SUMMARY DOCUMENT

NATIONAL SUMMARY GUIDANCE

FOR NURSING AND MIDWIFERY QUALITY CARE-METRICS DATA MEASUREMENT IN

CHILDRENS SERVICES 2018

To be used in conjunction with the National Guideline for Nursing and Midwifery Quality Care-Metrics Data Measurement in Childrens Services 2018 (ONMSD 2018 - 028)

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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 Children's 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 Children's 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 Children's 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 Children's Research Report (HSE, 2018a) and the National Guideline for Nursing and Midwifery Quality Care-Metrics Data Measurement in Childrens Services 2018 (ONMSD 2018 -028).

1.2.4 All nurses and midwives within Children's services, 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 Childrens Services 2018 (ONMSD 2018 - 028) 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 Children's Services (ONMSD 2018 - 028), will enable consistency in the reliability and validity of the data collection to support a standardised approach in Children's 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.

2.0METRICS, INDICATORS & ADVICE FOR CHILDREN'S SERVICES

The following Quality Care-Metrics are available for Children's Services as outlined in Figure 1.

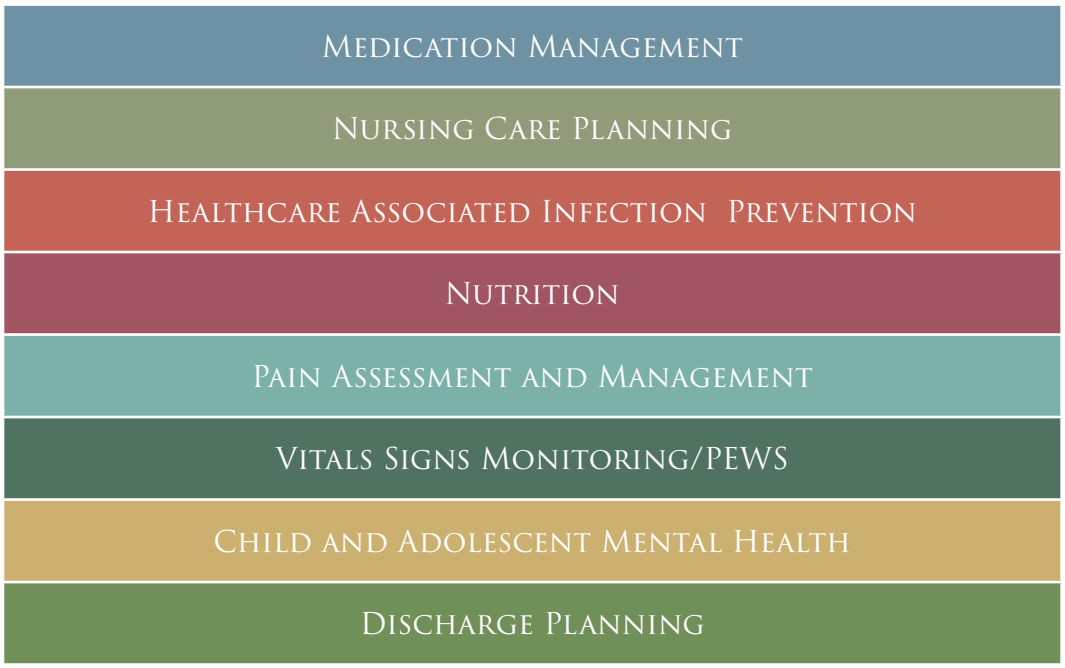

Figure 1: Childrens Services Quality Care-Metrics

2.1 Medication Management Quality Care-Metric

Medication Management **I** = Indicator, **A** = Data Collectors Advice, **N/A** = Not Applicable		
1	**I**	**Security for the storage of medicinal products is managed by the registered nurse**
	A	Mark **Yes** if keys/access to storage of medicinal products is being managed by a registered nurse. Mark **No** if person holding the keys/access to storage of medicinal products is not a registered nurse. Mark **N/A** if medicinal products are not stored within the ward/unit.
2	**I**	**All medicinal products are stored in a locked cupboard/locked fridge or within a locked room**
	A	Mark **Yes** if cupboard or room is locked or accessible by security code or pass key. Mark **No** if medicinal products are accessible in an unsecured cupboard/room. Mark **N/A** if medicinal products are not stored within the ward/unit.

