SUMMARY DOCUMENT

NATIONAL SUMMARY GUIDANCE

FOR NURSING AND MIDWIFERY QUALITY CARE-METRICS DATA MEASUREMENT IN

ACUTE CARE 2018

To be used in conjunction with the National Guideline for Nursing and Midwifery Quality Care-Metrics Data Measurement in Acute Care 2018 (ONMSD 2018 - 030)

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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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1.0 INITIATION OF QUALITY CARE-METRICS AT SERVICE LEVEL

1.1 Purpose

1.1.1 The purpose of this summary guidance is to ensure a consistent approach to the implementation of Quality Care-Metrics by Acute Care services.

1.1.2 This summary guidance 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 Acute Care 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.

1.2 Scope

1.2.1 This summary guidance applies to all registered nurses and midwives within Acute Care services, who are engaged with Quality Care-Metrics in nursing and midwifery practice.

1.2.2 This summary guidance does not apply to other disciplines outside of nursing and midwifery.

1.2.3 The application of this summary guidance is aligned to the Quality Care-Metrics Acute Care Research Report (HSE 2018) and the National Guideline for Nursing and Midwifery Quality Care-Metrics Data Measurement in Acute Care 2018 (ONMSD 2018 -030).

1.2.4 All nurses and midwives within Acute Care who are engaged with Quality Care-Metrics in nursing and midwifery practice, should complete the Signature Sheet in the National Guideline for Nursing and Midwifery Quality Care-Metrics Data Measurement in Acute Care 2018 (ONMSD 2018 - 030), to indicate that they have read, understood and agree to the guideline. The completed signature sheet should be retained at service level.

1.3 Objective

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

1.4 Outcomes

1.4.1 Application of this summary guidance, in conjunction with the National Guideline for Nursing and Midwifery Quality Care-Metrics Data Measurement in Acute Care (ONMSD 2018 - 030), will enable consistency in the reliability and validity of the data collection to support a standardised approach in Acute Care services nationally.

1.4.2 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.

2.0 METRICS, INDICATORS AND ADVICE FOR ACUTE CARE

The following Nursing Quality Care-Metrics are available for Acute Care Services as outlined in Figure 1.

Figure 1: Acute Care Quality Care-Metrics

2.1 Patient Monitoring and Surveillance Quality Care-Metric

PATIENT MONITORING & SURVEILLANCE **I** = Indicator, **A** = Data Collectors Advice, **N/A** = Not Applicable		
1	**I**	**The patient's baseline physiological observations were assessed and recorded on admission/transfer using the National Early Warning System (NEWS)**
	A	Mark **Yes**, if the patient's baseline physiological observations/vital signs and aggregate score were assessed and recorded on admission or transfer to the ward/unit, using the NEWS. Physiological observations/vital signs should include **all** of the following: Respiratory rate, Oxygen saturation- SpO2, Inspired oxygen-FiO2, Heart rate, Blood pressure, Temperature, Level of consciousness. Mark **No** if **all** of the patient's baseline physiological observations/vital signs are not recorded on admission to ward/unit. Mark **No** if NEWS aggregate score is not calculated appropriately on the NEWS chart. Mark **N/A** if the patient is on a clearly defined end-of-life pathway. If the individual is an in-patient for longer than 1 month mark **N/A** and then proceed to indicator 2.
2	**I**	**The patient's physiological observations have been reassessed and recorded using the NEWS at the appropriate frequency**
	A	Mark **Yes** if **all** the patient's physiological observations/vital signs and aggregate score were reassessed and recorded (as listed at indicator 1), **at the appropriate frequency**, as directed by the NEWS National Clinical Guideline *and a minimum observation frequency is adhered to*. Check records for the previous 72 hours. Mark **No** if the patient's physiological observations have not been reassessed at the *appropriate frequency* as directed by the NEWS guideline- during the previous 72 hours. Mark **No** if all observations (as listed at indicator 1) are not recorded. Mark **No** if the aggregate score is inaccurate or not recorded on NEWS chart. Mark **N/A** if the patient is on a clearly defined end-of-life pathway. **Note:** *In the hospital setting the minimum standard for the assessment of vital signs, utilising the NEWS parameters, is every 12 hours.*
3	**I**	**There is documented evidence of an increased frequency of monitoring and recording of vital signs in response to any deterioration in the patient's condition**
	A	Mark **Yes** if there is documented evidence of an increased frequency of monitoring and recording of vital signs in response to any deterioration in the patient's condition as per the NEWS National Clinical Guideline. Check nursing records and NEWS chart for the previous 72 hours. Mark **No** if there is no documented evidence of increased frequency of monitoring and recording of vital signs in response to any deterioration in the patient's condition as per the NEWS National Clinical Guideline. Check nursing records and NEWS chart for the previous 72 hours. Mark **N/A** if there is no documented evidence of deterioration in the patient's condition recorded in the previous 72 hours or the patient is on a clearly defined end of life pathway..

4	**I**	**In the event of a deterioration there is documented evidence of escalation of care as per NEWS Escalation Protocol**
	A	Mark **Yes**, if in the event of deterioration, there is documented evidence of escalation of care as per the NEWS Escalation Protocol Flow Chart. Check records for the previous 72 hours. Mark **No** if there is no evidence that care was escalated according to the NEWS escalation protocol where there is evidence of deterioration in the past 72 hours. Mark **N/A** if there is no documented deterioration and escalation was not required - as per the NEWS Escalation Protocol Flow Chart. **Note:** *Evidence of escalation refers to both escalation to the Nurse in charge and medical personnel (see NEWS Escalation Protocol Flow Chart).*
5	**I**	**The ISBAR tool was used to document the escalation of care**
	A	Mark **Yes** if there is documented evidence that the ISBAR tool was used when communicating the escalation of care. Check records for the previous 72 hours. Mark **No** if there is no documented evidence that the ISBAR tool was used when communicating the escalation of care. Check records for the previous 72 hours. Mark **N/A** if escalation was not required in the previous 72 hours. **Note:** *ISBAR tool can be recorded using sticker or hand notation.*
6	**I**	**The nursing care provided to manage a deterioration in the patient's condition has been recorded**
	A	Mark **Yes** if there is documented evidence of the nursing care that has been provided to manage any deterioration. Check nursing records for the previous 72 hours. Mark **No** if there is no documented evidence of the nursing care that was provided to manage the deterioration. Mark **N/A** if there has been no documented deterioration in the patient's condition during the previous 72 hours.
7	**I**	**If infection is suspected to be the cause of the patient's deterioration, care is escalated using the sepsis screening form in accordance with the NEWS Escalation Protocol**
	A	Mark **Yes** if care is escalated using the sepsis screening form when infection is suspected as a cause for deterioration and in accordance with the NEWS Escalation Protocol. Check records for the previous 72 hours. Mark **No** if the Sepsis form is not completed when infection is suspected as a cause for deterioration in accordance with the NEWS Escalation Protocol. Mark **N/A** if infection is not suspected to be the cause of the patient's deterioration and in accordance with NEWS escalation Protocol or there is no documented deterioration.

2.2 Health Care Associated Infection Prevention and Control Quality Care-Metric

HEALTHCARE ASSOCIATED INFECTION PREVENTION & CONTROL **I** = Indicator, **A** = Data Collectors Advice, **N/A** = Not Applicable		
1	**I**	**The patient's infection status has been documented**
	A	Mark **Yes** if the patient's 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 left blank.
2	**I**	**The patient's infection status has been communicated to the multi-disciplinary team**
	A	Mark **Yes** if there is documented evidence in the nursing records that the patient's infection status and any associated risk/precautions required has been communicated to the wider multidisciplinary team (MDT). Mark **No** if there is no record of any communication with the wider MDT in relation to infection status and associated risk/precautions in the nursing documentation. Mark **N/A** if the patient does **not** have a current infection or infection risk requiring communication with the MDT.
3	**I**	**The patient's infection status has been communicated to the patient**
	A	Mark **Yes** if there is documented evidence in the nursing documentation that the patient's infection status has been discussed with the patient. Mark **No** if there is no evidence that infection status has been discussed with the patient. Mark **N/A** if the patient does **not** have a current infection or infection risk requiring discussion with the patient.
4	**I**	**A care bundle has been completed for each invasive device in use**
	A	Mark **Yes** if the appropriate care bundle for **each** invasive device in use has been fully completed. **All** components of the care bundle must be undertaken and up to date. Mark **No** if a care bundle for any invasive device in use has not been completed **or** is not up to date. Mark **N/A** if the patient does not have an invasive medical device in use.

2.3 Pain Assessment and Management Quality Care-Metric

PAIN ASSESSMENT AND MANAGEMENT **I** = Indicator, **A** = Data Collectors Advice, **N/A** = Not Applicable		
1	**I**	**Pain is assessed and documented within 24 hours of admission/transfer using a validated tool that is consistent with the patient's age, condition and ability to understand**
	A	Mark **Yes** when there is a documented pain assessment, using a validated tool, that is consistent with the patient's age, condition and ability to understand, within 24 hours of admission/transfer. Mark **No**, if there is no pain assessment documented using a validated tool that is consistent with the patient's age, condition and ability to understand within 24 hours of admission/transfer. **Note:** *all patients should be assessed on admission/transfer to ascertain if pain is present.*
2	**I**	**Pain is reassessed and documented using a validated tool at least every 12 hours**
	A	Mark **Yes** if a pain assessment is documented, using a validated tool, at least every 12 hours. Check records for the previous 72 hours. Mark **No** if a pain assessment is not documented, using a validated tool, at least every 12 hours. Check records for the previous 72 hours. Mark **N/A** if initial pain assessment does not indicate the presence of pain and reassessment was not indicated.
3	**I**	**Pain is assessed and documented using a validated tool before a pain relieving intervention**
	A	Mark **Yes** if a pain assessment is documented using a validated tool before a pain-relieving intervention Check records for previous 72 hours. Mark **No** if a pain assessment is not documented using a validated pain tool before a pain-relieving intervention. Mark **N/A** if the patient's pain score did not require a pain relieving intervention within the last 24 hours.
4	**I**	**Pain is assessed and documented using a validated tool within 1 hour after a pain relieving intervention**
	A	Mark **Yes** if a pain assessment is documented using a validated tool within one-hour after a pain relieving intervention. Check records for previous 72 hours. Mark **No** if a pain assessment is not documented using a validated tool within 1 hour after a pain-relieving intervention. Check records for previous 72 hours. Mark **N/A** if the patient's pain score did not require a pain relieving intervention within the last 72 hours.

