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

OLDER PERSON SERVICES 2018

OFFICE OF THE
NURSING AND MIDWIFERY SERVICES DIRECTOR
HEALTH SERVICE EXECUTIVE

NURSING & MIDWIFERY
QUALITY
CARE-METRICS

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Office of the
Nursing & Midwifery
Services Director

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Is this document a:

Policy		Procedure		Protocol		Guideline	X

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

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 - 029**
Version Number:	**1**
Publication Date:	**2018**
Date for revision:	**2021**
Electronic Location:	**www.hse.ie/eng/about/who/onmsd/safecare/qcm/qcm-ppgs.html**

Version	Date Approved	List section numbers changed	Author

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1.0 INITIATION OF QUALITY CARE-METRICS AT SERVICE LEVEL

1.1 Glossary of Terms and Definitions

Clinical Governance:
Clinical governance is "…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 Metrics:
Nursing metrics are agreed standards of measurement for nursing and midwifery care, where care can be monitored against agreed standards and benchmarks (Foulkes 2011).

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

Procedure:

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

Quality Care-Metrics:

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

Quality Care Process Metric:

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

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 2018a).

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 2018a).

1.2 Abbreviations

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

1.3 Introduction

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

1.3.2 Nurses and midwives are a well-educated, highly skilled 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 and Development Units (NMPDU), Quality Care-Metrics were developed and implemented in over 100 clinical areas across the North West, North East & Dublin North and endorsed by the Office of the Nursing & Midwifery Services Director (ONMSD) Health Service Executive (HSE).

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

1.4.4 In 2014, the ONMSD entered into a service level agreement with HEFT to provide access to the TYC nationally to HSE organisations across the Republic of Ireland. The online web based measurement system TYCHSE 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 was achieved through the 7 Work-streams Working Groups (HSE 2018a).

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

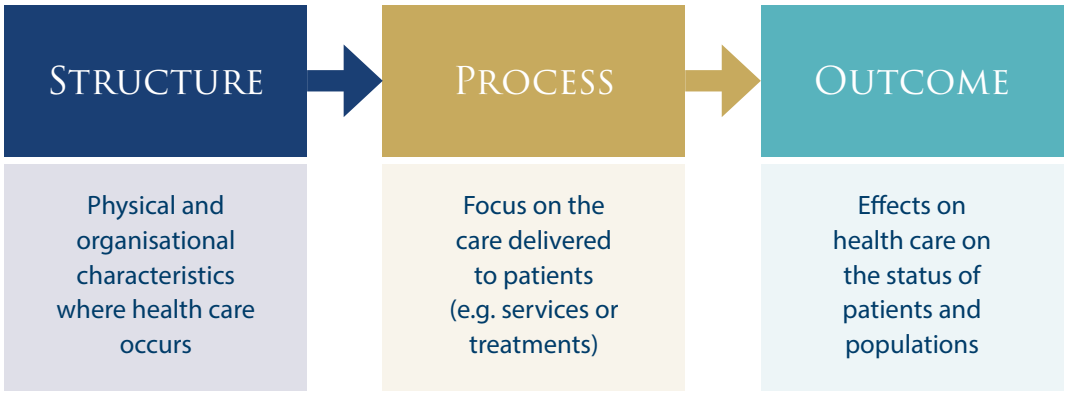

Figure 1: Donabedian's Conceptual Model for Evaluating Quality of Care (1966)

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

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

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

Work-streams

Nursing and Midwifery Quality Care-Metrics standardised across seven workstreams

Figure 2: Quality Care-Metrics Work Streams

1.5.6 Nursing and Midwifery Quality Care-Metrics currently consist of a core suite of quality indicators across seven care groups; Acute, Older Persons, Mental Health, Intellectual Disability, Midwifery, Public Health Nursing services and Children's services (Figure 2).

Figure 3 demonstrates the updated metrics which are available for measurement and monitoring across the regions utilising Quality Care-Metrics.

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

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				

1.6 Rationale for Measuring Nursing and Midwifery Care

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

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

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

1.7 Clinical Governance

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

1.7.2 Quality Care-Metrics supports Directors of Nursing/Midwifery to provide an accountability system that enables assessing, monitoring, reporting and feedback to teams about performance and identifies areas for improvement (HSE 2014; Donaldson et al 2005); using "real time" information regarding the quality of care patients/clients are receiving.

1.8 Benefits

1.8.1 Quality Care-Metrics 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, 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 Older Person 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 Older Person 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 Older Person 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 Older Person Research Report (HSE, 2018).

1.10.5 All nurses and midwives within Older Person services, who are engaged with Quality Care-Metrics in nursing and midwifery practice, should complete Appendix 1, Signature Sheet to indicate that they have read, understood and agree to the guideline. The completed signature sheet should be retained at service level.

1.11 Objective

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

1.12 Outcomes

1.12.1 The guideline provides a framework 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 Older Person services nationally.

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

2.0METRICS, INDICATORS AND ADVICE FOR OLDER PERSON SERVICES

The following Nursing Quality Care-Metrics are available for Older Person Services enabling capture of the nursing element of the Comprehensive Geriatric Assessment (CGA)

CGA Physical Assessment

1 Skin Integrity
2 Assessment and Management of Pressure Ulcers
3 Optimising Nutrition and Hydration
4 Pain Assessment and Management
5 Medicines Prescribing
6 Medicines Administration
7 Infection Prevention and Control

CGA Psychological Assessment

14 Psychological Nursing Assessment
15 Responsive Behaviour Support
16 Safeguarding Vulnerable Adults

CGA Functional Assessment

8 Activities of Daily Living
9 Falls risk
10 Falls Prevention
11 Continence Assessment, promotion and Management
12 Frailty Nursing Assessment
13 End of Life and Palliative care

CGA Social and Environment

17 Social Assessment
18 Activities (Holistic), Social Engagement

Post Assessment Care

19 Person Centred Care Planning
20 Misuse of Druge Act (MDA) Medicines
21 Medicines Storage and Custody
22 Person Experience

Figure 4: Older Person Services Nursing Quality Care-Metrics

2.1 Skin Integrity Quality Care-Metric

SKIN INTEGRITY **I** = Indicator, **A** = Data Collectors Advice, **N/A** = Not Applicable		
1	**I**	**A skin care inspection has been completed on admission, transfer and prior to discharge**
	A	Mark **Yes** if a skin care inspection has been completed on admission/transfer. If discharge is imminent, check that the skin care inspection has taken place prior to discharge. Mark **No** if a skin care inspection has not been completed on admission/transfer. Mark **N/A** If the individual is in residence for longer than 6 months.
2	**I**	**The skin integrity care plan identifies and manages the risk factors associated with impaired skin integrity**
	A	Mark **Yes** if the risk factors (malnutrition, incontinence, immobility) are identified / documented in the skin integrity care plan. Mark **Yes** if a skin care management plan is in place to limit negative effects of these factors on skin integrity (both elements must be present to Mark Yes). Mark **No** if the risk factors associated with skin integrity are not identified /documented. Mark **No** if a skin care management plan to limit negative effects has not been initiated. Mark **N/A** if there is documented evidence that these risk factors are not of concern to this individual.

2.2 Assessment and Management of Pressure Ulcers Quality Care-Metric

ASSESSMENT AND MANAGEMENT OF PRESSURE ULCERS **I** = Indicator, **A** = Data Collectors Advice, **N/A** = Not Applicable		
1	**I**	**A full pressure ulcer risk assessment was completed on admission**
	A	Mark **Yes** if a full pressure ulcer risk assessment was completed on admission /transfer (within 8 hours) using a validated tool. All components of the risk assessment must be completed to answer **Yes**. Mark **No** if a full assessment was not completed within 8 hours of admission /transfer. Examples of validated tools are the Braden scale, the Waterlow score, the Norton risk assessment scale. Mark **N/A** If the individual is in residence for longer than six months. *Note - a new risk assessment should be completed on return from a general hospital or on return from home/respite as per local policy.*

2	**I**	**If a pressure ulcer is present, the grade is documented**
	A	Mark **Yes** if the pressure ulcer is graded in the wound management care plan using the Pressure Ulcer Advisory Panel Classification System. Mark **No** if the pressure ulcer is not graded as above. Mark **N/A** if no pressure ulcer is present.
3	**I**	**The pressure ulcer risk was re-assessed and documented in response to any changes to the individual's condition**
	A	Mark **Yes** if re-assessment was completed following a documented change in the individual's condition in the past 4 weeks. Mark **No** if re-assessment was not completed despite a documented change in the individual's condition in the past 4 weeks. Mark **N/A** if the individual's condition is unchanged in the past 4 weeks.
4	**I**	**If identified at risk, the individual is commenced on S.S.K.I.N bundles for pressure ulcer prevention & management**
	A	Mark **Yes if Skin Surface-Skin Inspection-Keep Moving-Incontinence-Nutrition & Hydration** (S.S.K.I.N.) **or** other pressure ulcer prevention & management care bundle have been commenced. Mark **No** if a pressure ulcer prevention & management care bundle was not commenced. Mark **N/A** if individual has been assessed as not at risk.
5	**I**	**Pressure relieving devices and alternative pressure therapies are in use if indicated in the risk assessment**
	A	Mark **Yes** if there is documented evidence of the use of pressure relieving devices and alternative pressure therapies in the care bundle/plan. Mark **No** if there is not documented evidence of the use of pressure relieving devices and alternative pressure therapies in the care bundle/plan despite being indicated in risk assessment. Mark **N/A** if the risk assessment does not indicate use of these devices / therapies.

2.3 Optimising Nutrition and Hydration Quality Care-Metric

OPTIMISING NUTRITION AND HYDRATION **I** = Indicator, **A** = Data Collectors Advice, **N/A** = Not Applicable		
1	**I**	**The individual's risk of malnutrition has been screened on admission**
	A	Mark **Yes** if there is documented evidence that the risk of malnutrition has been screened on admission. *An appropriate tool must be used e.g. Malnutrition Universal Screening Tool (MUST).* Mark **No** if the risk of malnutrition was not screened on admission. Mark **N/A** If the individual is in the healthcare system for longer than 6 months. Mark **N/A** if the individual is on a clearly defined end of life pathway.