3	I	**Where medication trolleys are in use, they 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 trolleys are locked when not in use. Mark **No** if not all trolleys are locked. Mark **Yes** if in a locked room when not in use. Mark **No** if trolley is not in a locked room and is not secured with chain and lock to wall. Mark **No** if there are items left accessible (unlocked) on end/side of trolley. Mark **N/A** if medication trolleys are not used.
4	I	**High alert medicine is identified and stored appropriately, as per local policy**
	A	Mark **Yes** if high alert medicines (e.g. Potassium Chloride, Gentamicin) are identified/ labelled and stored appropriately to ensure safe administration. Mark **No** if high alert medication is stored in the unit but not flagged as high alert medicines. Mark **N/A** if ward/unit does not currently store high alert medication.
5	I	**There is easy access to an up-to-date drug formulary**
	A	Mark **Yes** if a drug formulary resource (e.g MIMS/BNFC etc.) is readily available within the ward/unit. It must be within two years of publication. It should be located to facilitate easy access for the nurse to reference medication details during medication administration. Mark **No** if drug formulary resource is unavailable or not within date.
6	I	**Misuse of Drugs Act (MDA) drugs register is checked and signed at each changeover of shifts by registered nursing staff (member of day staff & night staff)**
	A	Mark **Yes** if MDA drugs register is checked and has two signatures for members of day staff and night staff on changeover of shift in last 72 hours. Where there is no night shift, Mark Yes if checked and signed at beginning of shift and end of shift (two signatures each time). Mark **No** if MDA drugs register is not checked and signed (two signatures) on changeover of shift in the last 72 hours **or** duty roster does not verify names were on these specific shifts (day and night shift if applicable). Mark **N/A** if unit does not store MDAs currently.
7	I	**Two signatures are entered in the MDA drug register for each administration of an MDA drug**
	A	Mark **Yes** if the MDA drugs register has two signatures entered for each MDA drug administered within the last 72 hours. Mark **No** if MDA drug register does not have two signatures entered for each MDA drug administered within the last 72 hours. Mark **N/A** if ward/unit does not store MDA drugs currently. Mark **N/A** if there has been no MDA drug administered within the last 72 hours.
8	I	**The MDA drug cupboard is locked and security around access to the MDA cupboard is held by a registered nurse**
	A	Mark **Yes** if cupboard is locked and MDA keys/access is held by the CNM or nurse designee. Mark **No** if cupboard is unattended and unlocked or if CNM or nurse designee does not know who has the MDA keys/access. Mark **N/A** if ward/unit does not store MDAs currently.

9	I	**Security for the storage of MDA drugs is kept separate to security for other medication**
	A	If keys are used, mark **Yes** if key are kept separate from other sets of keys as MDA keys should not travel with other keys. Mark **No** if MDA keys are not separate from other sets of keys. Mark **N/A** if ward/unit does not store MDAs currently. Mark **N/A** if a security system other than keys is utilised in the ward/unit.
10	I	**The child's prescription documentation includes their legible name and healthcare record number**
	A	Mark **Yes** if Name and Healthcare Record Number (HCRN) are on each page. Where organisations do not use HCRN, Date of Birth (DOB) is a valid unique identifier. Mark **No** if all sheets do not have two identification details. Mark **No** if detachable prescription sheets do not have details. Mark **No** if name/HCRN/unique identifier is not legible.
11	I	**The child's identification band has correct and legible name and healthcare record number/unique identifier**
	A	Mark **Yes** if Name and Healthcare Record Number (HCRN)/unique identifier are on ID Band and are legible. Mark **No**, if child is not wearing ID Band or if Name and Healthcare Record Number (HCRN)/ unique identifier are not on ID Band or are not legible. Mark **N/A** if an alternative method of identification other than identification bands are utilised as a method of identification on the ward/unit.
12	I	**The child's allergy status is clearly identifiable on the front page of the prescription chart**
	A	Mark **Yes** if allergy status is clearly identifiable on the front page of the prescription chart (e.g. medication allergies, diagnosed food allergies) or 'No Known Allergies' is stated. Mark **No** if left blank or it is not stated.
13	I	**The child's weight and date of weight are recorded on the front page of the prescription chart**
	A	Mark **Yes** if child's weight and date of weight is recorded on the front page of prescription chart to ensure drug calculations can be accurate. Mark **No** if weight and date of weight is not recorded.
14	I	**The child's locker and bedside/surrounding environment are free of unsecured prescribed medicinal products**
	A	Mark **Yes** if bed space (e.g. top of locker, bed table) does not have any unsecured prescribed medicinal products. Mark **No** if unsecured prescribed medications are found in the child's bed space.
15	I	**The generic name is used as appropriate for each medicine prescribed**
	A	Mark **Yes** if the generic name is used for medications with the following exceptions: combination products or narrow therapeutic index drugs. Mark **Yes** if brand name is used for - combination products, narrow therapeutic index drugs where brand should not be changed - e.g. theophylline MR, lithium preparations, anti-epileptic medication, immunosuppressant drugs (e.g. ciclosporin, tacrolimus, mycophenolate), modified release preparations, controlled drug oral opiates, insulins. Mark **No** if generic name is not used for drugs other than combination products or narrow therapeutic index drugs.

