children's, Public Health
- 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'

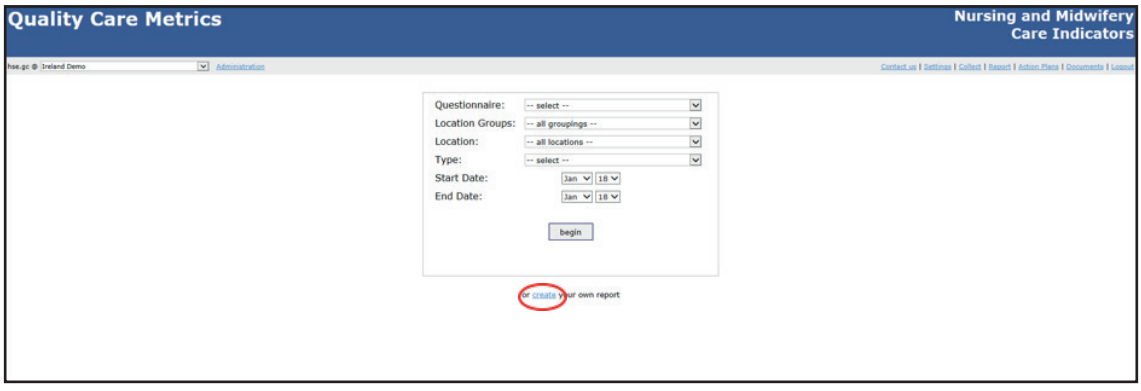


Figure 19: Create your own Report

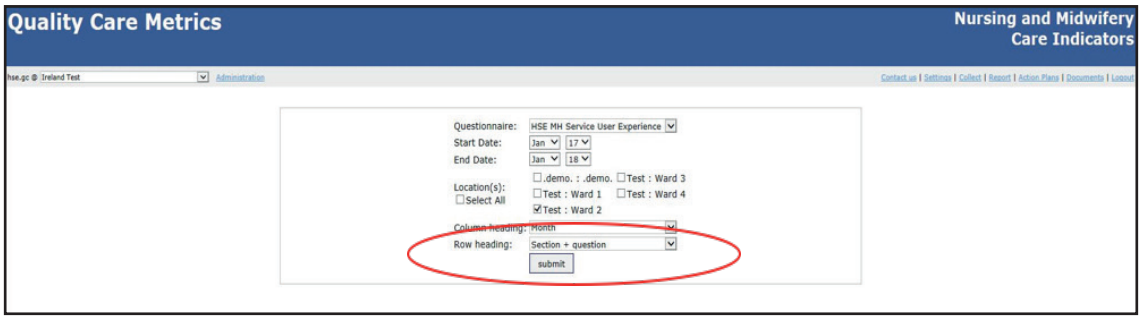


Figure 20: Create your own Report; Column Heading: Month and Row Heading: Section and Question

- This selection, **'Column heading: Month and Row Heading: Section and Question'** supports the CNM/CMM 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'