2	I	**The individual's risk of malnutrition has been re-screened 4 monthly or more frequently if condition requires**
	A	Mark **Yes** if there is documented evidence that a 4 monthly re-screen (or more frequent if required) has been completed using an appropriate tool. Mark **No** if re-screening is not completed within a maximum of 4 months from the previous assessment date. Mark **N/A** if the re-screening due date has not yet been reached. Mark **N/A** if the individual is on a clearly defined end of life pathway.
3	I	**A plan of care has been developed based on the individual's risk of malnutrition**
	A	Mark **Yes** if a documented plan of care has been developed based on the malnutrition risk identified. Mark **No** if a plan of care has not been developed or it is not based on the identified risk. Mark **N/A** if individual's assessed risk does not indicate development of a nutritional care plan.
4	I	**The individual has access to fluids suited to their assessed needs**
	A	Mark **Yes** if the individual has access to fluids suited to their assessed needs. Mark **No** if the individual does not have access to fluids suited to their assessed needs. Check that fresh fluids are easily available in the individual's immediate proximity.
5	I	**The diet provided is varied and suited to the assessed needs of the individual**
	A	Mark **Yes** if the diet provided is suited to the assessed needs of individual. *Check quantity, variety, consistency and frequency of the diet provided.* Mark **No** if the diet provided is not suited to the assessed needs of the individual.
6	I	**The individual's oral health status was screened on admission**
	A	Mark **Yes** if there is documented evidence that the individual's oral health status has been screened on admission. Mark **No** if the individual's oral health status was not screened and documented on admission. Mark **N/A** If the individual is in residence for longer than 6 months.
7	I	**The individual's oral health status was re-screened 4 monthly or more frequently if condition requires**
	A	Mark **Yes** if there is documented evidence of a 4 monthly re-rescreen of the oral health status (or more frequently if required). Mark **No** if re-screening has not taken place within a maximum of 4 months from the previous assessment date. Mark **N/A** if the re-screening due date has not been reached.

2.4 Pain Assessment and Management Quality Care-Metric

PAIN ASSESSMENT AND MANAGEMENT **I** = Indicator, **A** = Data Collectors Advice, **N/A** = Not Applicable		
1	**I**	**On admission pain is assessed and documented using a validated tool**
	A	Mark **Yes** if a pain assessment has been completed on admission using a validated tool **and** if the tool is consistent with the individual's condition and ability to understand. Both elements and all tool components must be present to Mark **Yes**. Mark **No** if a pain assessment has not been completed on admission using a validated tool. Mark **No** if the validated tool used is not consistent with the individual, condition and ability to understand. Mark **N/A** If the individual is in the healthcare system for longer than 6 months.
2	**I**	**The individual's pain is re-assessed as required**
	A	Mark **Yes** if there is documented evidence that the individual's pain has been re-assessed as required in the last 72 hours using a validated tool. Mark **No** if the individual's pain (in the last 72 hours) has not been re-assessed as required using a validated tool. Mark **N/A** if there is documented evidence that the individual has not experienced pain in the last 72 hours.
3	**I**	**If indicated by the assessment, a pain management care plan is in use and includes pharmacological and non-pharmacological interventions**
	A	Mark **Yes** if a pain management care plan is in use which includes pharmacological and non-pharmacological interventions. Mark **No** if a pain management care plan is not in use and/or does not include pharmacological and non-pharmacological interventions. Mark **N/A** if the pain assessment does not indicate the requirement for a pain management care plan.

2.5 Medicines Prescribing Quality Care-Metric

MEDICINES PRESCRIBING **I** = Indicator, **A** = Data Collectors Advice, **N/A** = Not Applicable		
1	**I**	**A medicines reconciliation was completed on admission, transfer or prior to discharge**
	A	Mark **Yes** if medicines reconciliation has been completed on admission/transfer. If discharge is imminent, check that medicines reconciliation has taken place prior to discharge. Mark **No** if medicines reconciliation has not been completed on admission/transfer. Mark **N/A** if the individual is in the healthcare system for longer than 6 months.

2	I	**A 4 monthly review of medicines has taken place**
	A	*Check that a medicines review was undertaken within the recommended 4 month period (or earlier if the individual's condition indicates).* Mark **Yes** if a documented review of medicines has taken place within a maximum of 4 months from the last review date. Mark **No** if review has not taken place within 4 months from the initial admission reconciliation date or last review date.
3	I	**The prescription is legible with correct use of abbreviations**
	A	Mark **Yes** if the prescription is clear and legible and any abbreviations used are from an approved national/local list. Mark **No** if prescription is not clear or legible or if unapproved abbreviations are used. (*International Units, Micrograms, Nanograms and units must not be abbreviated*), check that quantities less than **1 gram** are written in **mg** and quantities less than **1 mg** are written in **micrograms** (e.g. 0.5g should be written as 500 mg).
4	I	**The minimum dose interval and/or 24 hour maximum dose is specified for all PRN medicines**
	A	Mark **Yes** if all prescribed **PRN** medicines inform the nurse of both the minimum dose interval and the maximum dose in 24 hours for when the medicine can be administered. (Both components must be present to mark **Yes**). Mark **No** if this information is not provided for each prescribed *PRN* medicine. Mark **N/A** if **PRN** medicines are not prescribed.
5	I	**Discontinued medicines are crossed off, dated and signed by a person with prescriptive authority**
	A	*Check for any discontinued medicines on the medication record.* Mark **Yes** if medicines are correctly crossed off as above and include the full date (Day/Month/Year) it was discontinued and the signature of the prescriber who has discontinued the medicine. Mark **No** if any element is incorrect or if all discontinued drug do not follow this standard. Mark **N/A** if there are no discontinued medicines on the medicines record. .
6	I	**The generic name is used for each medicine unless the prescriber indicates a branded medicine and states 'do not substitute'**
	A	Mark **Yes** if the generic name is used for each medicine with the following exceptions: combination products or narrow therapeutic index drugs. Mark **Yes** if the 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. *Refer to local policy for branded medicines which should not be substituted with an alternative brand.* Mark **No** if the generic name is not used for drugs other than combination products or narrow therapeutic index drugs.

2.6 Medicines Administration Quality Care-Metric

MEDICINES ADMINISTRATION **I** = Indicator, **A** = Data Collectors Advice, **N/A** = Not Applicable		
1	**I**	**The medicine administration record provides details of the individual's legible name and health care record number**
	A	*Check all pages of the medicines administration record that are in use.* Mark **Yes** if the Name and Healthcare Record Number (HCRN) are on each page. Where organisations do not use a HCRN, the Date of Birth (DOB) or unique identifier (UI) number are valid identifiers. Mark **No** if all pages do not have two valid identifiers (name and one other – DOB or UI). Mark **No** if the name/HCRN/DOB/unique identifiers are not legible.
2	**I**	**The allergy status is clearly identifiable on the front page of the medicine administration record**
	A	Check both the prescription and medication administration record. Mark **Yes** if the allergy status is clearly identifiable e.g. 'No known allergies'. Mark **No** if the allergy status box/section is blank.
3	**I**	**Prescribed medicines not administered have an omission code entered and appropriate action taken**
	A	*All medicines should be initialled at time of administration. Check medicines administered in the last 72 hours.* Mark **Yes** if omission codes are entered and initialled by the nurse omitting the medicine in the last 72 hours. Mark **Yes** if the nursing notes record appropriate actions taken by the nurse in response to medicines omitted (e.g. Doctor informed, pharmacy contacted and individual's condition reviewed as appropriate) Both components must be present to Mark Yes. Mark **No** if an omission code is not entered **or** if it is not initialled by the nurse when a medicine is omitted in the last 72 hours. Mark **No** if documentation of the appropriate action taken following omission of a prescribed medicine is not recorded. Mark **N/A** if all medicines in the last 72 hours were administered and there was no requirement for an omission code.5
4	**I**	**There are no unsecured prescribed medicinal products in the individual's environment**
	A	*Medicines should be administered at the prescribed time and not stored for later consumption.* Mark **Yes** if unsecured medicinal products are not found within the individual's environment (top of locker, dining area, sitting area etc) Mark **No** if unsecured medicinal products are found within the individual's environment Mark **N/A** for unsecured medicinal products (marked with the resident's name) which are exempted (e.g. Mycostatin oral suspension and Corsodyl mouth washes necessary for pre identified residents and resident's own inhalers).

5	**I**	**The frequency of medicine administration is as prescribed**
	A	Check the medicines administration record for the last 72 hours. Mark **Yes** if all medicines in the last 72 hours are administered at the prescribed time. Mark **No** if all medicines (in the last 72 hours)are not administered at the time prescribed. Mark **N/A** for prescribed medicines placed 'on hold' by the prescriber.

2.7 Infection Prevention and Control Quality Care-Metric

INFECTION PREVENTION AND CONTROL **I** = Indicator, **A** = Data Collectors Advice, **N/A** = Not Applicable		
1	**I**	**All invasive medical devices are managed in accordance with local policy/care bundles**
	A	Check records for the last 72 hours Mark **Yes** if the appropriate care bundle for each invasive medical device has been completed, dated and signed - e.g. subcutaneous / peripheral intravenous catheter, urinary catheter, peg tube etc. Mark **No** if a care bundle for any invasive medical device in use is not completed. Mark **No** if the care bundle is not dated and signed. Mark **N/A** if individual does not have an invasive medical device in use.
2	**I**	**Infection and sepsis alert /status are recorded in the nursing record**
	A	Mark **Yes** if the individual's current infection status is documented in the allocated section of the nursing documentation. Mark **No** if the infection status is not documented in the allocated section of the nursing documentation i.e. it is unfilled.

2.8 Activities of Daily Living Quality Care-Metric

ACTIVITIES OF DAILY LIVING **I** = Indicator, **A** = Data Collectors Advice, **N/A** = Not Applicable		
1	**I**	**An assessment of the activities of daily living was completed on admission**
	A	Mark **Yes** if there is documented evidence of a completed assessment of the ADLs on admission. Mark **No** if a full assessment of the ADLs was not completed and documented on admission. Mark **N/A** if the individual has been in residence for more than 6 months.
2	**I**	**Activities of daily living were re-assessed 4 monthly or more frequently if condition requires**
	A	Mark **Yes** if there is documented evidence that four monthly reviews of ADL are completed (or more frequently if required). Mark **No** if re-assessment of the ADLs was not completed within a maximum of 4 months from the previous assessment date. Mark **N/A** if review date has not yet been reached.