16	I	**The date of commencement of the most recent prescription is recorded**
	A	Mark **Yes** if dates of commencement of all medication prescribed on this admission are recorded. This must include the Day/Month/Year. Mark **No** if all parts of date are not present.
17	I	**The prescription is written in un-joined letters**
	A	Mark **Yes** if the prescription is clear, legible and written un-joined lowercase letters or block capitals. Mark **No** if prescription is not clear or legible and is not written in either un-joined lower case letters or block capitals.
18	I	**The decimal point is clearly marked**
	A	Mark **Yes** if the child's medication prescription contains a decimal and the decimal point is clearly marked. Also mark **Yes** if, for quantities less than 1, a zero is written in front of the decimal point (e.g. 0.5 ml). Mark **No** if the decimal point is not clearly marked or if for quantities less than 1, a zero does not precede the decimal point.
19	I	**The correct legible dose of the medication is recorded with correct use of abbreviations**
	A	Mark **Yes** if the correct dose is prescribed and legible, with the correct use of abbreviations. Mark **No** if the incorrect dose of the medication is prescribed or illegible. Mark **No** if unapproved abbreviations are used. (*International Units, Micrograms, Nanograms and units must not be abbreviated*), check that quantities less than 1 gram are written in **mgs** (e.g. 500 mgs not 0.5g) and quantities less than 1 mg are written in **micrograms** (e.g. 500 micrograms not 0.5mg).
20	I	**The route of medication administration is recorded**
	A	Mark **Yes** if the correct medication administration route is prescribed. Mark **No** if medication administration route is not prescribed.
21	I	**Prescribed medication not administered have an omission code entered and appropriate action taken**
	A	Mark **Yes** if omission codes are used and prescription sheet contains the initials of the nurse omitting prescribed medication in last 72 hours. Documentation of appropriate action following omission of administration of prescribed medication must also be evident in the nursing documentation. Mark **No** if no omission code is used when a prescribed medication is not administered in the last 72 hours or it is not initialled when a drug is not administered. Mark **N/A** if all prescribed medications are administered in the last 72 hours and there is no requirement for an omission code.
22	I	**The time of medication administrations is as prescribed**
	A	Mark **Yes** if all medications were administered at the correct time as per the prescription chart in the last 72hrs. Mark **No** if all medications were not administered at the correct time as per the prescription chart in the last 72hrs.

23	**I**	**The minimum dose interval and/or 24-hour maximum dose is specified for all pro re nata (PRN) medication**
	A	Mark **Yes** if all medication prescribed *"as required/PRN"* states the minimum dose interval for when medication can be administered and/or maximum 24-hour dose. Mark **No** if this information is not provided. Mark **N/A** if no medications are prescribed "as required/PRN".
24	**I**	**The prescription has an identifiable prescriber's signature**
	A	Mark **Yes** if the signature includes NMBI Personal Identification Number (PIN)/Medical Council Number (MCN). Mark **Yes** if prescribers name and signature are identifiable from online signature bank, local signature bank or signature bank on the Drug Prescription Sheet. Mark **No** if PIN/MCN is not present or signature is not readily identifiable itself or from local signature bank. The prescriber's signature can be identifiable if written clearly, if it contains an NMBI Personal Identification Number (PIN) or Medical Council Number (MCN) which is searchable online www.nmbi.ie or www.medicalcouncil.ie or there is an up to date local signature bank.
25	**I**	**Discontinued medications are crossed off, dated and signed by a person who has prescriptive authority**
	A	Check for any discontinued medications on the prescription chart. Mark **Yes** if the drug is correctly crossed out and includes the full date (Day/Month/Year) it was discontinued and an identifiable signature of the prescriber who has discontinued the medication. Mark **No** if any element is not correct. Mark **No** if all discontinued medications do not follow the standard. Mark **N/A** if no medications on the prescription chart have been discontinued.

2.2 Nursing Care Planning Quality Care-Metric

Nursing Care Planning **I** = Indicator, **A** = Data Collectors Advice, **N/A** = Not Applicable		
1	**I**	**The child's name, date of birth and healthcare record number/unique identifier are on each page**
	A	Check documentation to ensure that the child's name, date of birth and HCRN/unique identifier are on each page of the nursing documentation. Mark **Yes** if all components are completed. Mark **No** if any component is omitted.
2	**I**	**The child's admission date and time are recorded**
	A	Mark **Yes** if both date and time are documented on the nursing admission. Time should be recorded using the 24 hour clock. Mark **No** if date/time is not entered using 24 hour clock or if any component is missing.