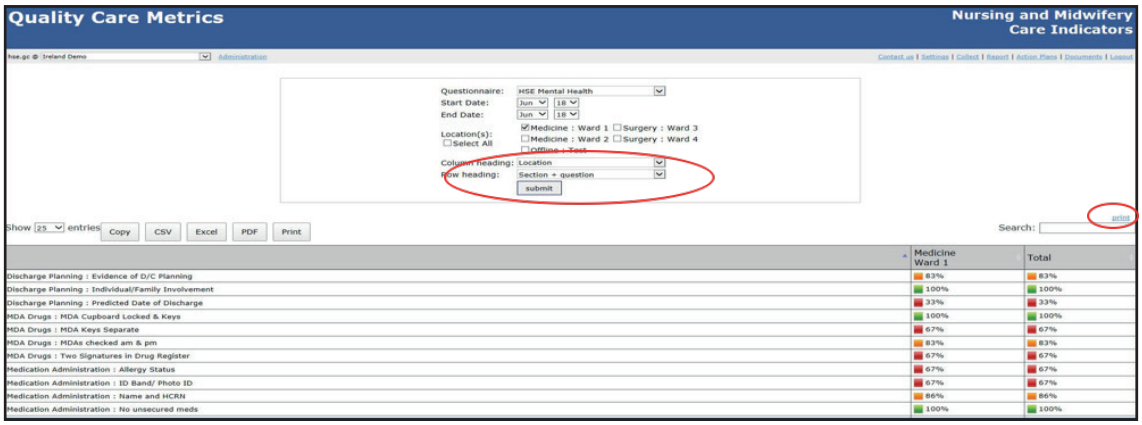


Figure 22: Create your own Report; Results; Column Heading: Location and Row Heading: Section and Question

- This selection, **'Column heading: Location and Row Heading: Section and Question'** supports the CNM/CMM 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. Mental Health, Acute, Children's, Public Health
- 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'

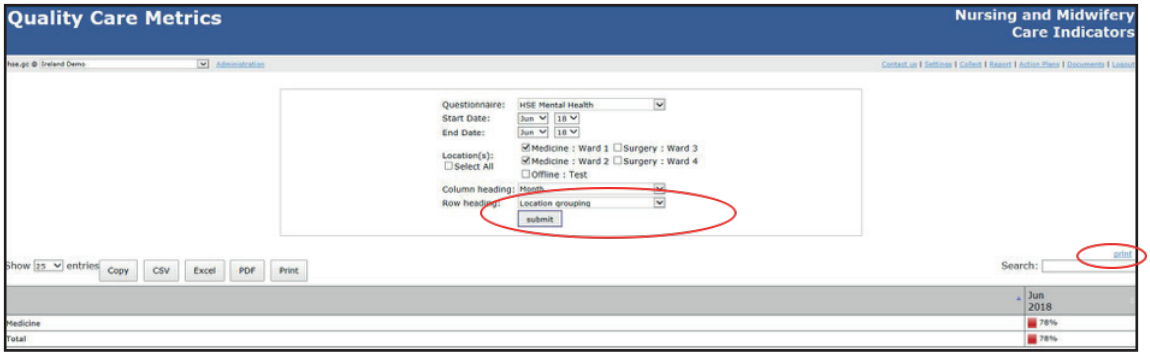


Figure 23: Create your own Report; Results; Column Heading: Month and Row Heading: Location Grouping

- 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).

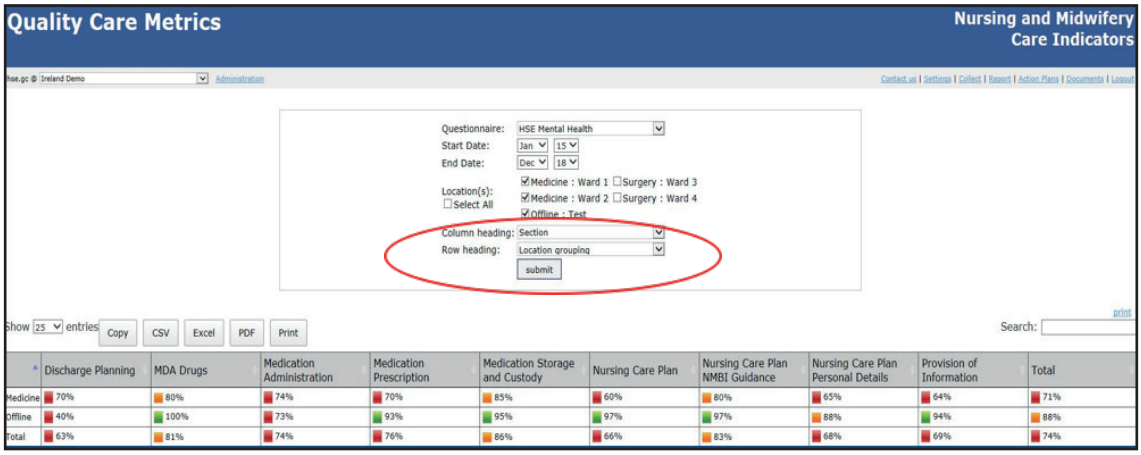


Figure 24: Create your own Report; Results; Column Heading: Section and Row Heading: Location Grouping

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.