2.9 Falls Risk Quality Care-Metric

FALLS RISK **I** = Indicator, **A** = Data Collectors Advice, **N/A** = Not Applicable		
1	**I**	**A falls risk assessment of the individual is completed within 24 hours of admission**
	A	Mark **Yes** if a falls risk assessment was completed using a validated tool within 24 hours of admission (e.g. Falls Risk Assessment Tool –FRAT). Mark **No** if a falls risk assessment was not been completed within 24hrs of admission. Mark **N/A** If the individual has been in residence for longer than 6 months.
2	**I**	**The individual is re-assessed at least every 4 months or earlier if indicated (e.g. following a change in status or a fall)**
	A	Mark **Yes** if there is documented that a falls risk re-assessment was undertaken within the recommended 4 month period (or earlier following a change in status or a fall) using a validated tool. Mark **No** if the re-assessment was not completed within a maximum of 4 months from the previous assessment date. Mark **N/A** if review date has not yet been reached

3	**I**	**A falls risk re-assessment is completed before person centred interventions are considered to minimise the risk of falls.**
	A	Mark **Yes** if there is documented evidence of a falls risk re-assessment prior to consideration of person centred interventions to minimise the risk of falls. *Check documentation for the last 72 hours. Interventions to minimise falls risk may include (but are not limited to) provision of mobility aids, change in footwear, moving bed/room closer to nurses station, bed exit/chair exit sensor alarm, floor mat sensors, hip protector – as per local policy.* Mark **No** if a falls risk re-assessment was not completed prior to consideration of person centred interventions to minimise the risk of falls in the last 72 hours. Mark **N/A** if person centred interventions has not been considered in the last 72 hours.

2.10 Falls Prevention Quality Care-Metric

FALLS PREVENTION **I** = Indicator, **A** = Data Collectors Advice, **N/A** = Not Applicable		
1	**I**	**A care plan has been initiated for the individual if identified as medium or high risk of falls**
	A	Mark **Yes** if a falls prevention care plan has been initiated for the individual identified at medium or high risk of falls. Mark **No** if a care plan has not been initiated for an individual identified at medium or high risk of falls. Mark **N/A** if the individual has not been identified as medium or high risk of falls.
2	**I**	**Where the individual has fallen, there is documented evidence of a review**
	A	Mark **Yes** if there is documented evidence of a completed review if the individual has fallen in last 72 hours. Check ward falls log book, incident book, care plan, Q-Pulse records. The review should include evidence of communication using the ISBAR communication tool if appropriate. Mark **No** if a post falls review was not completed for any falls in the last 72 hours. Mark **N/A** if the individual has not fallen within the last 72 hours.

2.11 Continence Assessment, Promotion and Management Quality Care-Metric

CONTINENCE ASSESSMENT, PROMOTION AND MANAGEMENT **I** = Indicator, **A** = Data Collectors Advice, **N/A** = Not Applicable		
1	**I**	**On admission, transfer and discharge a continence assessment is completed**
	A	Mark **Yes** if a continence assessment has been completed using a validated tool on admission /transfer. If discharge is imminent, check that a continence assessment was completed prior to discharge. Mark **No** if a continence assessment has <u>not</u> been completed on admission /transfer. Mark **N/A** If the individual is in the healthcare system for longer than 6 months.

2	**I**	**A continence re-assessment was completed 4 monthly or more frequently if condition requires**
	A	Mark **Yes** if there is documented evidence that a 4monthly re-assessment (or more frequent if required) has been completed. Mark **No** if re-assessment is not completed within a maximum of 4 months from the previous assessment date. Mark **N/A** if review date has not yet been reached
3	**I**	**A continence promotion care plan is in place - if indicated in the continence screening**
	A	Mark **Yes** if an appropriate continence promotion care plan is in place. Mark **No** if an appropriate continence promotion care plan is not in place. Mark **N/A** if the continence assessment does not indicate the requirement for a continence promotion/management care plan.

2.12 Frailty Nursing Assessment Quality Care-Metric

FRAILTY NURSING ASSESSMENT **I** = Indicator, **A** = Data Collectors Advice, **N/A** = Not Applicable		
1	**I**	**A frailty assessment was completed on admission**
	A	Mark **Yes** if there is documented evidence of a frailty assessment on admission using a validated tool. Mark **No** if a frailty assessment was not completed and documented on admission. Mark **N/A** if the individual has been in residence for longer than 6 months.
2	**I**	**A frailty re-assessment was completed 4 monthly or more frequently if condition requires**
	A	Mark **Yes** if there is documented evidence that a 4 monthly re-assessment (or more frequently if required) has been completed. Mark **No** if re-assessment is not completed within a maximum of 4 months from the previous assessment date Mark **N/A** if review date has not yet been reached..

2.13 End of Life and Palliative Care Quality Care-Metric

END OF LIFE AND PALLIATIVE CARE **I** = Indicator, **A** = Data Collectors Advice, **N/A** = Not Applicable		
1	**I**	**The individual's end of life care preferences are identified and documented**
	A	Mark **Yes** if there is documented evidence of a discussion with the individual, identifying their end-of-life care preferences. Mark **No** if evidence of a discussion with the individual, identifying their end of life care preferences is not documented .
2	**I**	**A holistic palliative care plan including spiritual needs and symptom management is in use and updated accordingly**
	A	Mark **Yes** if there is documented evidence of a holistic palliative care plan including spiritual needs and holistic symptom management. Mark **Yes** if the holistic palliative care plan has been updated within the specified time frame at local level. Mark **No** if evidence of a holistic palliative care plan including spiritual needs and holistic symptom management is not documented. Mark **No** if the holistic palliative care plan has not been updated in the specified time frame at local level. Mark **N/A** if the individual's current condition does not indicate the use of a holistic palliative care plan.
3	**I**	**The individual's resuscitation status is clearly documented**
	A	Mark **Yes** if there is documented evidence of the individual's resuscitation status. Mark **No** if the individual's resuscitation status is not documented.

COMPREHENSIVE GERIATRIC ASSESSMENT – PSYCHOLOGICAL ASSESSMENTS

2.14 Psychological Nursing Assessment Quality Care-Metric

PSYCHOLOGICAL NURSING ASSESSMENT **I** = Indicator, **A** = Data Collectors Advice, **N/A** = Not Applicable		
1	**I**	**A psychological nursing assessment was completed on admission**
	A	Mark **Yes** if there is documented evidence of a completed psychological nursing assessment of mood/depression, cognition and confusion/delirium on admission using validated tools. Mark **No** if a psychological nursing assessment of mood/depression, cognition, and confusion/delirium was not completed on admission. Mark **No** if any element - mood/depression, cognition, confusion/delirium is absent from the assessment. Mark **N/A** if the individual has been in residence for more than 6 months.

2	I	**A psychological nursing re-assessment was completed 4 monthly or more frequently if condition requires**
	A	Mark **Yes** if there is documented evidence that a 4monthly re- assessment (or more frequently if required) has been completed Mark **No** if re-assessment is not completed within a maximum of 4 months from the previous assessment date. Mark **No** if any element – mood/depression, cognition, confusion or delirium is absent from the assessment. Mark **N/A** if re-assessment date has not been reached.

2.15 Responsive Behaviour Support Quality Care-Metric

RESPONSIVE BEHAVIOUR SUPPORT **I** = Indicator, **A** = Data Collectors Advice, **N/A** = Not Applicable		
1	I	**An assessment of responsive behaviour is completed on admission - if evidence of responsive behaviour is identified**
	A	Check admission documentation for identification of responsive behaviour (e.g. transfer letter from other healthcare site, reports from community / family). Mark **Yes** if responsive behaviour has been identified and an assessment of responsive behaviour has been completed. Mark **No** if responsive behaviour has been identified and an assessment of responsive behaviours has not been completed. Mark **N/A** if there is documented evidence the individual does not require an assessment of responsive behaviour assessment (responsive behaviour has not been identified prior to/on admission/transfer). Mark **N/A** If the individual has been in the service longer than 6 months.
2	I	**A responsive behaviours re-assessment was completed 4 monthly or more frequently if required**
	A	Mark **Yes** if there is documented evidence that a 4 monthly re-assessment (or more frequently if required) has been completed. Mark **No** if re-assessment is not completed within a maximum of 4 months from the last assessment date. Mark **Yes** if a review of responsive behaviours has taken place within the required timeframe and is documented. Mark **No** if review has not taken place within a maximum of 4 months from initial assessment Mark **N/A** if review date has not yet been reached
3	I	**A responsive behaviour care plan is in place- if indicated in the assessment**
	A	Mark **Yes** if a responsive behaviour care plan is in place. Mark **No** if a responsive behaviour plan is not in place. Mark **N/A** if responsive behaviour assessment does not indicate use of a care plan.

4	**I**	**PRN psychotropic medicines are administered only following a review and employment of non pharmaceutical interventions**
	A	Mark **Yes** if there is documented evidence of non-pharmaceutical interventions being used /considered prior to administration of *PRN* psychotropic medicines. Mark **No** if the consideration/use of non-pharmaceutical interventions prior to administration of *PRN* psychotropic medicines is not documented. Mark **N/A** if the individual is not receiving *PRN* psychotropic medicines.
5	**I**	**A record of all PRN psychotropic medicines administered to the individual is maintained**
	A	Mark **Yes** if all *PRN* psychotropic medicines administered to the individual are recorded in the individual's medicines administration record. Mark **No** if all *PRN* psychotropic medicines administered to the individual are not recorded in the individual's medicines administration record.

2.16 Safeguarding Vulnerable Adults Quality Care-Metric

SAFEGUARDING VULNERABLE ADULTS **I** = Indicator, **A** = Data Collectors Advice, **N/A** = Not Applicable		
1	**I**	**Safeguarding vulnerable adults procedures are well publicised, easy to access and at an appropriate level to promote understanding**
	A	The National Safeguarding Office of the HSE provides an easy to read leaflet on safeguarding for service users - *Easy Read Leaflet* (latest version) Mark **Yes** if copies of the easy read leaflet are readily available to residents Mark **Yes** where individual has a sight/reading difficulty, safeguarding procedures are highlighted using other communication methods that promote resident understanding (e.g. verbal explanations documented in care plan/communication plan) Mark **Yes** if materials are displayed (notices) informing residents/visitors/staff of the contact person if they have a safeguarding concern (all 3 must be present in order to Mark Yes) Mark **No** if copies of the easy read leaflet are not readily available to residents Mark **No** if safeguarding procedures are not highlighted using other communication methods that promote resident understanding (e.g. verbal explanations documented in care plan), where individual has a sight/reading difficulty Mark **No** if materials (notices) are not displayed informing residents/visitors/staff of the contact person if they have a safeguarding concern
2	**I**	**Easily accessible information is available to the individual on their rights to advocacy**
	A	Mark **Yes** if leaflet/notice/information on their rights to advocacy is available to the individual. Mark **No** if leaflet/notice/information on their rights to advocacy is not available to the individual.