5	I	**An adverse drug reaction associated with administered pain treatments is communicated with the medical team/prescriber**
	A	Mark **Yes** if an adverse drug reaction has occurred associated with an administered pain treatment (e.g.: sedation, change in respiratory status, nausea and vomiting) and there is documented evidence of communication with the medical team/prescriber. Check records for the past 72 hours. Mark **No** if there is no documented evidence of communication with the medical team/prescriber and an adverse reaction associated with pain treatments has occurred. Check records for the past 72 hours. Mark **N/A** if there are no adverse reactions associated with pain treatments administered or no pain treatments have been administered to the patient in the past 72 hours. **Note:** *An adverse reaction or side effect is an unwanted or unintentional reaction that a person may have after taking a medicine (HPRA 2018).*
6	I	**Communicated with the medical team/prescriber when there is an identified need for patient pain review**
	A	Mark **Yes** if there is documented evidence of communication with the medical team/prescriber when there is an identified need for patient review e.g. for initiation of pain management, report of severe pain or for modification of pain treatment plan. Check records for the past 72 hours. Mark **No** if there is no documented evidence of communication with the medical team/prescriber when there is an identified need for patient review e.g. for initiation of pain management, report of severe pain or for modification of pain treatment plan. Check records for the past 72 hours. Mark **N/A** if there is no identified need for patient pain review e.g. if a pain assessment is documented using a validated tool demonstrating evidence of reducing pain scores associated with pain relieving interventions or no pain.
7	I	**Pain-related education is provided to the patient and/or family on pain management on admission**
	A	Mark **Yes** if there is documented evidence of the provision of pain management education to the patient and/or family, on admission. Mark **No** if there is no documented evidence of the provision of pain management education to the patient and/or family, on admission. Mark **N/A** if there is documented evidence that patient does not require pain management.
8	I	**Pain-related education is provided to the patient and/or family on pain management prior to discharge**
	A	Mark **Yes** if there is documented evidence of pain-related education provision to the patient and/or family on pain management prior to discharge. Mark **No** if there is no documented evidence of pain-related education provision to the patient and/or family on pain management prior to discharge. Mark **N/A** if the patient's discharge preparation has not yet commenced or there is documented evidence that patient does not require pain management.

2.4 Nutrition and Hydration Quality Care-Metric

NUTRITION AND HYDRATION **I** = Indicator, **A** = Data Collectors Advice, **N/A** = Not Applicable		
1	**I**	**The patient's risk of malnutrition has been screened on admission/transfer**
	A	Mark **Yes** if there is documented evidence that the risk of malnutrition has been screened, using a validated tool, within 24hrs of admission/transfer. Mark **No** if there is no documented evidence of malnutrition screening, using a validated tool, within 24 hours of admission/transfer. Mark **N/A** if patient does not require malnutrition screening as per organisational policy e.g. a predicted short-stay / in-patient for less than 24 hours, documented evidence that the patient has refused malnutrition screening or the patient is on a clearly defined end-of-life pathway.
2	**I**	**A plan of care has been developed based on the patient's risk of malnutrition**
	A	Mark **Yes** if a documented plan of care has been developed based on the identified malnutrition risk. Mark **No** if a plan of care has not been developed or it is not based on the identified risk. Mark **N/A** if patient does not require malnutrition screening as per organisational policy e.g. a predicted short-stay / in-patient for less than 24 hours, or documented evidence that the patient has refused malnutrition screening or the patient is on a clearly defined end-of-life pathway.
3	**I**	**The patient's risk of malnutrition has been re-screened**
	A	Mark **Yes** if there is documented evidence that the patient's risk of malnutrition has been re-screened weekly using a validated tool. Mark **No** if there is no evidence that the patient's risk of malnutrition has been re-screened weekly using a validated tool. Mark **N/A** if the reassessment due date has not been reached, the patient is on a clearly defined end- of-life pathway or there is documented evidence that the patient has refused re-screening.
4	**I**	**The patient's oral health status assessment has been completed**
	A	Mark **Yes** if there is documented evidence that the patient's oral health status has been assessed if indicated using a validated tool in accordance with local /national PPPGs. Mark **No** if there is no evidence that the patient's oral health status has been assessed when indicated, in accordance with local/national PPPGs. Mark **N/A** if the patient does not require oral health status assessment as per organisational policy i.e. patients is not at risk of breakdown of oral integrity or does not require assistance with oral care in accordance with local/national PPPGs.
5	**I**	**The nursing care provided for the patient's oral health has been documented**
	A	Mark **Yes** if there is documented evidence of the nursing care provided in accordance with the needs identified on oral health status assessment. Mark **No** if there is no documented evidence of oral health care being provided when a need has been identified on oral health status assessment. Mark **N/A** if the patient's oral health status assessment has not identified a need for the provision of nursing care or if patient did not require oral health status assessment as per organisational policy. **Note:** *Frequency of oral care is determined by patient comfort and status of oral cavity and according to the oral health assessment.*

6	I	**Changes in the patient's bowel pattern have been assessed, recorded and managed**
	A	Mark **Yes** if there is evidence that changes in the patient's bowel pattern has been assessed, recorded and there is evidence that it is being managed. Check notes for the previous 72 hours. Mark **No** if there is no evidence that changes in the patient's bowel pattern have been assessed, recorded and managed. Check notes for the previous 72 hours. Mark **N/A** if there is documented evidence that the bowel pattern remains unchanged in line with baseline nursing assessment.

2.5 Continence Assessment and Management Quality Care-Metric

CONTINENCE ASSESSMENT AND MANAGEMENT **I** = Indicator, **A** = Data Collectors Advice, **N/A** = Not Applicable		
1	I	**A continence assessment has been recorded on admission/ transfer if applicable**
	A	Mark **Yes** if a continence assessment using a validated tool has been recorded on admission/transfer if applicable. Mark **No** if a continence assessment was not recorded on admission and/or transfer when applicable, or a validated tool has not been used. Mark **N/A** if a continence assessment is not required e.g. patients with long term catheters or urinary stoma.
2	I	**Fluid balance monitoring has been recorded in full and there is evidence that it is being totalled and managed.**
	A	Mark **Yes** if fluid balance monitoring has been recorded in full and there is evidence that it has been totalled and managed every 24 hours or in accordance with local PPPGs. Check notes for the previous 72 hours. Mark **No** if fluid balance monitoring has not been recorded though indicated on the care plan and/or there is no evidence that it is being recorded in full, totalled and managed. Check notes for the previous 72 hours. Mark **N/A** if the patient does not require fluid balance monitoring in accordance with local PPPGs.
3	I	**Changes in the patient's urinary continence pattern have been assessed, recorded and managed**
	A	Mark **Yes** if **all** elements in the indicator are present and there is evidence that changes in the patient's urinary continence pattern have been assessed, recorded and managed. Check notes for the previous 72 hours. Mark **No** if there is no evidence that changes in the patient's urinary continence pattern have been assessed, recorded and managed. Check notes for the previous 72 hours. Mark **N/A** if there is documented evidence that the urinary continence pattern remains unchanged in line with baseline nursing assessment.

2.6 Care Plan Development and Evaluation Quality Care-Metric

CARE PLAN DEVELOPMENT AND EVALUATION **I** = Indicator, **A** = Data Collectors Advice, **N/A** = Not Applicable		
1	**I**	**The care plan has been developed with the patient and reflects the patient's current condition and goals**
	A	Mark **Yes** if there <u>is</u> evidence that the care plan has been developed with the patient on admission/transfer <u>and</u> that it reflects the patient's current condition and goals. Mark **No** if there is no evidence that the care plan has been developed with the patient on admission/transfer. Mark **No** if the care plan does not reflect the patient's current condition or goals.
2	**I**	**The patient's self-care activities have been assessed**
	A	Mark **Yes** if the patient's self-care activities, to maintain independence of daily living, <u>have</u> been assessed on admission/transfer <u>and</u> the assessment has been dated, timed and signed by the assessing nurse. Mark **No** if the patient's self-care activities have <u>not</u> been assessed on admission/transfer or the assessment has not been dated, timed and signed by assessing nurse.
3	**I**	**The nursing interventions/supports given to the patient to improve their self-care activities has been documented**
	A	Mark **Yes** if there <u>is</u> documented evidence of the nursing interventions/supports given to the patient to improve their self-care activities, to maintain independence of daily living. Mark **No** if there is <u>no</u> documented evidence of the nursing interventions/supports given to the patient to improve their self-care activities. Mark **N/A** if there is documented evidence that the patient does <u>not</u> require support to improve their self-care activities.
4	**I**	**The progress made by the patient to improve their self-care activities has been documented in the care plan**
	A	Mark **Yes** if there <u>is</u> documented evidence in the care plan of the progress made by the patient to improve their self-care activities. Mark **No** if the progress made by the patient to improve their self-care activities has <u>not</u> been recorded.
5	**I**	**The patient's care plan has been reassessed in accordance with local PPPGs**
	A	Mark **Yes** if there <u>is</u> evidence within the patient's care plan of regular reassessment according to local PPPGs timeframe. Mark **No** if there is <u>no</u> evidence within the patient's care plan of regular reassessment according to local PPPGs timeframe. Mark **N/A** if reassessment due date has <u>not</u> been reached.
6	**I**	**There is evidence of a discharge plan that reflects the patient's current condition/ progress**
	A	Mark **Yes** if there <u>is</u> documented evidence of a discharge plan which incorporates the patient's current condition/progress. Mark **No** if there is <u>no</u> documented evidence of a discharge plan which incorporates the patient's current condition/progress. Mark **N/A** if the patient is on a clearly defined end-of-life pathway that will not include discharge or transfer.