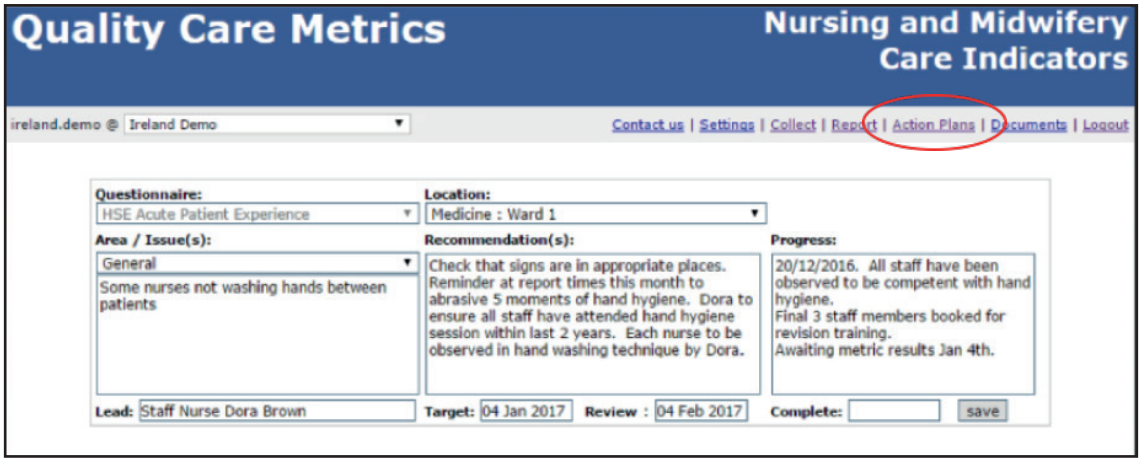


Figure 25: Accessing Action Planning on TYC HSE

7.1.2 Users can also generate or print an Action Plan "Report" through the reporting 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/CMM 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 HSE' users and potential users through

- 'QCM Explained'
- 'IImplementing QCM'
- Using 'Test Your Care HSE';
- 'Improving Practice' section focused on Action Planning
- 'News' to keep users and those with an interest in Quality Care-Metrics up to date in Quality Care-Metrics 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.