2.17 Social Assessment Quality Care-Metric

SOCIAL ASSESSMENT **I** = Indicator, **A** = Data Collectors Advice, **N/A** = Not Applicable		
1	**I**	**A social assessment was completed on admission**
	A	Mark **Yes** if there is documented evidence of a social assessment completed on admission. Mark **No** if evidence is not documented of a full social assessment completed on admission. Mark **N/A** if the individual has been in residence for more than 6 months.
2	**I**	**A social re-assessment was completed 4 monthly or more frequently if condition requires**
	A	Mark **Yes** if there is documented evidence that a 4 monthly re-assessment (or more frequent if required) has been completed. Mark **No** if re-assessment is not completed within a maximum of 4 months from the previous assessment date Mark **N/A** if re-assessment is not yet due.

2.18 Activities (Holistic) / Social Engagement Quality Care-Metric

ACTIVITIES (HOLISTIC) / SOCIAL ENGAGEMENT **I** = Indicator, **A** = Data Collectors Advice, **N/A** = Not Applicable		
1	**I**	**A social activity plan of the individual's interests and hobbies is completed**
	A	Mark **Yes** if there is a completed social activity plan documenting the individual's interests and hobbies. Mark **No** if the individual does not have a completed social activity plan documenting their interests and hobbies.
2	**I**	**Social activity plans are re-assessed 4 monthly or more frequently if required**
	A	Mark **Yes** if there is documented evidence that a 4 monthly re-assessment (or more frequent if interests dictate) has been completed. Mark **No** if re-assessment is not completed within a maximum of 4 months from the previous assessment date Mark **N/A** if re-assessment date has not yet been reached.

3	**I**	**The individual is involved in the development of their social activity plan**
	A	Mark **Yes** if there is documented evidence of the individual's involvement in the development of their social activity plan. Where the individual is non-verbal, mark **Yes** if there is evidence of significant other/family involvement in social activity plan. Mark **No** if evidence is not documented of the individual's (or significant other/family) involvement in the development of their social activity plan.
4	**I**	**The individual participates in the social activities identified in their plan**
	A	Mark **Yes** if there is documented evidence of the individual's involvement in the social activities outlined in the plan. Mark **No** if evidence is not documented of the individual's involvement in the social activities outlined in their social activity plan.

POST ASSESSMENT CARE

2.19 Person Centred Care Planning Quality Care-Metric

PERSON CENTRED CARE PLANNING **I** = Indicator, **A** = Data Collectors Advice, **N/A** = Not Applicable		
1	**I**	**After a comprehensive assessment, the care plan reflects person centred interventions including any record of specialist referrals**
	A	*Check care plan for the last 4 weeks.* Mark **Yes** if the care plan reflects person centred interventions specific to the individual **and** if the care plan includes a record of specialist referrals where appropriate. Mark **No** if the care plan does not reflect person centred interventions. Mark **No** if the care plan does not record specialist referrals where these are indicated by the comprehensive assessment.
2	**I**	**The individual is involved in decision making regarding his/her care**
	A	Mark **Yes** if there is documented evidence in the care plan of the individual's involvement in decision making regarding care within the individual's capacity as per local PPPG.. Mark **No** if evidence is not documented in the care plan of the individual's involvement in decision making regarding care.
3	**I**	**The individual is supported to care for him/herself**
	A	Mark **Yes** if there is documented evidence that the individual is supported to care for him/herself to the level appropriate to his/her capacity. Mark **No** if evidence is not documented in the care plan of support provided to enable self-care. Mark **N/A** if the individual is fully nursing care dependant / self care is not an option.

4	I	**Intimate personal care is planned in accordance with individual wishes**
	A	Mark **Yes** if there is documented evidence in the care plan of the individual's preferences as regards intimate personal care and if the provision of intimate care is carried out in accordance with these wishes. Mark **No** if the care plan does not clearly record the individual's wishes for the provision of intimate personal care. Mark **No** if the provision of intimate care is not carried out in accordance with the individual's wishes.
5	I	**The individual's preferences and choices are documented**
	A	Mark **Yes** if the individual's preferences and choices are documented. Mark **No** if the individual's preferences are not documented.

2.20 Misuse of Drugs Act (MDA) Medicines Quality Care-Metric

MISUSE OF DRUGS ACT (MDA) MEDICINES **I** = Indicator, **A** = Data Collectors Advice, **N/A** = Not Applicable		
1	I	**Misuse of Drugs Act (MDA) medicines are checked & signed at each changeover of shift by nursing staff (member of day staff & night staff)**
	A	Mark **Yes** if the MDA medicines register has two signatures for members of day staff and night staff on changeover shifts in last 72 hours. Verify from duty roster that the nurses signing were on different shifts. Where there is no night shift the MDA medicines register must be signed by two nurses at the start and end of each shift. Mark **No** if the MDA medicines register does not have two signatures at changeover of shift /beginning and end of shift (if no night duty)and duty roster does not verify that the nurses signing were on these specific shifts. Mark **N/A** if unit does not currently store MDA medicines.
2	I	**Two signatures are entered in the MDA medicines register for each administration of an MDA medicine**
	A	Mark **Yes** if the MDA medicines register has two signatures for each MDA medicine administration for last 72 hours. Mark **No** if two signatures are not entered for each MDA medicine administration in the last 72 hours. Mark **N/A** if the unit does not currently store MDA medicines.
3	I	**The MDA medicine cupboard is locked**
	A	Mark **Yes** if the MDA medicine cupboard is locked. Mark **No** if the MDA medicine cupboard is unlocked. Mark **N/A** if unit does not currently store MDA medicines.

4	**I**	**A designated nurse holds the MDA keys separate from other medicine keys**
	A	Mark **Yes** if the MDA medicine keys are held by the CNM or a registered nurse designee separate from other medicine keys. Mark **No** if CNM or nurse designee are not holding the keys on their person, separate from other keys. Mark **N/A** if unit does not currently store MDA medicines.

2.21 Medicines Storage and Custody Quality Care-Metric

MEDICINES STORAGE AND CUSTODY **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 the keys are held by a registered nurse on their person. Mark **No** if the person holding the keys is not a registered nurse or if keys are not held by a person.
2	**I**	**All medicinal products are stored in a locked cupboard/room and trolleys are locked and secured as per local policy**
	A	Mark **Yes** if cupboard/room is locked or accessible only by security code or pass key and if all trolleys are locked and secured when not in use. Mark **No** if medicinal products are accessible in an unlocked cupboard/room. Fridge does not need to be locked if in a locked room. Mark **No** if not all trolleys are locked and secured. Mark **No** if trolley is not in a locked room or is not secured with chain and lock to wall. Mark **No** if there are medicines left accessible on end/side of trolley.
3	**I**	**An up-to-date medicines formulary resource is available and accessible**
	A	Mark **Yes** if a medicines formulary (MIMS/BNF/IMF etc.) is available on the medicines trolley. Paper editions must be within two years of publication. It must be located on/close to the trolley to facilitate easy access for the nurse to reference medicine details during drug administration. Online and book format are both acceptable. Mark **No** if a medicines formulary is unavailable or not within date.

2.22 Person Experience Quality Care-Metric

Person Experience Quality Care-Metric

The following Person Experience Quality Care-Metric is available for collection monthly. It is recommended to collect a sample size of 25% (approximately 5-10 residents) of the overall unit/ward, monthly. The collection of this metric may be carried out in a number of ways depending on the individual's abilities and preference:

1. The data collector may print a Person Experience questionnaire sheet for completion by a randomly selected resident with return to the nurse/data collector or to a collection point which provides anonymity for the individual.
2. The data collector may read out the options to the resident and select the appropriate answer based on their responses.
3. The data collector may offer the resident the use of a mobile IT Tablet (if available) to select the answers anonymously themselves.

Person Experience
Ask resident: Are your preferences and choices maintained in the person centred care plan
Ask resident: Do you have enough opportunity for privacy for example when you have visitors?
Ask resident: When you ring the call bell, does it get answered quickly enough?
A process is in place to capture the individual's experiences of the service **Ask resident: have you been made aware of any process you can use to talk about or write down your experience of this service?**

3.0 IMPLEMENTATION FRAMEWORK

3.1 Purpose

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

3.2 Foundations of the Framework

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

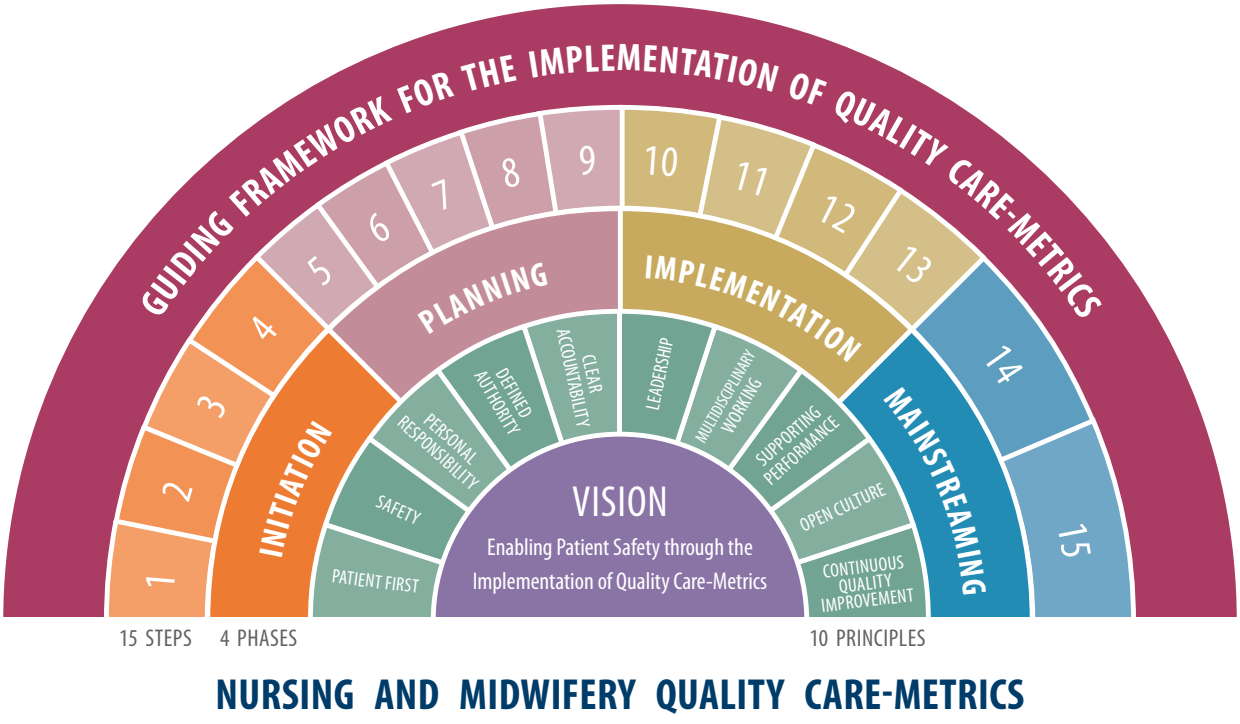

Figure 5: Framework for Implementation of Quality Care-Metrics

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

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

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

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

Figure 7: Guiding Principles Descriptor

3.2.3 Implementation Phases

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

- Initiation
- Planning
- Implementation
- Mainstreaming

The steps to support implementation are outlined in Figure 8.