7	**I**	**The patient's discharge plan has been discussed with the patient and documented**
	A	Mark **Yes** if there is documented evidence that the patient's discharge plan has been discussed with the patient and/or family as appropriate. Mark **No** if there is no documented evidence that the patient's discharge plan has been discussed with the patient and/or family as appropriate. Mark **N/A** if the patient is on a clearly defined end-of-life pathway that will not include discharge or transfer.
8	**I**	**A care plan for End-of-Life has been completed which incorporates a holistic needs assessment and symptom management plan**
	A	Mark **Yes** if a care plan for end-of-life is indicated and this has been completed incorporating a holistic needs assessment **and** symptom management plan. Mark **No** if a care plan for end-of-life is indicated and has not been completed. Mark **No** if a care plan for end-of-life is present but it does not incorporate a holistic needs assessment **and** symptom management plan. Mark **N/A** if an end-of-life care plan is not indicated.
9	**I**	**If an individual is identified as a vulnerable person, concerns regarding neglect and abuse have been documented**
	A	Mark **Yes** if an individual is identified as a vulnerable person and there are concerns regarding neglect and abuse, there is evidence that these concerns have been documented. Mark **No** if an individual is identified as a vulnerable person and there are concerns regarding neglect and abuse but these have not been documented. Mark **N/A** if the patient is not identified as a vulnerable person or if identified as a vulnerable person there is no concern regarding neglect and abuse. **Note:** *"A Vulnerable Person is an adult who may be restricted in capacity to guard himself / herself against harm or exploitation or to report such harm or exploitation. The restriction of capacity may arise as a result of physical or intellectual impairment vulnerability to abuse is influenced by both context (e.g. social or personal circumstances) and individual circumstances" Safeguarding Vulnerable Persons at Risk of Abuse National Policy & Procedures (HSE 2014b).*
10	**I**	**If an individual is identified as a vulnerable person, concerns have been reported to the appropriate authorities according to national and local policy**
	A	Mark **Yes** if an individual is identified as a vulnerable person and there are concerns regarding neglect and abuse there is evidence that these have been reported to the appropriate authorities in accordance with national and local policy. Mark **No** if an individual is identified as a vulnerable person, there are concerns regarding neglect and abuse but these have not been reported to the appropriate authorities in accordance with national and local policy. Mark **N/A** if the patient is not identified as a vulnerable person or if identified as a vulnerable person there is no concern regarding neglect and abuse.

2.7 Care Plan NMBI Guidance Quality Care-Metric

CARE PLAN NMBI GUIDANCE **I** = Indicator, **A** = Data Collectors Advice, **N/A** = Not Applicable		
1	**I**	**The patient's name and healthcare record number (HCRN) is on every page of the nursing record**
	A	Check documentation for the previous 72 hours to ensure that the individual's name and HCRN (i.e. hospital number) are on each page/screen. Mark **Yes** if individual's name and HCRN are on each page/screen. Mark **No** if individual's name and HCRN are not on each page/screen.
2	**I**	**All nursing entries include the nurse's signature, the date and time**
	A	Mark **Yes** if all nursing entries within the last 72 hours are dated, timed using the 24hr clock and signed. Mark **No** if all nursing entries within the last 72 hours are not dated, timed using the 24hr clock and signed. **Note:** *If other healthcare professionals write in the record, the nurses status/ grade should also be included with their signature. Best practice also indicates that each signature should be included on a local signature bank (NMBI 2015).*
3	**I**	**Any alterations in nursing documentation are as per NMBI guidelines**
	A	Mark **Yes** if any alterations in nursing documentation within the last 72 hrs are as per NMBI guidelines i.e. bracketed with a single line through them so the original entry is still visible. The alteration must be signed and dated with initials of nurse altering the record. Mark **No** if alterations within the last 72 hours do not follow this format. Mark **N/A** if no alterations have been made within the last 72 hours.
4	**I**	**All records are legible, in permanent black ink**
	A	Mark **Yes** if all entries within the last 72 hours are legible and written in permanent black ink. Mark **No** if all entries within the last 72 hours are not legible, or are not written in permanent black ink.
5	**I**	**Student entries are countersigned by the supervising nurse**
	A	Mark **Yes** if all student nurse/midwife entries within the last 72 hours are countersigned by the supervising nurse. Mark **No** if any student nurse/midwife entries within the last 72 hours are not countersigned by the supervising nurse. Mark **N/A** if there are no entries by a student nurse/midwife within the last 72 hours.
6	**I**	**All entries are in chronological order**
	A	Mark **Yes** if all entries in the nursing documentation within the last 72 hours are in chronological order or if the reason for any variance from this is correctly documented. Mark **No** if any entries within the last 72 hours are not in chronological order. Mark **No** if any variance to the chronological order of entries has not been correctly documented e.g. late entries.

7	I	**Any abbreviations/grading systems used are from a national or locally approved list/ system**
	A	Mark **Yes** if any abbreviations/grading systems used in entries within the last 72 hours are from a national or locally approved list/system. Mark **No** if abbreviations used in entries within the last 72 hours are not from a national or locally approved list/system. Mark **N/A** if abbreviations are not used in any entries within the last 72 hours.

2.8 Medication Safety Quality Care-Metric

MEDICATION SAFETY **I** = Indicator, **A** = Data Collectors Advice, **N/A** = Not Applicable		
Note: The indicators below are checking the following: All prescribed medication is administered in accordance with local and national policies, procedures, protocols and guidelines (PPPGs)		
1	I	**The patient's weight and date of weight are recorded on the front page of the medication record**
	A	Mark **Yes** if weight and date of weight are recorded on the front page of the medication record (to ensure drug calculations can be accurate). Mark **No** if weight and date of weight are not recorded on the front page of the medication record. Mark **N/A** if no medication record is required.
2	I	**The patient's identification wristband is on the patient and details are legible and correct**
	A	Mark **Yes** if **all** of the following are present: • The patient ID wristband is on the patient. • At least two identifiers, name and HCRN or Date of Birth (DOB) (if HCRN is not in use). • The information on the ID wristband is correct and legible. Mark **No** if **any** of the above elements are not present or are incorrect or illegible.
3	I	**Patient identification is legible and correct on the medication record**
	A	Mark **Yes** if the patient identification on the medication record has at least two identifiers on each page in use and the information is legible and correct. Mark **No** if the patient identification on the medication record does not have at least two identifiers on each page in use, **or** the information is illegible or incorrect. Mark **N/A** if no medication record is currently in use.
4	I	**The allergy status is clearly identifiable on the front page of the medication record**
	A	Mark **Yes** if the allergy status is clearly identifiable on the front page of the medication record. Mark **No** if the allergy status is not clearly identifiable or if it is left blank on the front page of the medication record.

5	I	**The prescription is legible with correct use of abbreviations**
	A	Mark **Yes** if the prescription is clear and legible with the correct use of abbreviations. Mark **No** if prescription is not clear or legible. Mark **No** if unapproved abbreviations are used. **Note:** *(International Units, Micrograms, Nanograms and units must not be abbreviated), check that quantities less than **1 gram** are written in **mgs** and quantities less than **1 mg** are written in **micrograms**.*
6	I	**An up-to-date medicines formulary/resource is available and accessible**
	A	Mark **Yes** if a drug formulary for e.g. IMF/MIMS/BNF etc. is available on the trolley. It must be within two years of publication. It should be located on the trolley to facilitate easy access for the nurse to reference drug details during drug administration. Online or book format are both acceptable. Mark **No** if it is not available or accessible or it is not within date.
7	I	**All medicines were administered at the prescribed frequency**
	A	Mark **Yes** if all medicines were administered at the prescribed frequency for the previous 72 hours or there is an omission code recorded for any deviation from the prescribed frequency. Mark **No** if medicine administration is not at the prescribed frequency in the previous 72 hours. Mark **N/A** if there are no current medicines prescribed.
8	I	**The minimum dose interval and/or 24 hour maximum dose is specified for all "as required" or PRN medicines**
	A	Mark **Yes** if all medicines prescribed "as required" or PRN states the minimum dose interval and/or the maximum 24 hour dose. Mark **No** if all medicines prescribed "as required" or PRN does not state the minimum dose interval and/or the maximum 24 hour dose. Mark **N/A** if there are no current "as required" or *PRN* medicines prescribed.
9	I	**Prescribed medicines not administered have an omission code entered**
	A	Mark **Yes** if any medicines not administered as prescribed have omission codes entered on the medication record and it contains the initials of the nurse omitting the medicine. Check records for the past 72 hours. Mark **No** if no omission code is entered **or** it is not initialled by the nurse when a medicine is not administered as prescribed. Mark **N/A** if all medicines are administered as prescribed and there is no requirement for an omission code in records for the last 72 hours.
10	I	**Prescribed medicines not administered have had appropriate action taken**
	A	Mark **Yes** if there is evidence of the appropriate action taken following omission of prescribed medicines. Mark **No** if documentation of the appropriate action following omission of prescribed medication is not recorded. Mark **N/A** if all medicines are administered and there was no medication omission in records for the last 72 hours. **Note:** *The appropriate action will be determined by the reason/code for the omission.*