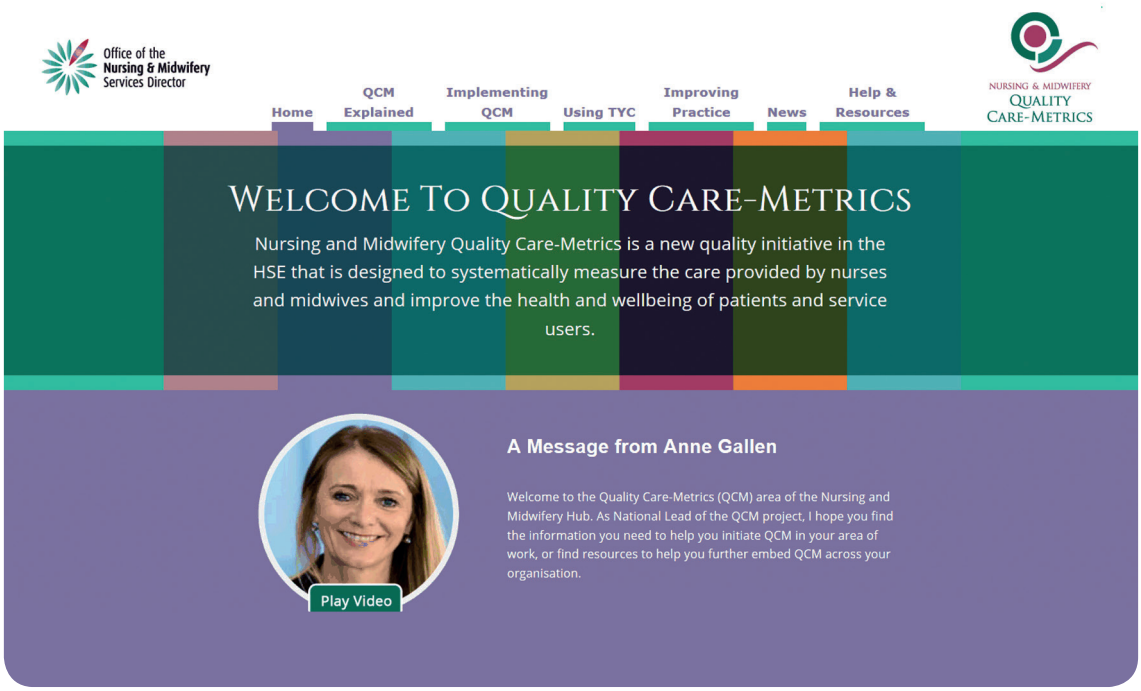


Figure 27: Quality Care-Metrics Hub

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 have been completed by each member of the Guideline Development Group as per Appendix IV 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 Governance Group.

1.7 Supporting Evidence

1.7.1 Legislation and regulation publications, which are relevant to the Mental Health 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.

- *Accreditation for Inpatient Mental Health Services (AIMS) Standards for Inpatient Wards – Working-Age Adults.* 4th Edition, (Cresswell & Beavon 2010)
- *Assisted Decision Making* (Capacity) Act. (2015)
- *National Standards for Residential Services for Children and Adults with Disabilities.* (HIQA 2013)
- *National Standards for Safer Better Healthcare.* (HIQA 2012)
- *General Guidance on the National Standards for Safer Better Healthcare.* (HIQA 2012a)
- *National Quality Standards for Residential Care Settings for Older People in Ireland.* (HIQA 2009)
- *Hygiene Services Assessment Scheme.* (HIQA 2006)
- *Nursing & Midwifery Quality Care-Metrics: Mental Health Research Report.* (HSE 2018)
- *A National Framework for Recovery in Mental Health Services. A National Framework for Mental Health Service Providers to support the Delivery of a Quality, Person Centred Service.* (HSE 2017)
- *Best Practice Guidance for Mental Health Services; Supporting you to meet Regulatory Requirements and towards Continuous Quality Improvement.* (HSE 2017a)
- *National Framework for Developing Policies, Procedures, Protocols and Guidelines (PPPGs).* (HSE 2016)
- *Advancing Recovery in Ireland. A guidance paper on implementing organizational and cultural change in Mental Health Services in Ireland.* (HSE 2016a)
- *National Consent Policy. National Consent Advisory Group.* (HSE 2014a)
- *Integrated Care Guidance: A Practical Guide to Discharge and Transfer from Hospital. Version 2,* (HSE 2014b)
- *A Vision for Psychiatric/Mental Health Nursing: A Shared Journey for Mental Health Care in Ireland.* (HSE 2012a)

- *Standards and Recommended Practices for Healthcare Records Management. Version 3,* (HSE 2011)
- *Code of Practice for Healthcare Records Management-Abbreviations.* (HSE 2010)
- *Risk Management in Mental Health Services: Guidance Document.* (HSE 2009)
- *Best Practice Principles for Risk Assessment and Safety Planning for Nurses working in Mental Health Services.* (Higgins et al. 2015)
- *Guide to Professional Conduct and Ethics for Registered Medical Council. 7th Edn.* (Medical Council 2009)
- *The Judgment Support Framework. Version 5,* (MHC 2018)
- *Code of Practice: Guidance for Persons working in Mental Health Services with People with Intellectual Disabilities.* (MHC 2009)
- *Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre.* (MHC 2009a)
- *A Recovery Approach with the Irish Mental Health Services: A Framework for Development.* (MHC 2008)
- *Quality Framework: Mental Health Services in Ireland.* (MHC 2007)
- *Nurses and Midwives Act.* (Government of Ireland 2011)
- *Nursing Home Support Scheme Act.* (Government of Ireland 2009)
- *Mental Health Act.* (Government of Ireland 2001)
- *Guidance to Nurses and Midwives on Medication Management.* (ABA 2007)
- *Standards for Registered Nurses and Midwives on Medication Administration.* (NMBI 2018) DRAFT
- *Scope of Nursing and Midwifery Practice Framework.* (NMBI 2015)
- *Code of Professional Conduct and Ethics for Registered Nurses and Registered Midwives.* (NMBI 2014)
- *Recording Clinical Practice Guidance to Nurses and Midwives.* (NMBI 2014a)