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

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

3.3 Governance

3.3.1 The ONMSD provides the overarching national governance that enables the development of a robust system and infrastructure for the introduction of Quality Care-Metrics in clinical organisations, where Directors of Nursing/Midwifery wish to implement same.

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

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

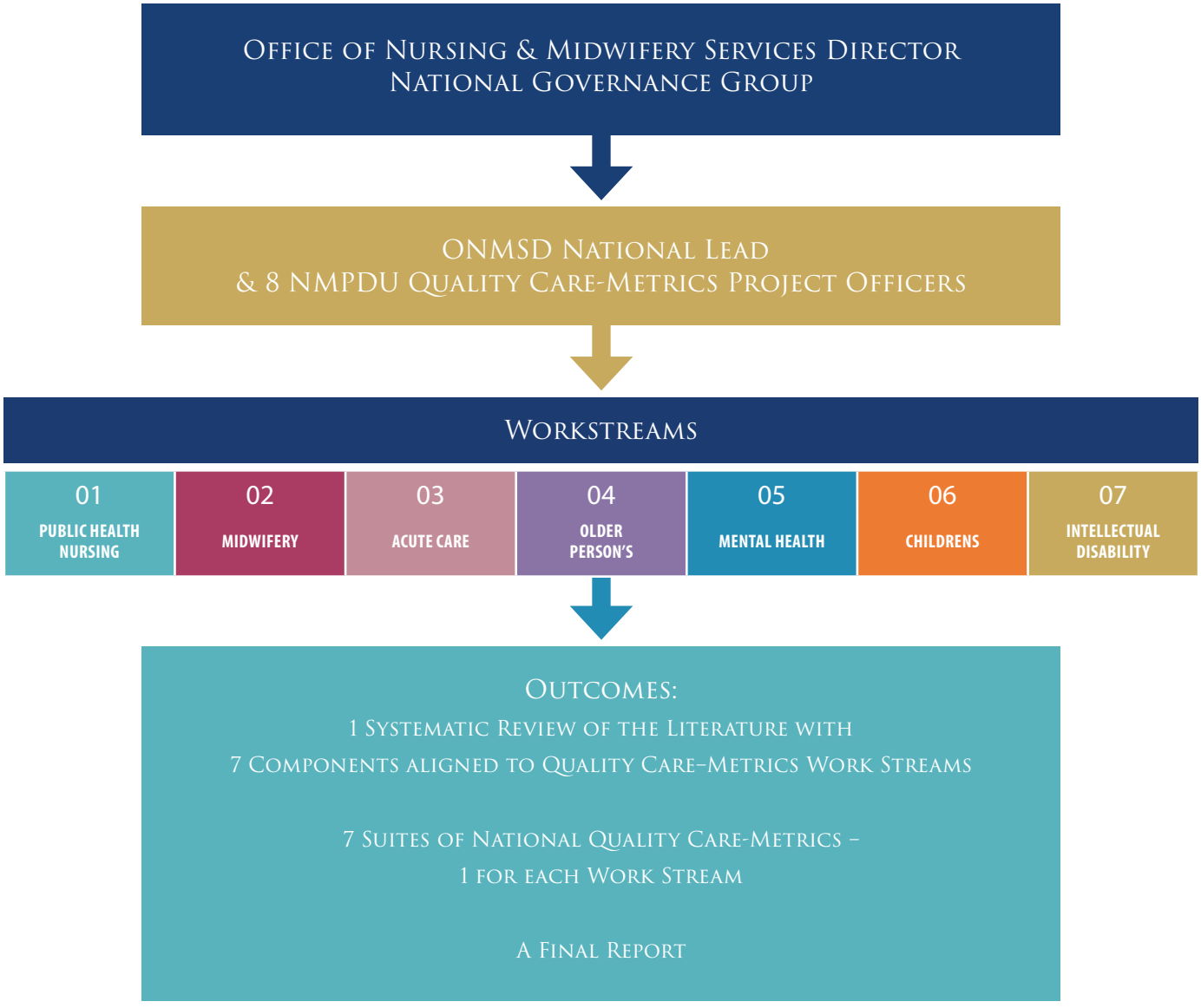

Figure 9: Nursing and Midwifery Quality Care-Metrics Governance Flow Chart

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

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

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

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

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

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

3.4 State of Readiness and Capacity Checklist

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

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

Figure 10: State of Readiness and Capacity Checklist

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

4.0 IMPLEMENTATION AT SERVICE LEVEL

4.1 Implementation Plan

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

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

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

4.2 Education/Training Plans for Implementation

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

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

4.3 Identification of Lead Person (s) Responsible for Implementation

4.3.1 As part of the governance structure at service level to support the implementation of Quality Care-Metrics, the Director of Nursing and Midwifery is required to nominate a Service Lead who will co-ordinate the implementation process through the development of a 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 work-streams.
- 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 TYCHSE system
- Liaise with Nominated Service Lead in relation to new site setup on the TYCHSE system and any technical issues experienced by users which may require escalation to the TYCHSE 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 TYCHSE 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 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 TYCHSE 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 appropriate action taken 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 TYCHSE 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.

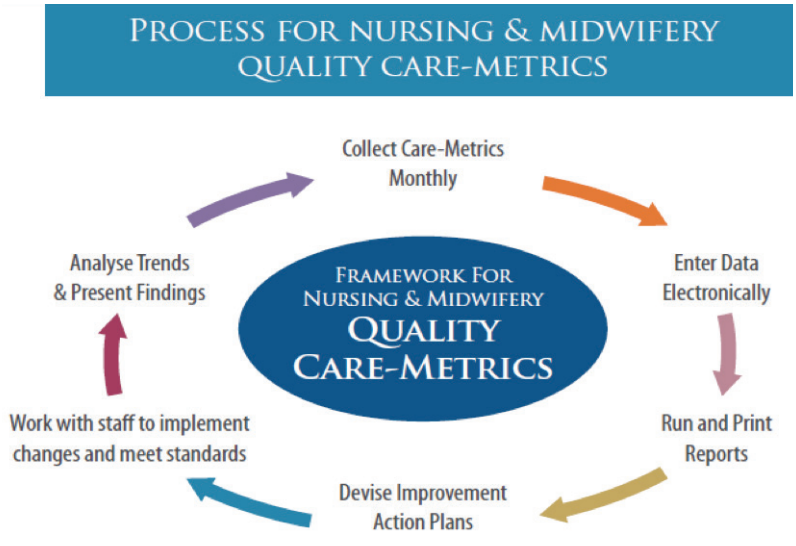

Figure 11: Undertaking Quality Care-Metrics at Service Level

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 required to examine the care records for the period of time outlined in the advice section or indicator

5.4 Accessing Test Your Care HSE System

5.4.1 The TYCHSE System is available nationally to agreed services implementing Nursing and Midwifery Quality Care-Metrics. The level of access users will have to the TYCHSE 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 TYCHSE 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 TYCHSE system disseminates the initial username and password to the user via two emails. Passwords can then be changed by the user by going to Settings on the TYC toolbar and entering a password of choice. Username and passwords should not be shared as they are unique to users and allow access to either data entry or reporting or both. The home page of the TYC HSE System is illustrated in Figure 12.

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

- **Collect:** Data Entry (to enter the 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)

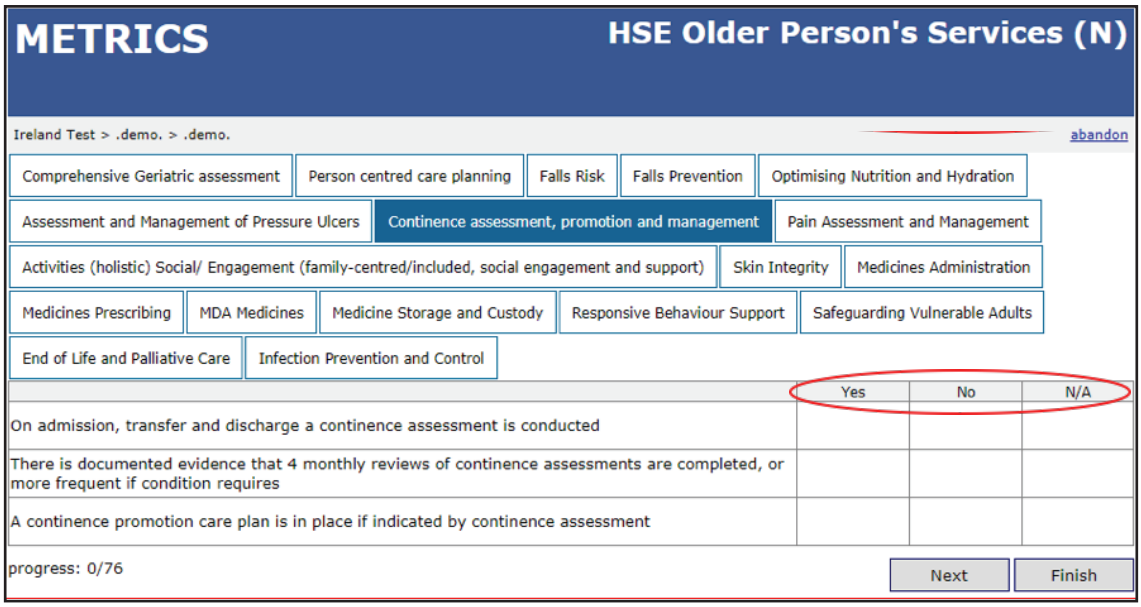

Figure 14: Data Entry: TYC HSE System (1)