11	I	**Independent verification of medication preparation and administration has taken place**
	A	Mark **Yes** if there is evidence of independent verification **(double-checking)** of medication preparation and administration **(2 nurse's sigs/initials)** in line with local PPPGs in records for the past 72 hours. Mark **No** if there is no evidence of independent verification (double-checking) of medication preparation and administration, where it was required, in line with local PPPGs as below. Check records for the past 72 hours. Mark **N/A** if no independent verification of medication preparation is required in line with local PPPGs and the medication record does not contain medications such as those listed above, in records for the past 72 hours. **Note:** *Double-checking is a significant nursing/midwifery activity to facilitate good medication management practices and is a means of reducing medication errors. Local PPPGs may require a system of independent verification for the administration of high-risk medicines, medicines whose dosage can change, dosages based on weight or requiring complex arithmetical calculations for intravenous medication and in particular certain categories of high-risk medication (e.g. Antimicrobials, Potassium, Insulin's, Narcotics, Opioids, Chemotherapy, Heparins and/or Anticoagulants (APINCH)) (NMBI 2018).*
12	I	**Appropriate action has been taken in response to any adverse reactions the patient has to any medication**
	A	*This indicator refers to medications other than pain medications **if** they are already assessed in the Pain Assessment and Management Metric at section 2.3 above* Mark **Yes** if an adverse drug reaction has occurred and there is documented evidence of communication with the medical team/prescriber **and** the patient. Both elements must be present. Check records for the past 72 hours. Mark **No** if there is no documented evidence of communication with the medical team/prescriber **and** the patient if adverse drug reactions have occurred. Check records for the past 72 hours. Mark **N/A** if there were no adverse drug reactions noted in the previous 72 hours or there are no current medicines prescribed. **Note:** *An adverse reaction...is an unwanted or unintentional reaction that a person may have after taking a medicine (HPRA 2018).*
13	I	**If a medication error has occurred there is evidence of appropriate monitoring and intervention in accordance with medication PPPGs**
	A	Mark **Yes** if a medication error has occurred and there is evidence of appropriate monitoring and intervention in accordance with medication PPPGs. Check records for the past 72 hours. Mark **No** if a medication error has occurred and there is no evidence of appropriate monitoring and/or intervention in accordance with medication PPPGs. Check records for the past 72 hours. Mark **N/A** if no medication error has occurred in the previous 72 hours. **Note:** *It is of primary importance upon noting a medication error that the patient's health is monitored. If a medication error has been identified, medical and nursing interventions should be implemented immediately to limit potential adverse effects/reactions. Patient safety is paramount (ABA 2007).*
14	I	**Medication-related education is provided by the nurse to the patient and/or family**
	A	Mark **Yes** if there is evidence of medication-related education provided by the nurse to the patient and/or family in relation to any commencement of new medication or changes to existing medication in the last 72 hours. Mark **No** if there is no evidence of any medication-related education having been provided by the nurse to the patient and/or family where there has been commencement of new medication or changes to existing medication in the last 72 hours. Mark **N/A** if the patient is not currently on any medication or there have been no additions or changes to medications in the past 72 hours.

2.9 Medication Storage and Custody Quality Care-Metric

MEDICATION 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 keys are held by a nurse on their person. Mark **No** if a registered nurse is not holding the keys. Mark **N/A** if medicinal products are not stored in the ward/unit.
2	**I**	**All medication trolleys are locked and secured as per local organisational policy and open shelves on the medication trolley are free of medicinal products when not in use**
	A	Mark **Yes** if all medication trolleys are locked and secured as per local organisational policy and open shelves on the medication trolley are free of medicinal products when not in use. Mark **No** if all medication trolleys are not locked, when not in use. Mark **No** if the medication trolleys are not in a locked room and/or is not secured with chain and lock to wall, when not in use. Mark **No** if there are medicinal products left accessible (unlocked) on end/side of trolley. Mark **N/A** if a medication trolley is not used in the ward/unit.
3	**I**	**MDA drugs are checked & signed at each changeover of shift by nursing staff (member of day staff & night staff)**
	A	Mark **Yes** if two signatures are present in the MDA drugs register on both the day and night changeover shift and if the duty roster verifies those staff were on those specific shifts. Check records for the previous 72 hours. Where there is no night shift; Mark **Yes** if checked and signed at beginning **and** end of each day shift. Mark **No** if two signatures are not present on the day and night changeover shift in the MDA drugs register or if the duty roster does not verify names were on these specific shifts. Check records for the last 72 hours. Mark **N/A** if the unit does not store MDAs drugs.
4	**I**	**The MDA Drugs cupboard is locked**
	A	Mark **Yes** if the MDA drugs cupboard is locked. Mark **No** if the MDA drugs cupboard is not locked and is unattended.
5	**I**	**The MDA drugs keys are held by the CNM or senior nurse designee**
	A	Mark **Yes** if a CNM or nurse designee holds the MDA Drugs keys. Mark **No** if a CNM or nurse designee does not hold the MDA Drugs keys or does not know who holds the keys. Mark **N/A** if unit does not store MDA Drugs.
6	**I**	**The MDA drugs keys are held separate or detached from all other sets of keys**
	A	Mark **Yes** if MDA Drugs keys are separate from main set of keys. Mark **No** if MDA Drugs keys are not separate from main set of keys. Mark **N/A** if unit does not store MDA Drugs.

7	I	**The patient bed space is free of any unsecured prescribed medicinal products**
	A	Mark **Yes** if unsecured prescribed medicinal products are not found at the bed space (e.g. top of locker, bed table). Unsecured medicinal products found at the patient's bed space which are exempt include for e.g. myostatin, own inhalers, mouthwash. Mark **No** if unsecured prescribed medicinal products are found at the bed space.

2.10 Falls and Injury Management Quality Care-Metric

FALLS AND INJURY MANAGEMENT **I** = Indicator, **A** = Data Collectors Advice, **N/A** = Not Applicable		
1	I	**A falls risk assessment was recorded on admission/transfer if applicable**
	A	Mark **Yes** if a falls risk assessment was recorded on admission/transfer to the ward in accordance with local PPPGs and it is dated, timed and signed. Mark **No** if a falls risk assessment was not undertaken on admission/ transfer to ward in accordance with local PPPGs **or** it is not dated, timed and signed. Mark **N/A** if the patient did not require a falls risk assessment in accordance with local PPPGs.
2	I	**If the patient is identified as at risk of falling, nursing interventions are in place to minimise the risk of falling**
	A	Mark **Yes** if the patient is identified at risk of falling and there is documented evidence in the care plan that nursing interventions are in place to minimise this risk. Mark **No** if the patient is identified at risk of falling and there is no documented evidence in the care plan that nursing interventions are in place to minimise this risk. Mark **N/A** if the patient is not identified at risk of falling.
3	I	**The patient, if identified at risk of falling, has been offered information about falls**
	A	Mark **Yes** if there is documented evidence that the patient, if identified at risk of falling, was offered information about falls. Mark **No** if there is no documented evidence that the patient, if identified at risk of falling, was offered information about falls. Mark **N/A** if the patient, is not identified at risk of falling.
4	I	**If a patient has fallen, the relevant post falls documentation have been completed**
	A	Mark **Yes** if the patient has fallen in the past 72 hours and there is evidence of the completion of the relevant post-falls documentation for each fall recorded. Mark **No** if the patient has fallen in the past 72 hours and there is no documented evidence of the completion of the relevant post-falls documentation for each fall recorded. Mark **N/A** if the patient has not fallen in the last 72 hours.

2.11 Delirium Prevention and Management Quality Care-Metric

DELIRIUM PREVENTION AND MANAGEMENT **I** = Indicator, **A** = Data Collectors Advice, **N/A** = Not Applicable		
1	**I**	**A delirium assessment has been completed**
	A	Mark **Yes** if a delirium assessment has been completed on admission/transfer, using a validated tool in accordance with local and national PPPGs and is dated timed and signed by the assessing staff member. Mark **No** if a delirium assessment has not been completed on admission/transfer using a valid tool in accordance with local and national PPPGs. Mark **No** if the assessment is not dated, timed and signed by the assessing nurse. Mark **N/A** if the patient is aged < 65 years, has no current acute episode of confusion or does not require screening for delirium in accordance with local and national PPPGs.
2	**I**	**If a patient has delirium, a care plan has been developed**
	A	If the presence of delirium has been confirmed in the delirium assessment: Mark **Yes** if there is documented evidence that a delirium care plan has been developed. Mark **No** if the there is no documented evidence that a delirium care plan has been developed. Mark **N/A** if there is documented evidence that the patient does not have delirium or the patient did not require a delirium assessment, in accordance with local and national PPPGs.
3	**I**	**There is documented evidence that a care plan for the patient with delirium has been evaluated**
	A	Mark **Yes** if there is documented evidence that the delirium care plan has been evaluated in accordance with local PPPGs timeframe, dated, timed and signed by the assessing nurse. Mark **No** if there is no documented evidence that the delirium care plan has been evaluated within the timeframe required by local PPPGs or if the evaluation has not been dated, timed and signed. Mark **N/A** if the patient has documented evidence that they do not have delirium or did not require delirium assessment, in accordance with PPPGs.

2.12 Wound Care Management Quality Care-Metric

WOUND CARE MANAGEMENT **I** = Indicator, **A** = Data Collectors Advice, **N/A** = Not Applicable		
1	**I**	**A comprehensive wound assessment has been completed**
	A	Mark **Yes** if there is documented evidence that a comprehensive wound assessment has been undertaken. Assessment must be dated, timed and signed by the assessing nurse. Mark **No** if a comprehensive wound assessment has not been undertaken or is not dated, timed and signed by the assessing nurse. Mark **N/A** if the patient has no wound. **Note:** *The wound assessment should include at a minimum: Type of wound and aetiology, location of wound, duration of wound, exudate description, condition of the wound bed, size of wound (Measurement), condition and sensation of peri-wound skin, presence of Infection, presence and nature of pain and objectives of wound healing as per the National Wound Management Guidelines (HSE 2018g, p 15).*
2	**I**	**The wound care plan has been re-evaluated**
	A	Mark **Yes** if there is documented evidence that the wound care plan has been re-evaluated in accordance with the National Wound Management Guidelines and this re-evaluation is dated, timed and signed. Mark **No** if the wound care plan has not been re-evaluated, dated, timed or signed. All elements must be present. Mark **N/A** if the patient has no wound.