3	I	**The child's presenting complaints/reason for admission/ attendance is recorded**
	A	Check documentation to ensure that the presenting complaint/ reason for admission/ attendance are recorded. Mark **Yes** if all components are completed. Mark **No** if information is omitted or not clearly recorded.
4	I	**The child's next of kin/family support details are recorded**
	A	Mark **Yes** if next of kin/family support details are recorded on the nursing admission documentation. Mark **No** if this information is not clearly recorded.
5	I	**The child's past medical/surgical history is recorded**
	A	Mark **Yes** if medical and surgical history are recorded and clearly documented on the nursing admission documentation. Mark **No** if history is not recorded on the nursing admission documentation.
6	I	**The child's allergy status is clearly identifiable on relevant nursing documentation**
	A	Mark **Yes** if allergy status is stated (e.g. medication allergies, diagnosed food allergies) or 'No Known Allergies' is stated on relevant nursing documentation. Mark **No** if left blank or allergy status is not stated.
7	I	**All sections of the nursing admission assessment documentation are completed within 24 hours of admission**
	A	Mark **Yes** if **all** sections of the nursing assessment have been undertaken within 24 hrs of admission. Mark **No** if **all** sections of the nursing assessment have not been completed within 24hrs of admission.
8	I	**Nursing care plans are evident and reflect the child's current condition**
	A	Mark **Yes** if a nursing care plan is in place for the child, which reflects the current nursing care needs of the child. Mark **No** if no care plan is devised for the child. Mark **No** if the care plan does not reflect the current nursing care needs of the child.
9	I	**Nursing interventions are individualised, dated, timed (using 24 hr clock) and signed**
	A	Mark **Yes** if nursing interventions (e.g. wound chart, mobilisation plan) are individualised, these should be dated, timed and signed by the assessing staff member. Mark **No** if **all** elements are not present.
10	I	**Evaluation of the nursing care plan is evident and has been updated accordingly**
	A	Mark **Yes** if evaluation of nursing care plan is undertaken in accordance with review date. Mark **No** if evaluation of nursing care plan is not evident. Mark **No** if evaluation of care plan is not in line with planned review date. Mark **N/A** if care plan evaluation review date has not been reached.

11	I	**All nursing records are legible and identifiable**
	A	Mark **Yes** if nursing entries are all legible and all written in permanent ink. Mark **Yes** if all entries have signature of nurse and that a signature bank is available for each signature corresponding to full name. Mark **No** if all elements are not adhered to.
12	I	**All nursing entries are in chronological order**
	A	Mark **Yes** if all entries in the nursing documentation are in chronological order for last 72 hours. Any variance from this, needs to be documented. Mark **No** if not in chronological order or variance not documented.
13	I	**All abbreviations/grading systems used in the nursing record are from a national or approved list/system**
	A	Mark **Yes** if any abbreviations used in the nursing record are from a national or approved list. Mark **No** if any abbreviations used in the nursing record are not on a national or approved list. Mark **N/A** if no abbreviations have been made on the nursing record.
14	I	**All alterations/corrections to the nursing record are as per NMBI guidance**
	A	Mark **Yes** if entries are bracketed with a single line through them and signed and dated with initials of person altering the record. Mark **No** if erasure fluid is used. Mark **No** if alterations do not follow this format. Mark **N/A** if no alterations have been made.
15	I	**Student entries are countersigned by a registered nurse**
	A	Mark **Yes** if **all** nursing student entries in the nursing documentation within the previous 72hrs have been counter signed by a registered nurse. Mark **No** if any student entries in the nursing documentation within the previous 72hrs have not been counter signed by a registered nurse. Mark **N/A** if there are no nursing students currently working in the ward/unit or there were no student entries in the child's nursing documentation during the previous 72hrs.
16	I	**There is evidence of promotion of child and family enablement documented in a communication care plan**
	A	Mark **Yes** if a communication care plan is in place which demonstrates evidence of the promotion of child and family involvement in the management of their illness. Mark **Yes** if there is evidence within the nursing documentation of child and family involvement in the child's care. Mark **No** if there is no evidence of a communication care plan or record within the nursing documentation demonstrating child and family involvement in the management and care of their child.

2.3 Healthcare Associated Infection Prevention Quality Care-Metric

HEALTHCARE-ASSOCIATED INFECTION PREVENTION **I** = Indicator, **A** = Data Collectors Advice, **N/A** = Not Applicable		
1	**I**	**The child's infection status/alert is recorded**
	A	Mark **Yes** if the child's current infection status (e.g. HCAI or communicable infection such as varicella-zoster virus) is evident in the nursing documentation. Mark **No** if the child has a current infection and there is no infection status/alert recorded in the nursing documentation. Mark **N/A** if the child does not have an infection.
2	**I**	**Infection Prevention and Control guidelines are available and accessible**
	A	Mark **Yes** if associated infection prevention and control guidelines are readily available within the ward/unit (e.g. on a Quality and Safety Management System; Q-Pulse) The guidelines must be the most current publication and should be located to facilitate easy access for the nurse to reference. Mark **No** if guidelines are unavailable or are not the most recent publication.
3	**I**	**There is evidence of appropriate nursing action in the event of a Healthcare-Associated Infection**
	A	Mark **Yes** if there is documented evidence of the nursing response and actions taken in the event that a child is diagnosed with a Healthcare-Associated Infection (HCAI) (e.g. isolation precautions/ use of personal protective equipment (PPE)) Mark **No** if there is no documented evidence of appropriate nursing action in the event of a HCAI. Mark **N/A** if the child does not have a HCAI
4	**I**	**The child's infection status and any associated risk is communicated to the family and multidisciplinary team**
	A	Mark **Yes** if there is evidence within the nursing documentation that the child's infection status and any associated risk/ precautions required has been communicated to the family and wider multidisciplinary team e.g. physiotherapist/ support staff. Mark **No** if there is no record of communication in relation to infection status and associated risk/precautions within the nursing documentation. Mark **N/A** if the child does not have an infection.
5	**I**	**There is evidence that a care bundle has been completed for each invasive medical device in use**
	A	Mark **Yes** if a care bundle is fully completed for each invasive medical device in use. All components of the care bundle must be undertaken and up to date. Mark **No** if the care bundle has not been completed for each invasive medical device in use or is not up to date. Mark **N/A** if the child does not have an invasive medical device in situ.