- 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

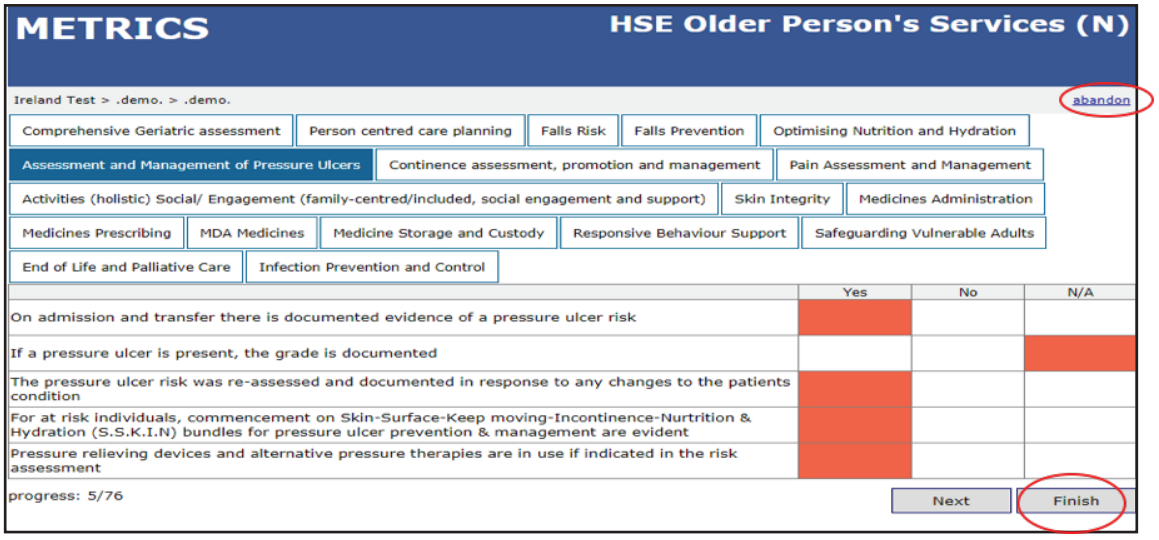

Figure 15: Data Entry: TYC HSE System (2)

6.0 QUALITY 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)

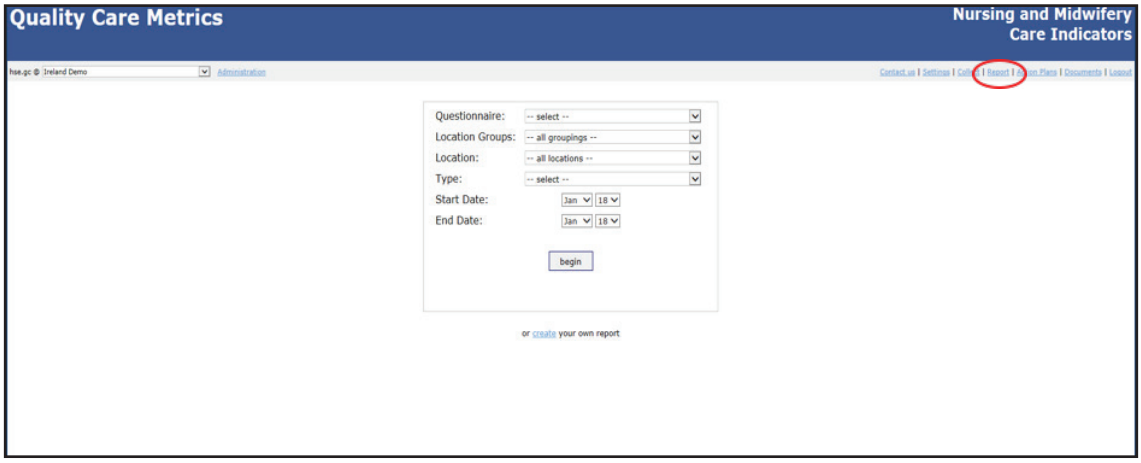

Figure 18: Accessing Reports from TYC HSE

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'

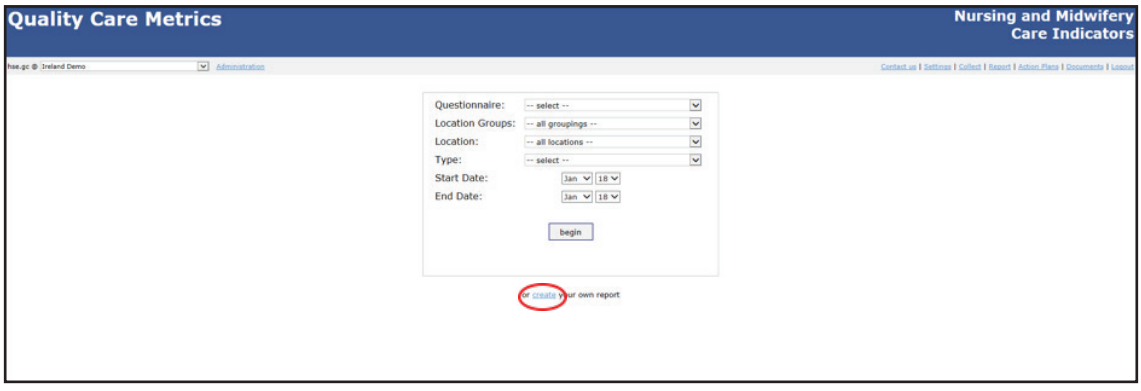

Figure 19: Create your own Report

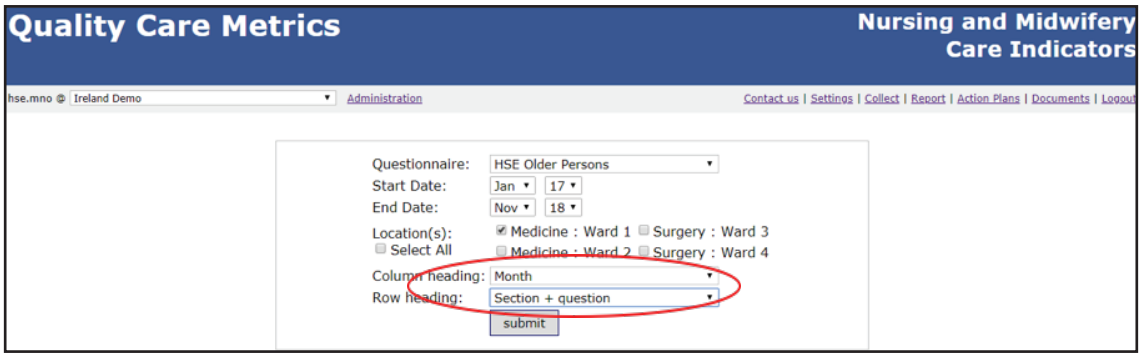

Figure 20: Create your own Report; Column Heading: Month and Row Heading: Section and Question

- 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'

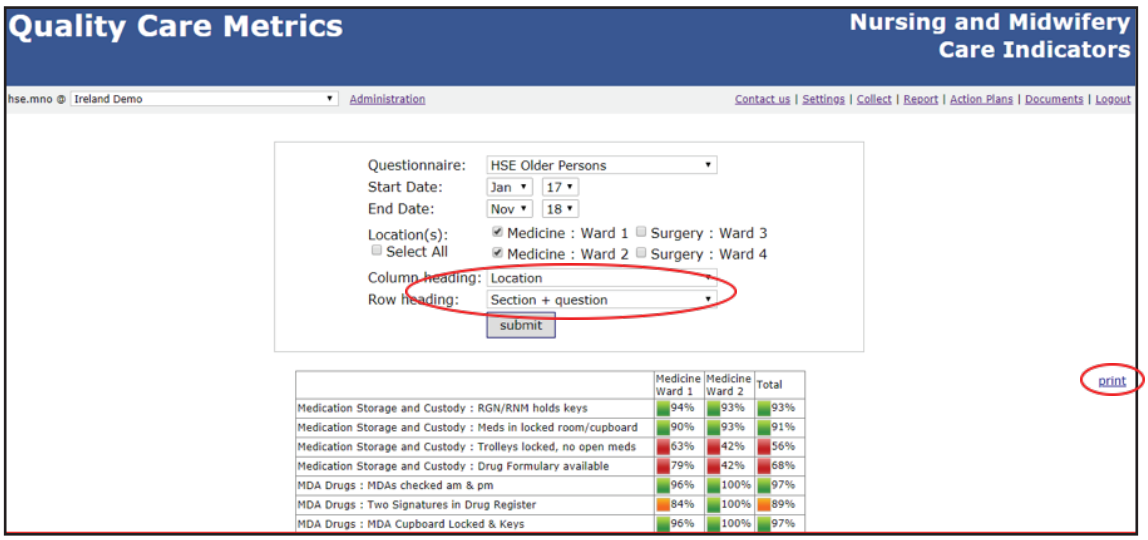

Figure 22: Create your own Report; Results; Column Heading: Location and Row Heading: Section and Question

- 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'

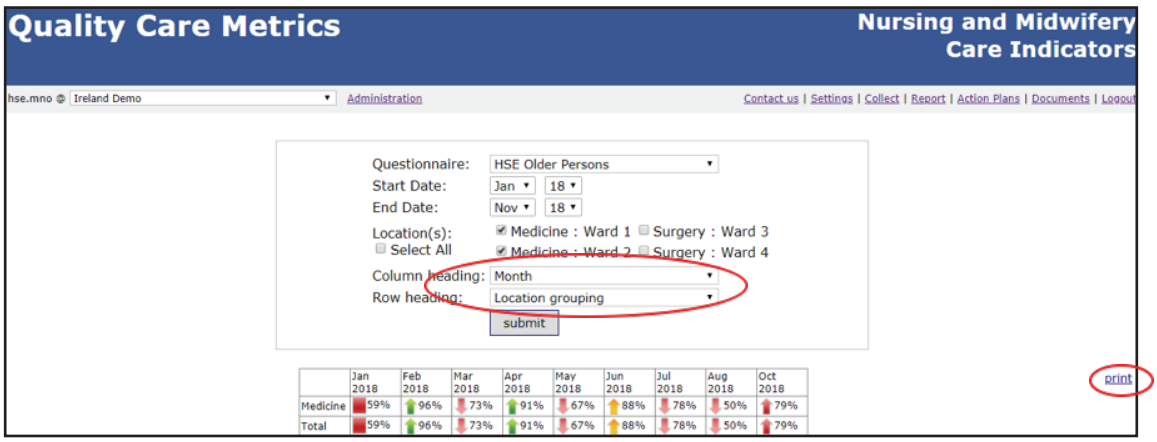

Figure 23: Create your own Report; Results; Column Heading: Month and Row Heading: Location Grouping

- 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).