2.13 Pressure Ulcer Prevention and Management Quality Care-Metric

PRESSURE ULCER PREVENTION AND MANAGEMENT **I** = Indicator, **A** = Data Collectors Advice, **N/A** = Not Applicable		
1	**I**	**A pressure ulcer risk assessment was recorded using a validated tool within 6 hours of admission or transfer**
	A	Mark **Yes** if a pressure ulcer assessment was completed using a validated tool within a ***maximum*** of 6 hours of admission/transfer to the ward and is dated, timed and signed by the assessing nurse. Mark **No** if a pressure ulcer assessment was not done within 6 hours of admission/transfer **or** if it is not dated, timed or signed by the assessing nurse.
2	**I**	**If a patient is identified as at risk, daily skin inspections have been recorded**
	A	If the patient has been identified as at risk; Mark **Yes** if at least once daily skin inspections have been documented dated, timed and signed, in the nursing records of the past 72 hours. Mark **No** if at least once daily skin inspections have not been documented in the nursing records for the past 72 hours **or** they are not dated, timed and signed. Mark **N/A** if the patient is not identified at risk of pressure ulcer development.

3	I	**The pressure ulcer risk was reassessed in response to any changes in the patient's condition**
	A	Mark **Yes** if there is documented evidence that the pressure ulcer risk was reassessed in response to any changes in the patient's condition or the patient's condition remains unstable. Check records for the past 72 hours. Mark **No** if reassessment has not been documented in response to any change in the patient's condition or if the patient is in an unstable condition. Check records for the past 72 hours. Mark **N/A** if the patient's condition has been stable in the past 72 hours. **Note:** *Repeat the risk assessment as often as required based on assessment of the patient's acuity. If the patient's condition is unstable re-assess every 48-72 hours until stable (HSE 2018g, p130).*
4	I	**The pressure ulcer risk was reassessed weekly**
	A	Mark **Yes** if there is documented evidence that the pressure ulcer risk was reassessed within a maximum of one week from previous assessment date when the patient has been stable and there has been no change in the patient's condition. Mark **No** if reassessment has not been documented within a maximum of one week from previous assessment date, when the patient has been stable and there has been no change in the patient's condition. Mark **N/A** if the patient's condition has changed and more frequent assessment has been undertaken or the time for reassessment has not yet been reached. **Note:** *If the patient's condition is stable weekly reassessment should be conducted unless there is a change in condition (HSE 2018g, p130).*
5	I	**If a *pressure* ulcer is present, the category/stage has been recorded**
	A	Mark **Yes** if a pressure ulcer is present and the category/stage has been recorded on the relevant documentation in accordance with organisational policy. Mark **No** if a pressure ulcer is present and the category/stage has not been recorded on the relevant documentation in accordance with organisational policy. Mark **N/A** if there is no pressure ulcer present.
6	I	**Reassessment and evaluation of the pressure ulcer have been completed**
	A	Mark **Yes** if a reassessment and evaluation of the ***pressure ulcer*** has been completed within the agreed timeframe in accordance with local PPPGs and organisational policy. Mark **No** if reassessment and evaluation of the pressure ulcer have not been completed in the relevant agreed timeframe. Mark **N/A** if there is no existing pressure ulcer or if the reassessment due date has not been reached.
7	I	**The frequency of patient repositioning is recorded**
	A	Mark **Yes** if the frequency of patient repositioning is recorded including repositioning regimes, specifying the frequency, position adopted and the evaluation of the outcome of the repositioning regime. Mark **No** if the frequency of patient repositioning is not recorded with the above inclusions. Mark **N/A** if there is documented evidence that the patient is not at risk of developing a pressure ulcer or does not have existing pressure ulcers or repositioning is contraindicated due to a current medical condition and an alternative preventative strategy has been provided (e.g. High specification mattress/bed).

8	I	**The use of pressure redistributing devices is recorded**
	A	Mark **Yes** if the use of pressure redistributing devices is recorded. Mark **No** if pressure redistributing devices are in use but not recorded. Mark **N/A** if the patient is not at risk and does not require pressure redistributing devices.

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

Note: Legislation, regulation and other publications, which are relevant to the Acute Care Quality Care-Metrics development, are listed in Appendix IV

3.0 PROCESS FOR QUALITY CARE-METRICS DATA COLLECTION

3.1 PROCESS

3.1.1 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.

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

3.1.3 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 2.0.

3.1.4 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.

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

Figure 2 outlines the process for undertaking Nursing and Midwifery Quality Care-Metrics.

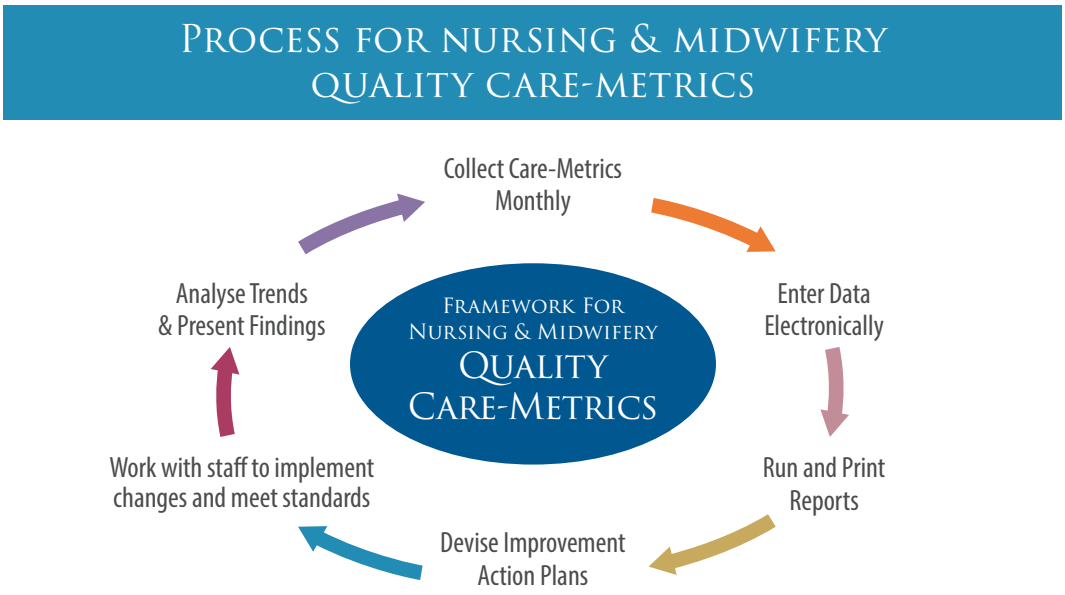

Figure 2: Undertaking Quality Care-Metrics at Service Level

3.2 Sample Size

3.2.1 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.

3.2.2 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.

3.3 Timing of Monthly Data Collections

3.3.1 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.

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

3.3.3 Data collectors are required to examine the care records for the period of time outlined in the advice section or indicator.

3.4 Accessing Test Your Care HSE System

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

Figure 3: TYC HSE System

3.4.2 To access the TYC HSE System, users log on to the Internet browser and open the website **http://www.testyourcarehse.com**. Users enter a username and password and click the login button. The TYC HSE system disseminates the initial username and password to the user via two emails. Passwords can then be changed by the user by going to Settings option on the TYC HSE toolbar and entering a password of choice. Username and passwords should not be shared as they are unique to users and allow access to either data entry or reporting or both. The home page of the TYC HSE System is illustrated in Figure 3.

3.4.3 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

3.4.4 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.

3.5 Data Entry

3.5.1 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.

3.5.2 A drop down menu (Figure 4) 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

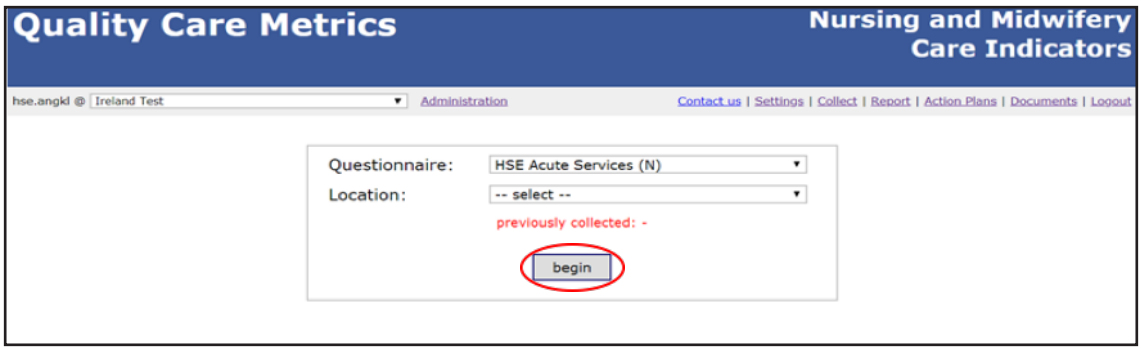

Figure 4: Data Entry: TYC HSE System

3.5.3 Data entry occurs through the selection of the predetermined answers 'Yes/No/Not Applicable' (Figure 5 and 6)

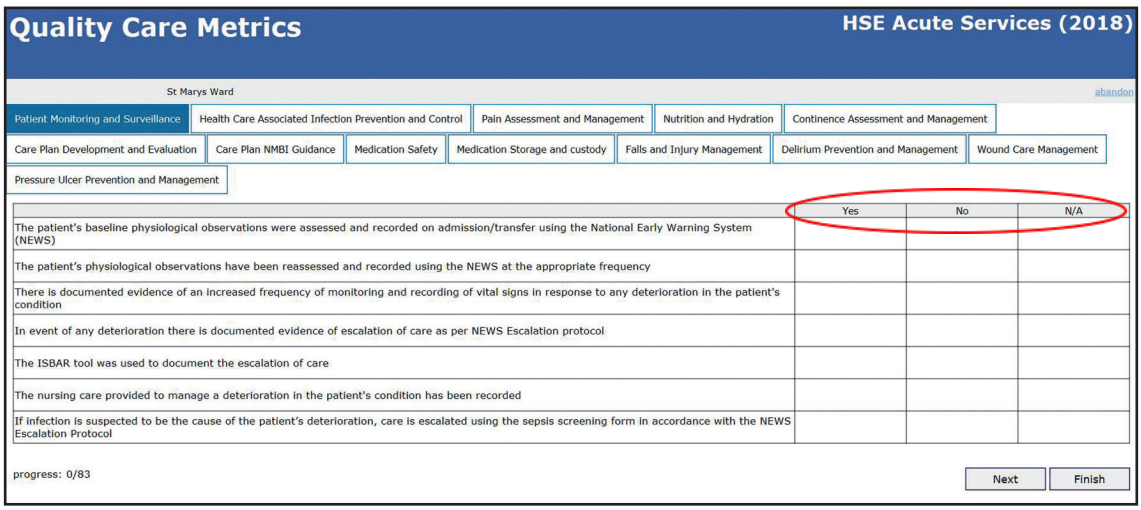

Figure 5: Data Entry: TYC HSE System (1)