2.4 Nutrition Quality Care-Metric

NUTRITION **I** = Indicator, **A** = Data Collectors Advice, **N/A** = Not Applicable		
1	**I**	**There is evidence of on-going monitoring of the child's weight**
	A	Mark **Yes** if the child's weight has been measured and recorded on admission and the child has been monitored for any weight loss or weight gain as appropriate. Mark **No** if there is no documented evidence of on-going monitoring of the child's weight. Mark **N/A** if ongoing weight monitoring is not medically indicated as per the individual care plan.
2	**I**	**There is evidence that the child's fluid balance has been assessed and managed**
	A	Mark **Yes** if an accurate fluid balance record has been maintained for the child and evidence of relevant nursing action taken to manage the child's hydration status as clinically appropriate. Mark **No** if an accurate fluid balance record has not been maintained or action taken to manage hydration has not been documented. Mark **N/A** if the child does not require fluid balance monitoring.
3	**I**	**Information and support is made available for breastfeeding mothers**
	A	Mark **Yes** if there is documented evidence that information and support has been provided to breastfeeding mothers to facilitate them to breastfeed. Mark **No** if there is no documented evidence of any information or support provided to breastfeeding mother. Mark **N/A** if the child is not receiving breastmilk.

2.5 Pain Assessment and Management Quality Care-Metric

PAIN ASSESSMENT AND MANAGEMENT **I** = Indicator, **A** = Data Collectors Advice, **N/A** = Not Applicable		
1	**I**	**The child's pain is assessed and recorded using a developmentally appropriate pain scoring tool**
	A	Mark **Yes** if there is evidence that the child's pain has been assessed and documented using a developmentally appropriate pain scoring tool at least every 12 hours. Mark **No** if there is no documentation of the child's level of pain using a developmentally appropriate pain scoring tool at least every 12 hours. Mark **N/A** if there is documented evidence that the child has not experienced pain within the last 24hrs.

2	**I**	**There is evidence that a pain care plan was initiated**
	A	Mark **Yes** if a pain care plan was initiated. Mark **No** if a pain care plan has not been initiated. Mark **N/A** if there is documented evidence that the child has not experienced pain within the last 24hrs and a pain care plan is not required.
3	**I**	**There is evidence that the child's pain management is recorded in nursing documentation**
	A	Mark **Yes** if the nursing plan of care to assess, manage and evaluate the child's pain is recorded in the nursing documentation/pain care plan. Mark **No** if there is no evidence of the child's pain management recorded in the nursing documentation/ pain care plan. Mark **N/A** if there is documented evidence that the child has not experienced pain within the last 24hrs and a pain care plan is not required.
4	**I**	**Re-evaluation of pain scores are recorded before and after a pain relieving intervention**
	A	Mark **Yes** if a pain assessment is documented using a developmentally appropriate tool before a pain-relieving intervention **and** a pain assessment is documented using a developmentally appropriate tool within one hour after a pain relieving intervention Mark **No** if a pain assessment is not documented using a developmentally appropriate pain tool before a pain-relieving intervention. Mark **No** if a pain assessment is not documented using a developmentally appropriate tool within one-hour post a pain relieving intervention. Mark **N/A** if the child's pain score did not require a pain relieving intervention within the last 24hrs.

2.6 Vital Signs Monitoring/ PEWS Quality Care-Metric

VITAL SIGNS MONITORING/PEWS QUALITY CARE-METRIC **I** = Indicator, **A** = Data Collectors Advice, **N/A** = Not Applicable		
1	**I**	**The child's baseline physiological observations were assessed, calculated and recorded using the age-appropriate national PEWS system**
	A	Mark **Yes** if the child's baseline physiological observations were assessed calculated and recorded on admission using the correct age-appropriate PEWS chart. Mark **No** if the child's baseline physiological observations were not recorded and/or PEWS score not calculated appropriately on the PEWS chart or an incorrect age chart was used.
2	**I**	**The child's physiological observations have been reassessed, calculated and recorded using the age-appropriate PEWS system**
	A	Mark **Yes** if the child's physiological observations have been reassessed, calculated and recorded as directed (e.g. hourly, 6 hourly) by the age-appropriate PEWS guideline during the previous 72hrs. Mark **No** if the child's physiological observations have not been reassessed, calculated and recorded as directed by the age-appropriate PEWS guideline during the previous 72hrs. Mark **No** if any data is missing or total score is not present/ or is inaccurate.