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 Quality Care-Metrics Data Collection in Mental Health 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 Intellectual Disability 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 Mental Health Services Quality Care-Metrics (2018).

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 Mental Health 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 Mental Health 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 National University of Ireland, Galway. It includes the final suite of Mental Health Nursing Process Metrics and Indicators developed from the research.

2.1.4 The Mental Health Nursing Process Metrics and Indicators are adapted from national and international evidence based practice including PPPGs and reflect what mental health 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 Mental Health Research Report (HSE 2018) and as listed in 1.7 Part B 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 mental health nurses to develop consensus on metrics to be measured.

Phase 3: A two-round online Delphi survey of mental health 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: Pubmed, Embase, PyscINFO, 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.

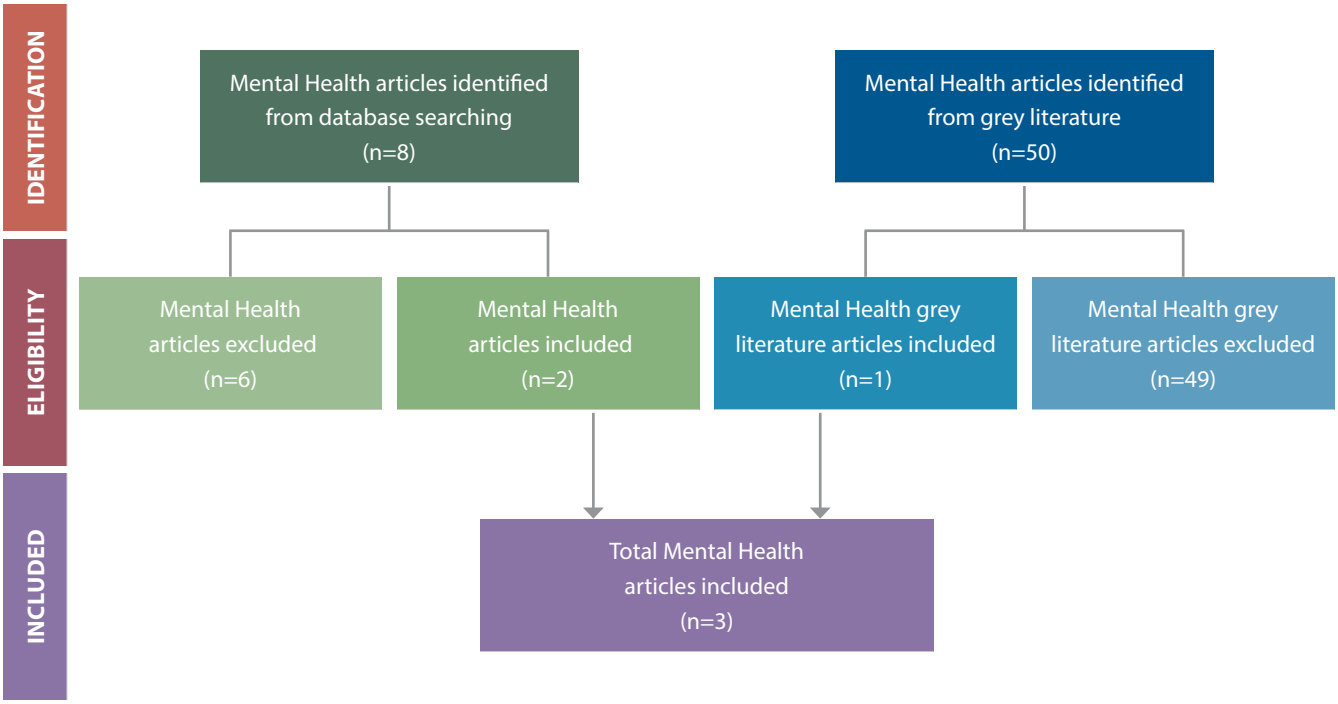
2.4 Method of Evidence Appraisal

2.4.1 Data Extraction: Work stream specific data extraction was conducted by two reviewers using a purposefully designed data extraction tool.

2.4.2 Results: The search conducted across 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 general, acute, children, intellectual disability, mental health, midwifery, older person, or public health nursing services and practice.

2.5 Summary of the Evidence from the Literature

2.5.1 The Systematic Literature Review for Mental Health found that **8** studies were identified as relevant to mental health nursing and a further **50** documents were identified from grey literature as relevant to mental health using the process as outlined in Figure 28. The supporting evidence from the literature for the guideline is derived, guided and referenced in the Quality Care-Metrics Mental Health Research Report (HSE 2018).



Adapted from: Moher D, Liberati A, Tetzlaff J, Altman DG, The PRISMA Group (2009). Preferred Reporting Items for Systematic Reviews and Meta-Analyses: The PRISMA Statement. PloS Med 6(7): e1000097. doi:10.1371/journal.pmed1000097

For more information, visit www.prima-statement.org