- 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

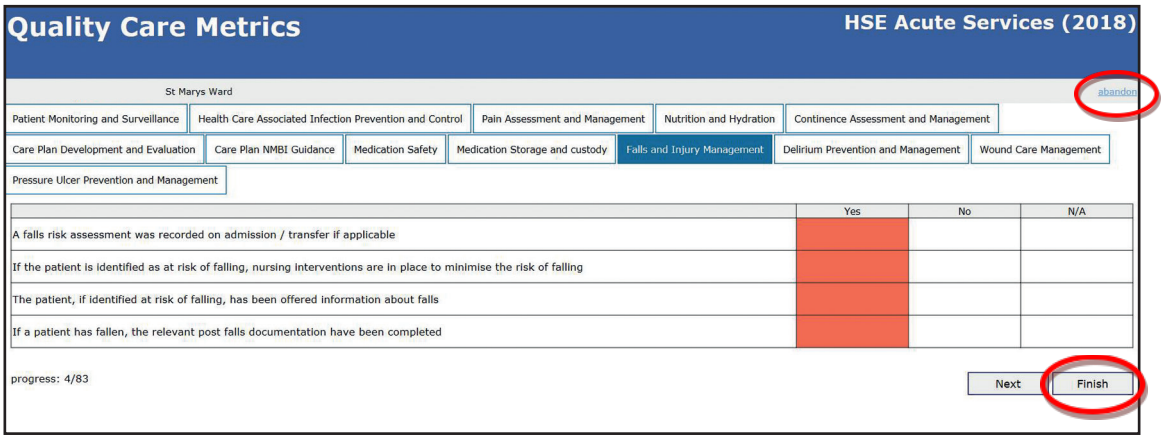

Figure 6: Data Entry: TYC HSE System (2)

4.0 QUALITY CARE-METRICS DATA ANALYSIS

4.1 Scoring System

4.1.1 Scores are illustrated easily using a Traffic Lights Scoring System which highlights areas of improvement, areas of risk and areas of excellence (Figure 7). 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.

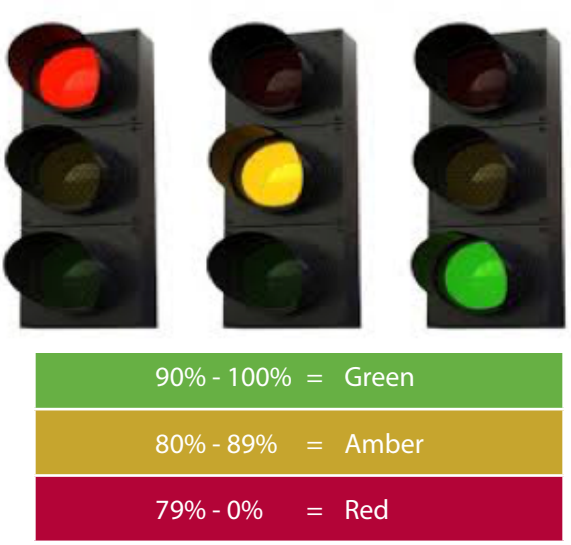

Figure 7: Traffic Light Scoring System

4.1.2 The highlighted score will be colour coded as illustrated in Figure 7 according to the score achieved and so could be any of the 3 colours green, red or amber and are displayed in three possible ways (Figure 8).

	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 8: Scoring System

4.2 Reporting

4.2.1 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.

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

4.2.3 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.

4.2.4 To access reporting click the **Report** tab in the top right hand corner (Figure 9)

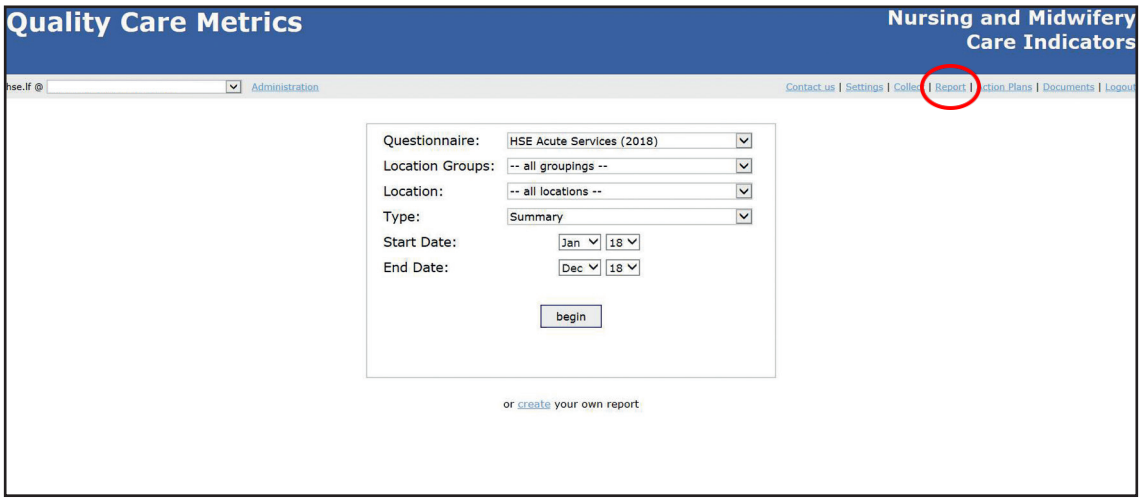

Figure 9: Accessing Reports from TYC HSE

4.2.5 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

4.2.6 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

4.2.7 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 10 and 11).

- 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'

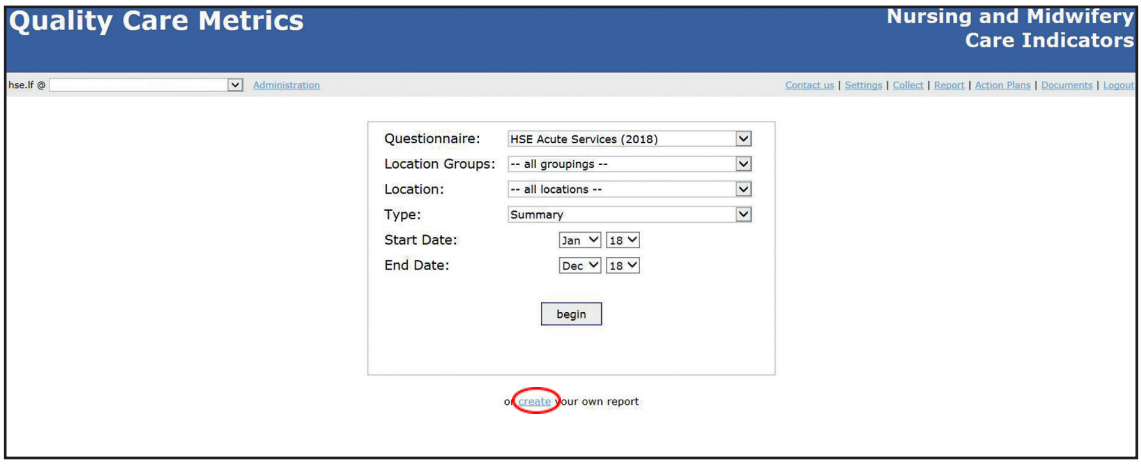

Figure 10: Create your own Report

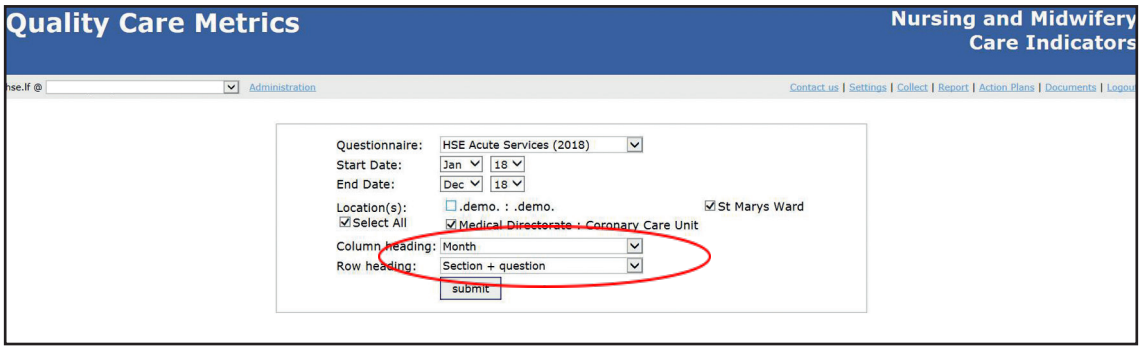

Figure 11: Create your own Report; Column Heading: Month and Row Heading: Section and Question

- 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 12).

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

4.2.8 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 10 and 13).