3	I	**Any deterioration in the child's condition is documented and there is evidence of adherence to the minimum observation frequency as per age-appropriate national PEWS guidelines**
	A	Mark **Yes** if frequency of vital signs is increased or decreased in response to change in condition as per the age-appropriate national PEWS guideline. Mark **No** if there is no evidence of change of frequency of vital signs relevant to change in condition. Mark **N/A** if no deterioration occurred.
4	I	**In the event of a deterioration, there is documented evidence of escalation of the child's care and communication to the medical team using the ISBAR as per the age-appropriate national PEWS escalation protocol**
	A	If there is evidence of deterioration in the child's condition during the previous 72hrs, mark **Yes** if there is documentation that the child's care was escalated and communicated as appropriate using ISBAR and the child was reviewed by appropriate personnel as per National PEWS escalation protocol. Mark **No** if there is no documented evidence of escalation and communication to appropriate personnel using ISBAR. Mark **N/A** if there has been no deterioration in the child's condition during the previous 72hrs.
5	I	**There is documentation of the nursing care that has been provided to manage a deterioration in the child's condition (management plan)**
	A	If there is evidence of deterioration in the child's condition during the previous 72hrs, mark **Yes** if there is documentation of the nursing care that has been provided to manage the deterioration. Mark **No** if there is no evidence of the nursing care that was provided to manage the deterioration. Mark **N/A** if there has been no deterioration in the child's condition during the previous 72hrs.
6	I	**In the event of infection/sepsis, there is documented evidence of escalation as per national PEWS sepsis/infection protocol**
	A	In the event of an incidence of infection/sepsis during the previous 72hrs, mark **Yes** if there is documentation of the escalation as per national PEWS sepsis/infection protocol. Mark **No** if there is no documented evidence of the escalation as per national PEWS sepsis/infection protocol. Mark **N/A** if the child has not had an incidence of infection/sepsis during the previous 72hrs.

2.7 Child and Adolescent Mental Health Quality Care-Metric

CHILD AND ADOLESCENT MENTAL HEALTH **I** = Indicator, **A** = Data Collectors Advice, **N/A** = Not Applicable		
1	**I**	**A child and adolescent mental health care plan has been initiated where appropriate**
	A	Mark **Yes** if there is evidence that a nursing plan of care for the child/adolescent's mental health concern (e.g. anxiety, self-harm, eating disorder, psychosis) has been documented and initiated where appropriate. Mark **No** if a referral has been made for the child, but no nursing care plan has been initiated. Mark **N/A** if mental health care is not required as medically indicated for the child.
2	**I**	**There is documentation within the nursing record/care plan when a mental health referral has been made for the child/adolescent**
	A	Mark **Yes** if there is documentation within the nursing record/care plan that a referral has been made to the relevant mental health service (e.g. ED mental health team, paediatrics liaison service). Mark **No** if it has not been documented in the nursing record/care plan that the child/adolescent has been referred to the relevant mental health service. Mark **N/A** if a mental health referral is not required for the child/adolescent.
3	**I**	**The child/adolescent and family have been given contact details for advice/follow up with the relevant child and adolescent mental health team/service**
	A	Mark **Yes** if there is documented evidence that the child and family have been given contact details of the relevant mental health team/service for on-going advice / follow up. Mark **No** if there is no documentation that the child and family have been given follow up mental health team/service contact information. Mark **N/A** if on-going mental health care is not required for the child.
4	**I**	**The reason for the application of clinical holding is documented**
	A	Mark **Yes** if the reason for clinical holding is documented following exploration of alternatives to clinical holding for non-urgent care. Mark **No** if there is no documentation of the reason for the application of clinical holding. Mark **N/A** if clinical holding was not required.
5	**I**	**Evidence for alternatives to clinical holding were explored**
	A	Mark **Yes** if there is documented evidence that alternatives to clinical holding were explored for non-urgent care including play therapy and distraction, age appropriate psychological preparation of the child and family for the procedure. Mark **No** if there is no documentation that alternatives to clinical holding were explored for non-urgent care. Mark **N/A** if clinical holding was not required.

2.8 Discharge Planning Quality Care-Metric

DISCHARGE PLANNING **I** = Indicator, **A** = Data Collectors Advice, **N/A** = Not Applicable		
1	**I**	**There is documented evidence of discharge planning**
	A	Mark **Yes** if there is documented evidence that integrated discharge planning has been commenced as soon as possible and at least within 24 hours of the child's admission (e.g. discharge care plan). Mark **No** if there is no evidence of integrated discharge planning following the child's admission.
2	**I**	**There is evidence of involvement of the child and family in the discharge plan**
	A	Mark **Yes** if there is documented evidence that the child and/or family have been involved/ consulted in the discharge plan. Mark **No** if there is no documented evidence of discharge planning discussions with the child and family. Mark **N/A** if the child is not admitted longer than 24 hours.
3	**I**	**There is evidence of the provision of post discharge advice to the child/family**
	A	Mark **Yes** if there is evidence in the discharge plan that the child/family has been provided with post discharge advice (e.g. contact details/follow up arrangements). Mark **No** if there is no documented evidence of the provision of post discharge advice. Mark **N/A** if the child is not admitted longer than 24 hours.