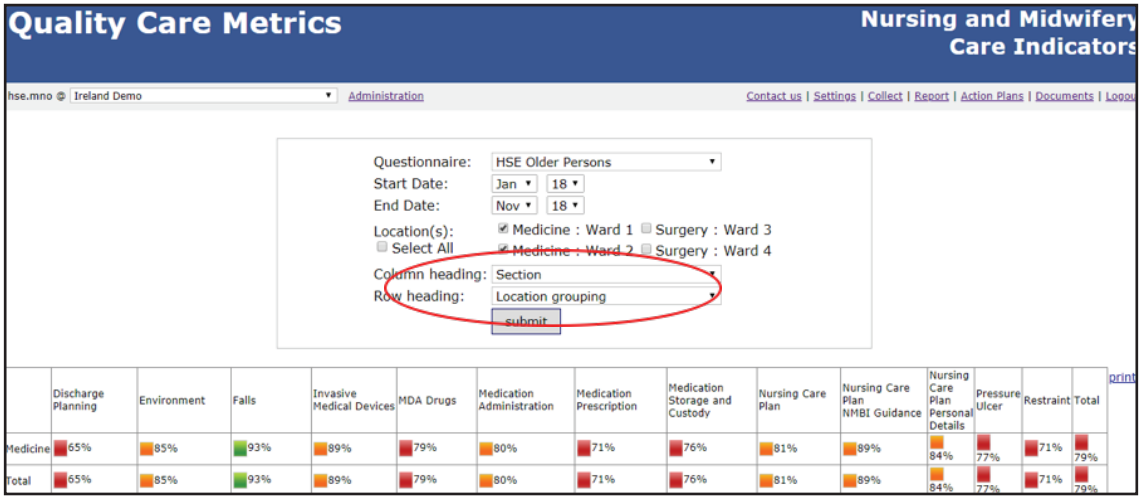

Figure 24: Create your own Report; Results; Column Heading: Section and Row Heading: Location Grouping

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 option. Click "Action Plans" and complete the data fields as per example below in Figure 25.

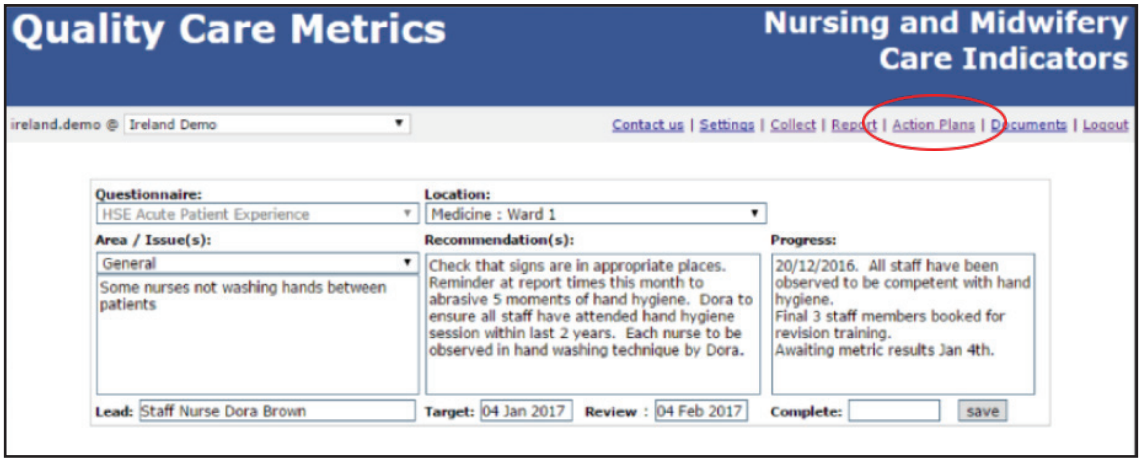

Figure 25: Accessing Action Planning on Test Your Care HSE

7.1.2 Users can also generate or print an **"Action Plan"** report through the 'Report' option by selecting **'Action Plan'** from the 'type' section 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 TYCHSE
- 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' users and potential users through

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

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

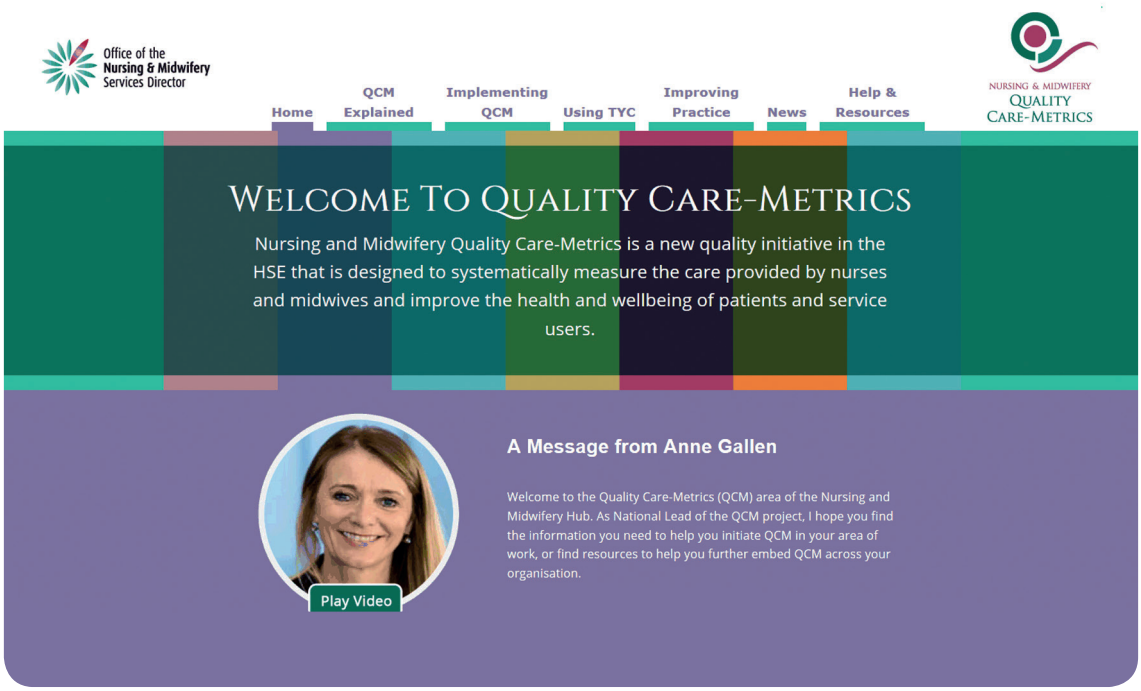

Figure 27: Quality Care-Metrics Hub

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

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

PART B:
Guideline Development Cycle

1.0 INITIATION

1.1 Purpose

Please refer to Part A, 1.9

1.2 Scope

Please refer to Part A, 1.10

1.3 Objective

Please refer to Part A, 1.11

1.4 Outcomes

Please refer to Part A, 1.12

1.5 Guideline Development Group

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

1.5.2 Guideline Conflict of Interest Declaration Forms 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 V for Membership of the Guideline Governance Group.

1.7 Supporting Evidence

1.7.1 Legislation and regulation publications, which are relevant to the Older Person 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.

The following table provides the supporting literature mapped to the final suite of OPS metrics (HSE 2018a)

Comprehensive geriatric assessment	
Relevant literature	(Arora et al 2007) (Brühl et al 2007) (Butler Maher et al 2012) (Care Record Audit Tool ND) (Chen et al 2011) (Feil at al. 2007) (Geriatric Depression Scale ND) (Guidance Document for Oral Hygiene Care 2016) (Guideline on delivery of dementia care ND) (Imhof et al 2012) (Multidisciplinary Risk Analysis for Challenging Behaviour ND) (Nakrem et al 2009) (Oral Care Policy ND) (Procedure for Metrics Data Collection 2015) (Record Keeping & Documentation Policy 2016) (Terrell et al 2009)
Standard	(HIQA National Quality Standards for Residential Care 2016) (US Nursing Home Standards) (US Nursing Home Quality Measures) (US Nursing Home Compare)

Person centred care planning	
Relevant literature	(Arora et al 2007) (Assessment and Care Planning for Nutritional Needs 2016) (Ensuring the Privacy and Dignity of our residents in St Joseph's Care Centre Service ND) (Guidance Document for Oral Hygiene Care 2016) (Meal Time Audit ND) (Nakrem et al 2009) (Oral Care Policy ND) (Protected Mealtime, provision of nutritionally balanced Meals and Guidance for Assisted Feeding in St Joseph's Care Centre ND) (Policy on the use of physical restraints in designated residential care units for older people 2011)
Standard	HIQA National Quality Standards for Residential Care 2016) (US Nursing Home Quality Measures)

Falls risk	
Relevant literature	(Gama at al 2011) (Imhof et al 2012)
Standard	(US Nursing Home Quality Measures) (ANA) (CALNOC Collaborative Alliance for Nursing Outcomes 2015)

Fall prevention	
Relevant literature	(Falls Prevention & Management 2016) (Procedure for Metrics Data Collection 2015) (Risk Management Policy 2016)
Standard	(US Nursing Home Quality Measures) (ANA) (CALNOC Collaborative Alliance for Nursing Outcomes)

Optimizing nutrition and hydration	
Relevant literature	(Arora et al 2007) (Assessment and Care Planning for Nutritional Needs 2016) (Nakrem et al 2009)
Standard	(HIQA National Quality Standards for Residential Care 2016) (Health Act 2007 (Care and Welfare of residents in designated centres for older people) regulations 2013)

Assessment and management of pressure ulcers	
Relevant literature	(Arora et al 2007) (Barthel Index Assessment ND) (Coleman et al 2014) (Nakrem et al 2009) (Procedure for Metrics Data Collection 2015) (Pressure Ulcer Prevention and Management Policy 2016) (Pressure ulcer prevention and management ND)
Standard	(International Guidelines for Pressure Ulcer Prevention 2016) (ANA) (CALNOC Collaborative Alliance for Nursing Outcomes) (US Nursing Home Compare) (US Advancing Excellence)

Continence assessment, promotion and management	
Relevant literature	(Imhof et al 2012) (Nakrem et al 2009)
Standard	(US Nursing Home Quality Measures)

Pain assessment and management	
Relevant literature	(Arora et al 2007) (Burfield et al 2012) (Butler Maher et al 2012) (Imhof et al 2012) (Nakrem et al 2009) (Terrell et 2009) (The Management of Pain in Residents in St Joseph's Care Centre ND)
Standard	(US Nursing Home Quality Measures) (HIQA National Standards for Residential Care Settings for Older People in Ireland 2009) (Professional Guidance for Nurses Working with Older People 2009)

Activities (physical, social, recreational and sensory) Social/engagement (family-centred/included, social engagement and support)	
Relevant literature	(Nakrem et al 2009)
Standard	NA