- 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'

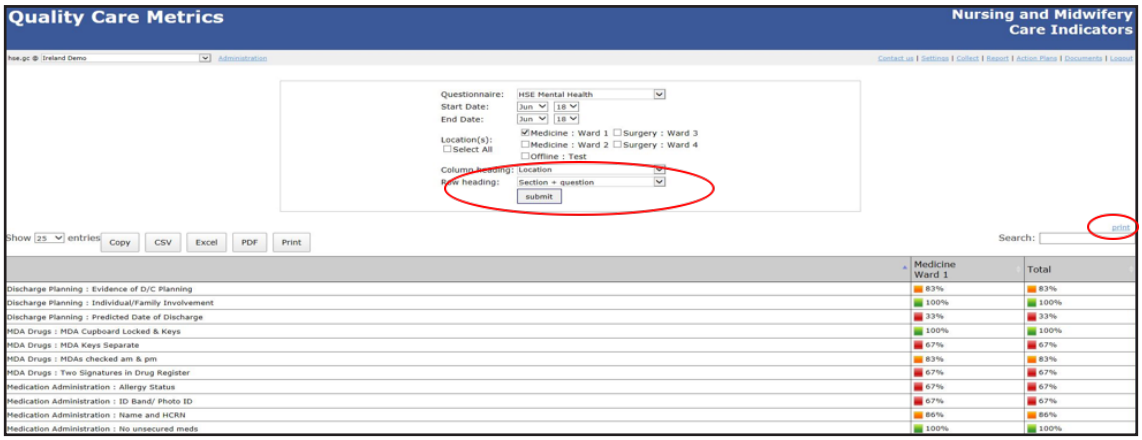

Figure 13: Create your own Report; Results; Column Heading: Location and Row Heading: Section and Question

- 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 13).

4.2.9 Create your own Report (3): if a more detailed report is required the 'Create your own report' option may be used (Figure 10 and 14).

- 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'

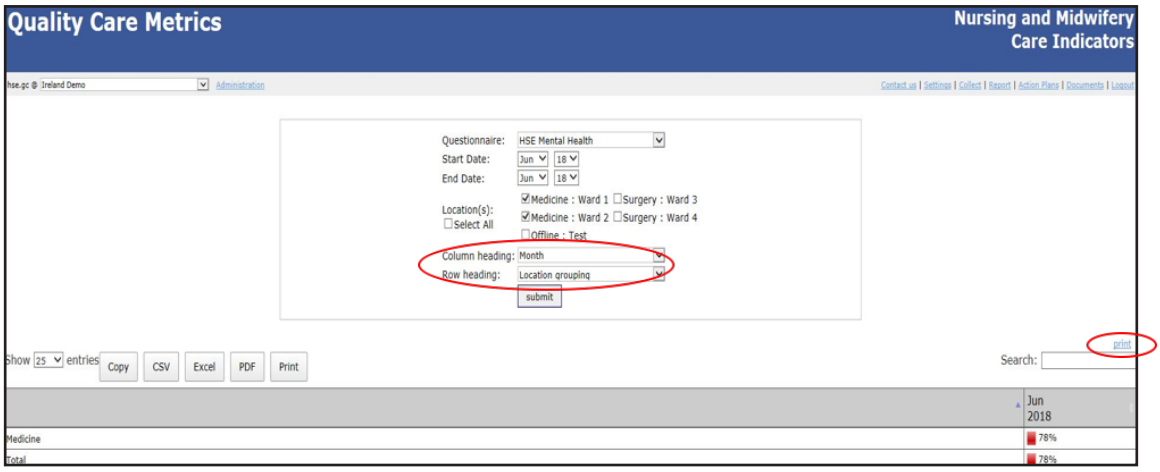

Figure 14: Create your own Report; Results; Column Heading: Month and Row Heading: Location Grouping

- This selection, **'Column Heading: Month and Row Heading: Location Grouping'** supports the ADoN/ADoM to compare groupings/divisions per month if set up (Figure 14).

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 15).

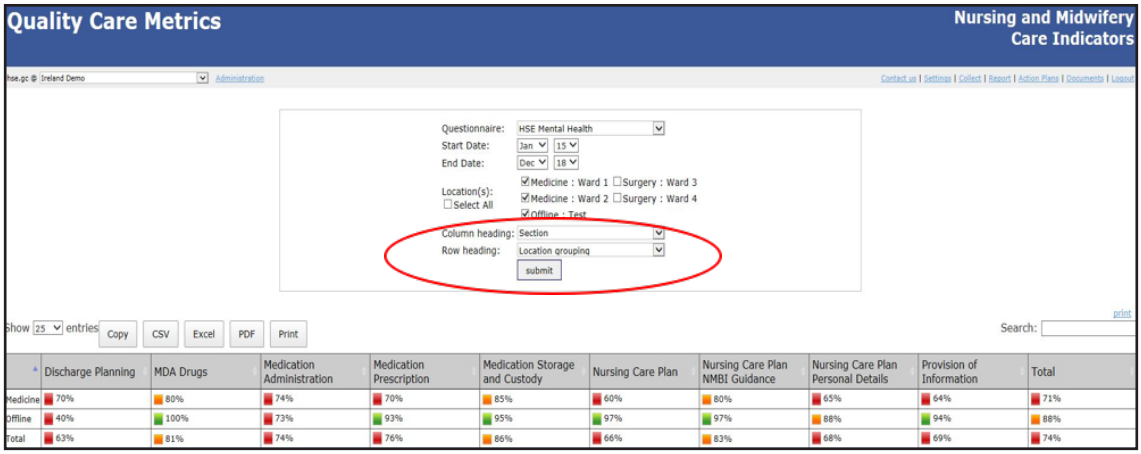

Figure 15: Create your own Report; Results; Column Heading: Section and Row Heading: Location Grouping

5.0 QUALITY CARE-METRICS ACTION PLANNING

5.1 Accessing Action Planning on Test Your Care HSE

5.1.1 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 16.

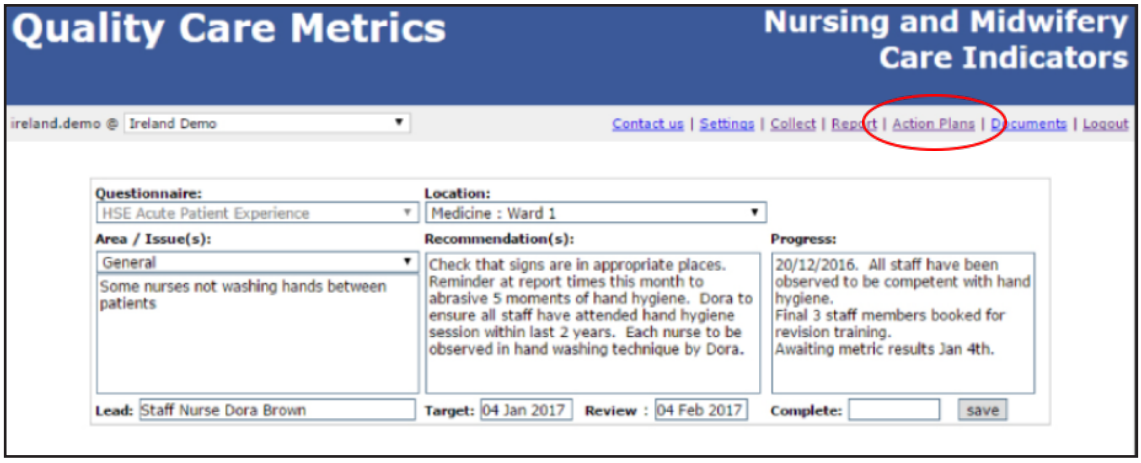

Figure 16: Accessing Action Planning on TYC HSE

5.1.2 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.

5.2 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

5.2.1 Step 1; Understanding Quality Care-Metrics Results

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

5.2.2 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

5.2.3 Step 3; Writing the Action Plan

- Having identified what areas (metric/indicator) to tackle - be SMART as guided by Figure 17
- 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 17: SMART Goals

5.2.4 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

5.2.5 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

5.2.6 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?

5.2.7 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

6.0 REFERENCES

Foulkes, M. (2011) Nursing metrics: measuring quality in patient care. *Nursing Standard.* 25(42): 40-45.

Health Service Executive (HSE)(2018) *Nursing & Midwifery Quality Care-Metrics: Acute Care Research Report.* HSE Office of Nursing & Midwifery Services Director: Dublin.

Health Service Executive (HSE) (2018a) National Guideline for Nursing and Midwifery Quality Care-Metrics Data Measurement in Acute Care 2018 (ONMSD 2018 - 030).
Available online at:
www.hse.ie/onmsd/safe-quality-care/nursing-and-midwifery-qualitycare-metrics

McHugh, M. L. (2012) Inter-rater reliability: The Kappa Statistic. *Biochemia Medica*. 22(3): 276–282.

Please note that the full references for the Supporting Evidence (Appendix IV) are available in the National Guideline for Nursing and Midwifery Quality Care-Metrics Data Measurement in Acute Care 2018 (ONMSD 2018 - 030)

7.0 APPENDICES

Appendix I
GLOSSARY OF TERMS AND DEFINITIONS

Appendix II
ABBREVIATIONS

Appendix III
Immediate Safety/Risk Identification Form for Nursing and Midwifery

Appendix IV
SUPPORTING EVIDENCE

Appendix I
Glossary of Terms and Definitions

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

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).

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

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

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

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

Appendix II
Abbreviations

ADoN/ADoM	Assistant Director of Nursing/Assistant Director of Midwifery
CNM/CMM	Clinical Nurse Manager/Clinical Midwife Manager
DOB	Date of Birth
HIQA	Health Information and Quality Authority
HCRN	Healthcare Record Number
HSE	Health Service Executive
MCN	Medical Council Number
MDA	Misuse of Drugs Act
NMBI	Nursing and Midwifery Board of Ireland
ONMSD	Office of the Nursing and Midwifery Services Director
PIN	Personal Identification Number
PPPG	Policies, Procedures, Protocols and Guidelines
QCM	Quality Care-Metrics
TYC HSE	Test Your Care Health Service Executive

Appendix III
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.