Figure 28: Study Selection Process Flow Diagram for Mental Health Work Stream

2.6 Consensus Process

2.6.1 Delphi Process: Two two-round Delphi surveys (Phase 2 & 3) were conducted consisting of four rounds of data collection and analysis in each to condense the opinions of participants into group consensus on what (a) metrics and (b) their indicators should be used. Responses to each round were collated, analysed, and redistributed to participants for further comment in successive rounds (HSE 2018).

2.6.2 Consensus Meeting: This phase comprised of a face-to-face meeting with key stakeholders (mental health nurses and service user representative) to review the findings from the Delphi surveys and build consensus on process nursing metrics and their respective indicators. Participants were provided with a Nursing and Midwifery Judgement Framework Tool adapted from Flenady et al. (2016) to use as guide in determining if the process metric/ indicator was appropriate for inclusion in the final suite of metrics (Figure 29).

DOMAIN	
01	**PROCESS FOCUSED** The metrics/ indicator contributes clearly to the measurement of mental health 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 Mental Health Quality Care-Metrics consensus meeting, **9** process metrics and **73** indicators were agreed upon for the new suite of Mental Health 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 Mental Health 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 1
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
Ciara White NMPDU Quality Care-Metrics Project Officer, NMPD HSE Dublin North
Deirdre Keown NMPDU Quality Care-Metrics Project Officer, NMPDU HSE North West
Denise Doolan NMPDU Quality Care-Metrics Project Officer, NMPDU HSE Dublin South Kildare Wicklow
Gillian Conway NMPDU Quality Care-Metrics Project Officer, NMPDU HSE West/Mid-West
Johanna Downey NMPDU Quality Care-Metrics Project Officer, NMPDU HSE South
Leonie Finnegan NMPDU Quality Care-Metrics Project Officer, NMPDU HSE South East
Margaret Nadin NMPDU Quality Care-Metrics Project Officer, NMPDU HSE Dublin North East
Mary Nolan NMPDU Quality Care-Metrics Project Officer, NMPDU HSE Midlands

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

Anne Brennan	DIRECTOR NMPDU
Caroline Kavanagh	PROJECT OFFICER NMPDU

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

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

Health Service Executive
Dr. Steevens' Hospital
Dublin 8
Ireland

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