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 TYCHSE 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 (ONMSD 2018 - 028) 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.

3.1.6 If safety concerns arise when collecting Quality Care-Metrics, the data collector should 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.

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

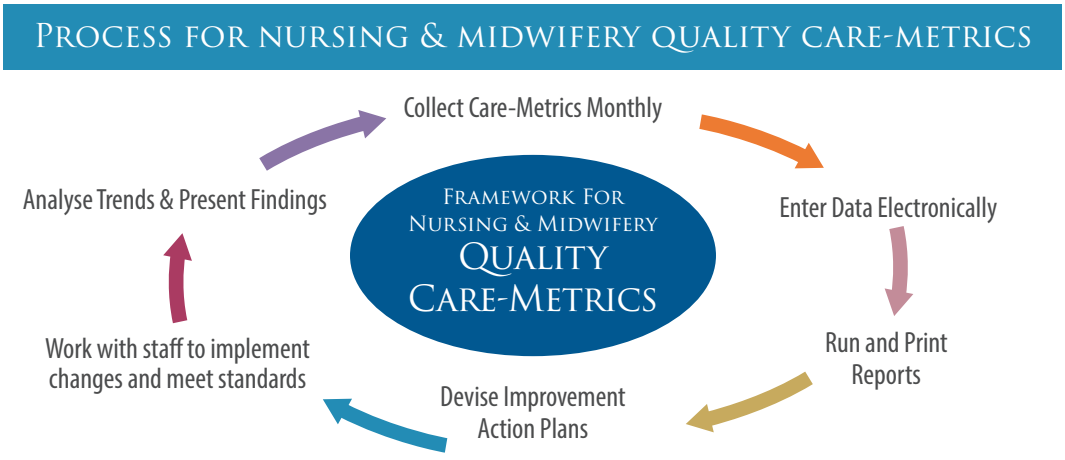

Figure 2: Undertaking Quality Care-Metrics at Service Level

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 only required to examine the healthcare records for the 72 hours preceding data collection.

3.4 Accessing Test Your Care HSE (TYC 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 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 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 Care-Metric responses for each clinical area)
- **Report:** Reporting on the results of the 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)

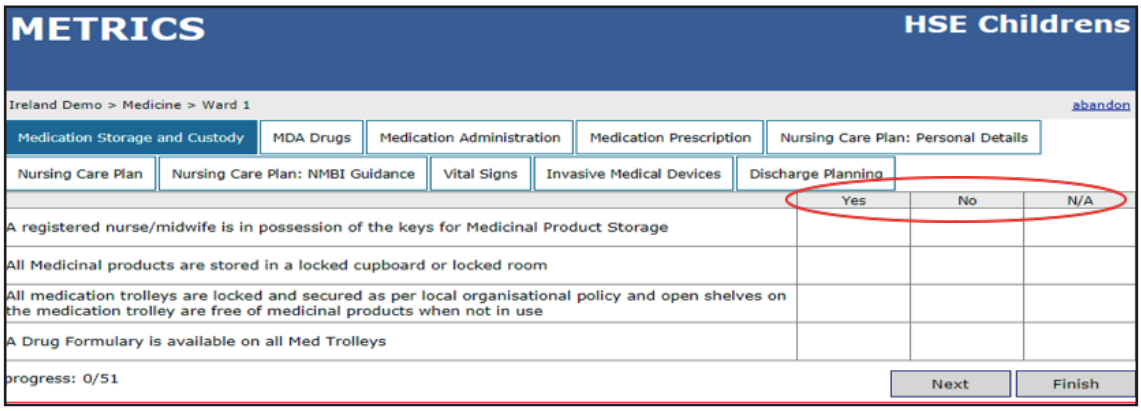

Figure 5: Data Entry: TYC HSE System (1)