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

To be Completed by the data collector undertaking Metric During the conduction of metrics in the ward today, the following safety/risk concerns are identified.		
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 IV
Supporting Evidence

Legislation and regulation publications, which are relevant to the Acute Care Quality Care-Metrics development are listed below.

The complete list of references can be accessed in the National Guideline for Nursing and Midwifery Quality Care-Metrics Data Measurement in Acute Care 2018 (ONMSD 2018 - 030)

Assessment Tool	Links to Validated Assessment Tools
Pain	
Numeric Pain Rating Scale	https://www.va.gov/PAINMANAGEMENT/docs/Pain_Numberic_Rating_Scale.pdf
Visual Analogue Scale	https://www.physiotherapyalberta.ca/files/pain_scale_visual_and_numerical.pdf
Brief Pain Inventory	http://www.npcrc.org/files/news/briefpain_short.pdf
McGill Pain Questionnaire	http://www.chcr.brown.edu/pcoc/MCGILLPAINQUEST.PDF
Edmonton Symptom Assessment System	http://palliative.org/NewPC/_pdfs/tools/ESAS-r.pdf
Behavioural Pain Scale	https://com-jax-emergency-pami.sites.medinfo.ufl.edu/files/2015/02/behavioral-pain-scale.pdf
Critical Pain Observation Tool	http://www.mghpcs.org/eed_portal/Documents/Pain/Critical_Care/ccPOT.pdf
Faces Pain Scale-Revised	https://hhs.texas.gov/sites/default/files//documents/doing-business-with-hhs/provider-portal/QMP/facespainscale.pdf
Faces Pain Scale-Revised	https://hhs.texas.gov/sites/default/files//documents/doing-business-with-hhs/provider-portal/QMP/facespainscale.pdf
Sedation Agitation Scale	http://www.icudelirium.org/docs/SAS.pdf
Richmond Sedation Agitation Scale	https://www.northernhealth.ca/Portals/0/Your_Health/HCC/Hospice%20Palliative%20Care/Assessment%20Tools/10-513-5008RichmondAgitationSedationScale(RASS).pdf
Leeds Assessment of Neuropathic Symptoms and Signs	http://www.endoexperience.com/documents/apx4_lanss.pdf
Neuropathic Pain Diagnostic Questionnaire (DN4)	http://nperesource.casn.ca/wp-content/uploads/2017/02/20100922NAlH3NeuropathicPainDiagnosticQuestionnaireDN4-1.pdf
Falls	
Berg Balance Scale	http://www.aahf.info/pdf/Berg_Balance_Scale.pdf
Dynamic Gait Index	http://www.dartmouth-hitchcock.org/dhmc-internet-upload/file_collection/gait_0109.pdf
Timed Up and Go Test	https://www.cdc.gov/steadi/pdf/TUG_Test-print.pdf

Delirium	
Confusion Assessment Method	https://www.viha.ca/NR/rdonlyres/6121360B-B90F-4EF3-88F6-D50CC4825EE7/0/camshortform.pdf
Confusion Assessment Method for the ICU	https://www.aacn.org/docs/EventPlanning/WB0016/Delirium-CAM-ICU-gwgqydl2.pdf
Intensive Care Delirium Screening Checklist	http://www.icudelirium.org/docs/2013-Tufts-ICU-Delirium-Screening-Checklist.pdf
NEECHAM Confusion Scale	https://www.mnhospitals.org/Portals/0/Documents/patientsafety/Delirium/Neecham%20Confusion%20Tool.pdf
Delirium Observation Screening Scale	http://www.primarycareforms.com/delerium%20observation%20score.pdf
Nursing Delirium Screening Scale (NuDESC)	https://www.caresearch.com.au/Caresearch/Portals/0/Documents/PROFESSIONAL-GROUPS/General-Practitioners/4-NuDescscaleCalvary_1.pdf
Memorial Delirium Assessment Scale	http://palli-science.com/sites/default/files/G_livre/TomeII/MDAS.pdf
4AT	https://www.guysandstthomas.nhs.uk/resources/our-services/acute-medicine-gi-surgery/elderly-care/4at.pdf https://www.hse.ie/eng/services/publications/clinical-strategy-and-programmes/delirium-ed-amau-algorithm-.pdf
Nutrition	
Oral Health Assessment Tool	https://www.nice.org.uk/guidance/ng48/resources/oral-health-assessment-tool-pdf-2543183533
The Holistic and Reliable Oral Assessment Tool	http://ltctoolkit.rnao.ca/sites/default/files/resources/oralcare/AssessmentTools/Oral_Health_AppEpage70_THROAT.pdf
Malnutrition Universal Screening Tool	https://www.bapen.org.uk/pdfs/must/must_full.pdf

Acute Care Mapping of Supporting Documents to Metrics Sections

Metric	References
Patient Monitoring and Surveillance	Department of Health (DOH), Ireland (2013) National Early Warning Score; National Clinical Guideline No. 1. Dublin: DOH. Scottish Intercollegiate Guidelines Network (SIGN) (2014) Care of Deteriorating Patients. SIGN Guideline 139. Scotland: SIGN National Institute of Health and Care Excellence (NICE) (2007) Acutely Ill Adults in Hospital: Recognising and Responding to Deterioration. NICE Guideline CG50. London: NICE Casey, A., Coen, E., Gleeson, M., Walsh, R., & the Acute Medicine Nursing Interest Group (2016) Setting the Direction - A Development Framework Supporting Nursing Practice Skills and Competencies in Acute Medical Assessment Units (AMAUs) and Medical Assessment Units (MAUs), Dublin: Office of Nursing and Midwifery Services Director & National Acute Medicine Programme, Clinical Strategy and Programmes Division, Health Service Executive Department of Health (DOH) (2014) Sepsis Management: National Clinical Guideline No.6. Dublin: DOH National Institute of Health and Care Excellence (NICE) (2016) Sepsis: Recognition, Diagnosis and Early Management. NICE Guideline NG51. London: NICE Higgins Y., Maries-Tillott C., Quinton S. & Richmond J. (2008) Promoting Patient Safety Using an Early Warning Scoring System. Nursing Standard 22(44) 35-40 Lees L. & Hughes T. (2009) Implementing a Patient Assessment Framework in Acute Care. Nursing Standard. 24(3), 35-43 Bennett K.A., Robertson L.C. & Al-Haddad M. (2015) Recognizing the Critically Ill Patient. Anaesthesia and Intensive Care Medicine 17(1), 1-4 Smith M.E. Chiovaro J.C., O'Neil M., Kansagara D., Quiñones A.R., Freeman M., Motu'apuaka M.L. & Slatore C.G. (2014) Early Warning System Scores for Clinical Deterioration in Hospitalized Patients: A Systematic Review. Annals of the American Thoracic Society 11(9), 1454-1465. Hall L., Wodchis W.P., Ma X. & Johnson S. (2013) Changes in Patient Health Outcomes from Admission to Discharge in Acute Care. Journal Nursing Care Quality, 28(1), 8-16. Thim T., Krarup N.H., Grove E.L., Rohde C.V. & Løfgren B. (2012) Initial Assessment and Treatment with the Airway, Breathing, Circulation, Disability, Exposure (ABCDE) Approach. International Journal of General Medicine 5, 117-121. Bennett P. (2012) Nursing quality indicators: the next steps in enhancing quality in emergency care. International Emergency Nursing, 20, 179-186. Barlow P. (2012) A practical review of the Glasgow Coma Scale and Score. The Surgeon, Journal of the Royal Colleges of Surgeons of Edinburgh and Ireland 10(2), 114-119. Reith F.C., Van den Brande R., Synnot A., Gruen R. &Maas A.I. (2016) The Reliability of the Glasgow Coma Scale: A Systematic Review. Intensive Care Medicine 42, 3-15 World Health Organisation (WHO) (2007) Communication During Patient Hand-Overs. Geneva: WHO Beckett C.D. & Kipnis G. (2009) Collaborative Communication: Integrating SBAR to Improve Quality/Patient Safety Outcomes. Journal of Healthcare Quality 31(5), 19-28.

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Health Care Associated Infection Prevention and Control	Health Information and Quality Authority (HIQA) (2017) National Standards for the Prevention and Control of Healthcare-Associated Infections in Acute Healthcare Services. Dublin: HIQA Health Service Executive (HSE) (2014) Prevention of Intravascular Catheter-related Infection in Ireland: Partial Update of 2009 National Guidelines. Dublin: HSE Department of Health (DOH), Ireland (2013) Prevention and Control Methicillin-Resistant Staphylococcus aureus (MRSA) National Clinical Guideline No.2. Dublin: DOH Royal College of Physicians Clinical Advisory Group on Healthcare Associated Infections in Association with Health Service Executive (HSE) Quality and Patient Safety (2012) Guidelines for the Prevention and Control of Multi-Drug Resistant Organisms (MDRO) Excluding MRSA in the Healthcare Setting. Dublin: HSE Health Service Executive (HSE) (2017) Guiding Framework for the Education, Training and Competence Validation in Venepuncture and Peripheral Intravenous Cannulation for Nurses and Midwives. Dublin: HSE Health Service Executive (HSE) (2017) Central Venous Access Device (CVAD) Assessment, Care and Monitoring. Dublin: HSE Standard Operating Procedure for Implementing Peripheral Vascular Cannula Care Bundles (2016) Dublin: Health Service Executive Bennett P. (2012) Nursing Quality Indicators: The Next Steps in Enhancing Quality in Emergency Care. International Emergency Nursing, 20, 179-186. Bucsit C. (2012) Vital Improvement. Standard Nurse, 32(1), 8-9.
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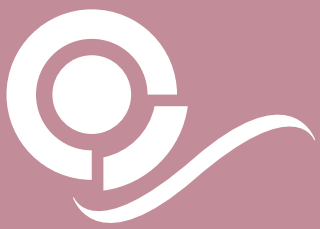

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