Skin Integrity	
Relevant literature	(Local Policy on Wound Management 2016)
Standard	(National best practice and evidence based guidelines for wound management 2009)

Medicines administration	
Relevant literature	(Guidance to Nurses and Midwives on Medication Management 2007) (Imhof et al 2012) (Medication Event Report Form ND) (Medication management audit tool ND) (Medication Error Report Form ND) (Procedure for Metrics Data Collection 2015) (Self-Administration of Medication ND)
Standard	(HIQA National Quality Standards for Residential Care 2016) (CALNOC Collaborative Alliance for Nursing Outcomes) (Standards for Medicines Management for Nurses and Midwives 2015)

Medicines prescribing	
Relevant literature	(Medication prescription metric ND)
Standard	(Practice Standards and Guidelines for Nurses and Midwives with Prescriptive Authority 2010)

MDA Medicines	
Relevant literature	(Guidance to Nurses and Midwives on Medication Management 2007) (Imhof et al 2012) (Medication Event Report Form ND) (Medication management audit tool ND) (Medication Error Report Form ND) (Procedure for Metrics Data Collection 2015) (Self-Administration of Medication ND)
Standard	(HIQA National Quality Standards for Residential Care 2016) (US Nursing Home Quality Measures) (ANA) (US Nursing Home Compare) (US Advancing Excellence) (CALNOC Collaborative Alliance for Nursing Outcomes) (Standards for Medicines Management for Nurses and Midwives 2015)

Medicine storage and custody	
Relevant literature	(Medication Management Policy For Services for Older Persons 2015) (Procedure for Metrics Data Collection 2015)
Standard	(HIQA 2016 National Quality Standards for Residential Care 2016)

Responsive behaviour support	
Relevant literature	(Brühl et al 2007) (Butler Maher et al 2012) (Chen et al 2011) (Feil at al. 2007) (Guideline on delivery of dementia care ND) (Imhof et al 2012) (Nakrem et al 2009) (Terrell et al 2009)
Standard	NA

Safeguarding vulnerable adults	
Relevant literature	(Risk Management Policy 2016) (Safeguarding Vulnerable Persons at Risk of Abuse 2014) (Vulnerable Persons at Risk of Abuse National Policy & Procedures 2014)
Standard	(HIQA National Quality Standards for Residential Care 2016)

End of life and palliative care	
Relevant literature	(Buck et al 2008) (Daily Flow Record For Care Of The Dying Resident ND) (End of Life Care Policy 2016) (End of Life care ND) (Forum on End of Life in Ireland 2015) (Guidelines for Pastoral Care 2016)
Standard	(HIQA National Quality Standards for Residential Care 2016)

Infection control	
Relevant literature	(Nakrem et al 2009)
Standard	(HIQA National Quality Standards for Residential Care 2016) (Guidelines for hand hygiene in Irish healthcare settings 2015)

Person experience	
Relevant literature	(Communication 2016) (Kajonis PJ and Kazemi A 2016) (McCance et al 2011) (Procedure for Metrics Data Collection 2015)
Standard	(UK Test your Care)

1.7.2 PPPGs being replaced by this PPPG:

- Guiding Framework for the implementation of Nursing and Midwifery Quality Care-Metrics in the Health Service Executive Ireland. HSE, (2015)
- Standard Operating Procedure for Nursing and Midwifery QCM Data Collection in Older Person 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 Mental Health 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 Older Person 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 Older Person 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 Older Person Research Report (HSE, 2018). This report outlines the research process undertaken as a collaborative between the ONMSD National Quality Care-Metrics Project Team and the University of Limerick; it includes the final suite of Older Person Nursing Process Metrics and Indicators developed from the research.

2.1.4 The Older Person Nursing Process Metrics and Indicators are adapted from national and international evidence based practice including PPPGs and reflect what older person 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 Older Person Research Report (HSE 2018a) and as listed in Figure 28 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 Older Person nurses to develop consensus on metrics to be measured.

Phase 3: A two-round online Delphi survey of Older Person 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 From the systematic review, eight articles were identified which were directly relevant to OPS. Additional searches included grey literature relevant to OPS and publications identified from hand searching. From this search, 37 documents from grey literature and six articles from hand searching were identified as relevant and included in the review. This resulted in 51 studies out of 7,575 included after full text screening.

A data extraction form was designed and studies were critically appraised. After several rounds of paper review, appraisal and data extraction by the four members of the OPS academic team, 33 OPS metrics were identified. Sixteen of the identified metrics were existing metrics with 17 new metrics identified.

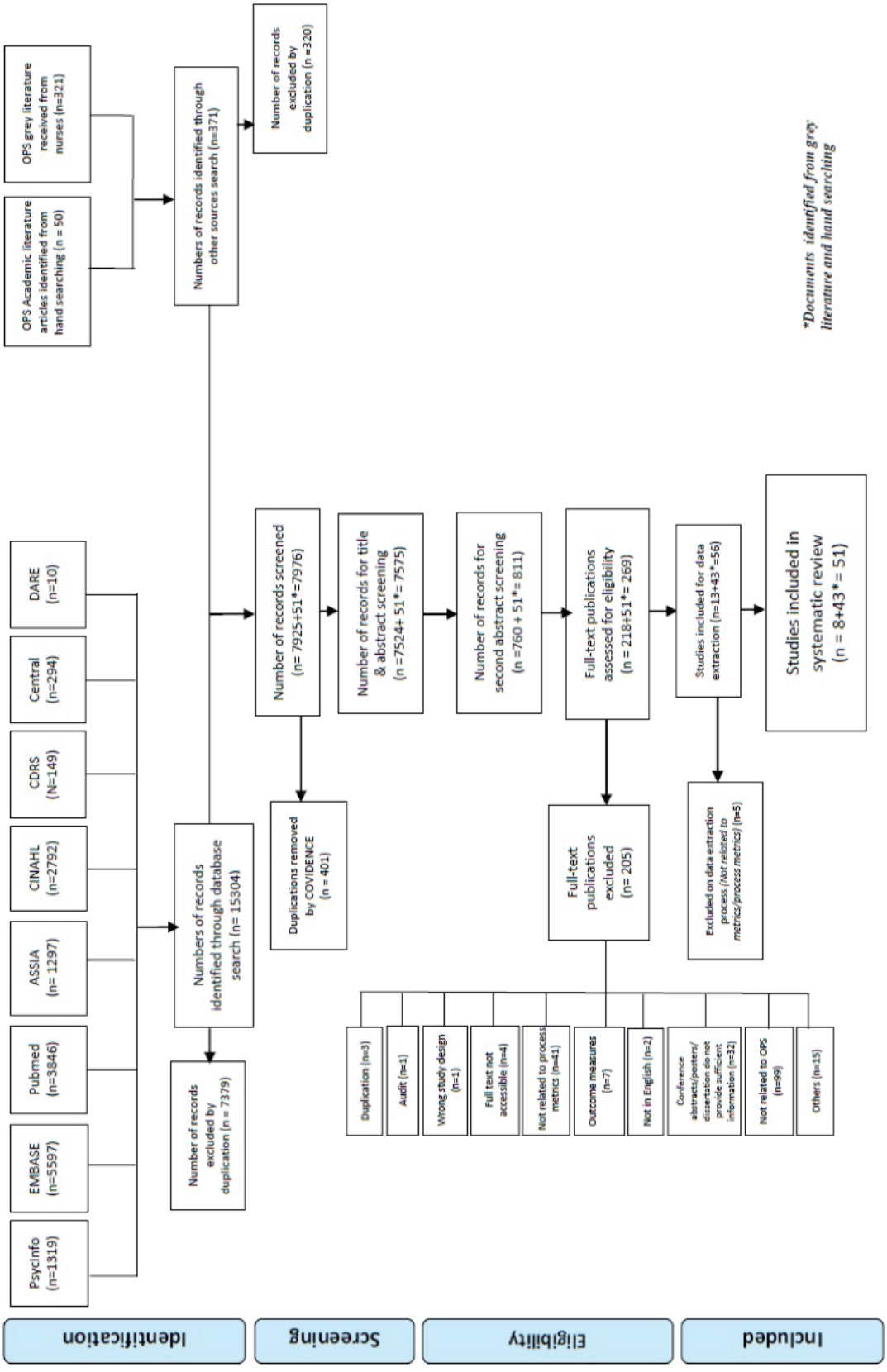

Figure 28: Study Selection Process Flow Diagram for Older Persons Services Workstream

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 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 (Older Person nurses of all grades, service user representative and key experts in Older Person nursing) 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 30).

DOMAIN	
01	**PROCESS FOCUSED** The metrics/indicator contributes clearly to the measurement of older person 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 Older Person Quality Care-Metrics consensus meeting, 19 metrics and 80 associated indicators reached 70% and thus were included in the new suite of Older Person Services Quality Care Process Metrics and Indicators. Following pilot of the metrics data collection guideline, the 19 metrics were further divided into 22 metrics with the number of indicators remaining unchanged to assist with data collection.

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 V) 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 Older Person 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

Appendix III
Membership of the Guideline Development Group

Appendix IV
Conflict of Interest Declaration Form

Appendix V
Additional Contributors/Reviewers PPPG

Appendix VI
Membership of the Guideline Approval Governance

Appendix I
Signature Sheet

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

Print Name	Signature	Area of Work	Date

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

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

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

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

To be Completed by the data collector undertaking Metric		
Name of Hospital/Service Location:		
Name of Ward:		
Name of Auditor:		
Metric Title:		
Date:		
Safety/Risk Issue Identified:		
Name of CNM or Nurse/Midwife in charge informed of Safety/Risk Issue:		
To be completed by CNM or Nurse in Charge		
Name of Unit Nursing Officer/ ADON informed of Safety/Risk Issue		
Please sign to confirm the relevant CNM3/ADON has been informed and record date informed.	**Date:**	**Signature of CNM/ Nurse in Charge** .....

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

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

Chairperson: **Dr. Anne Gallen** National Lead for Nursing & Midwifery Quality Care-Metrics
Angela Killeen NMPDU Quality Care-Metrics Project Officer, NMPD HSE North West
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/Reviewers PPPG

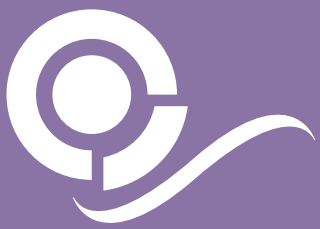
Ms Joan Donegan	DIRECTOR, NMPD DUBLIN NORTH EAST.

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

www.hse.ie/go/onmsd