- 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

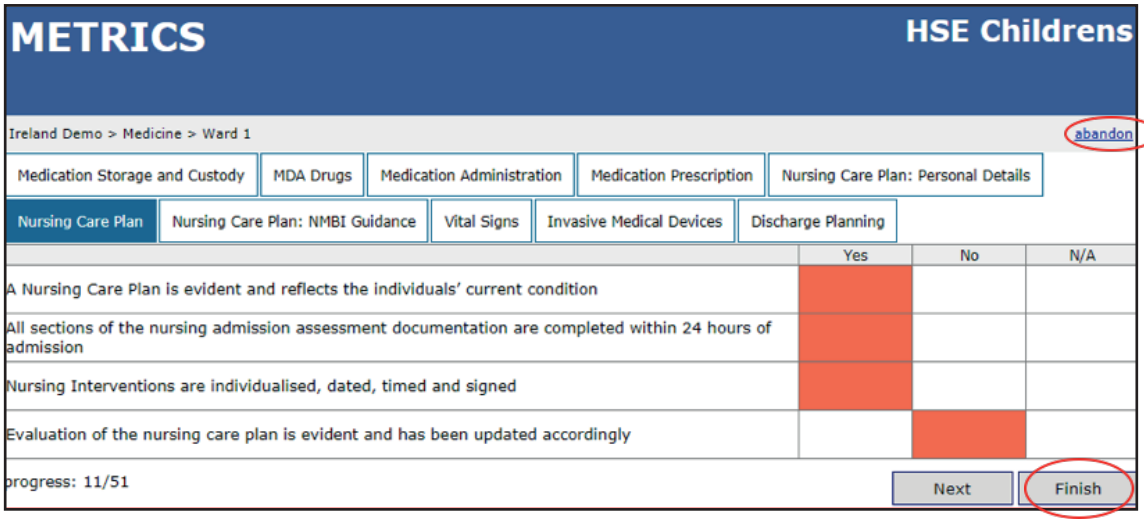

Figure 6: Data Entry: TYC HSE System (2)

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.

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

Figure 7: Traffic Light Scoring System

4.1.2 The highlighted score will be colour coded as illustrated in Figure 7 and is shown in three 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)

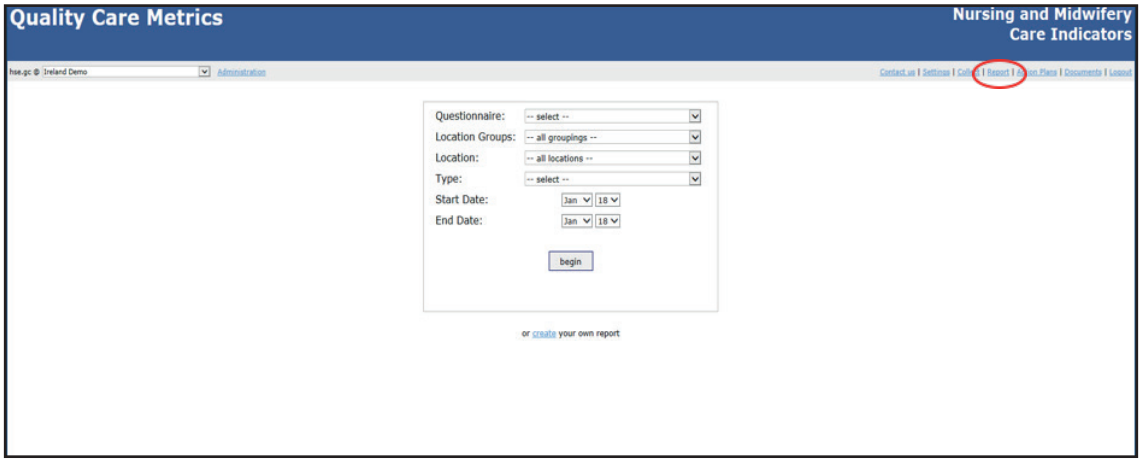

Figure 9: Accessing Reports from TYC HSE

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. Midwifery, Acute, Theatre, Children's, Public Health
- **Location Groups** – Select groupings such as antenatal, labour, postnatal 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. Midwifery, Acute, Theatre, Children's, Public Health
- **Location Groups** – Select groupings such as antenatal, labour, postnatal 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. HSE Children's. HSE Theatre etc.
- 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'

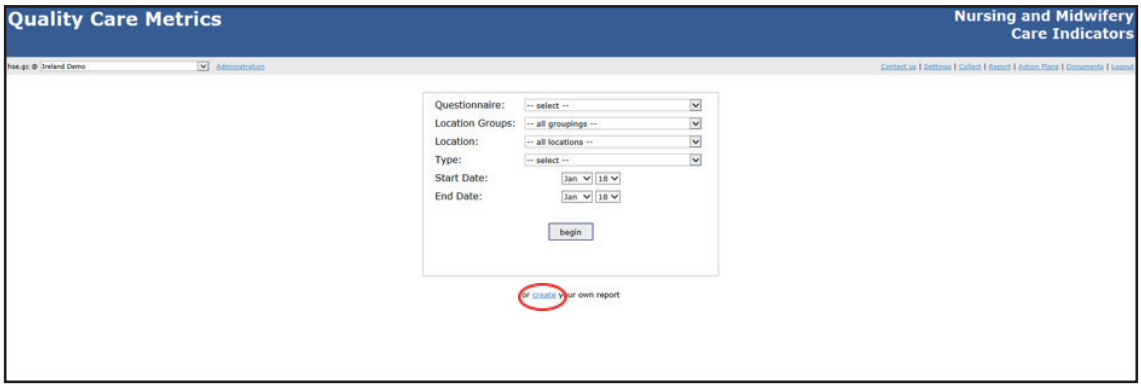

Figure 10: Create your own Report

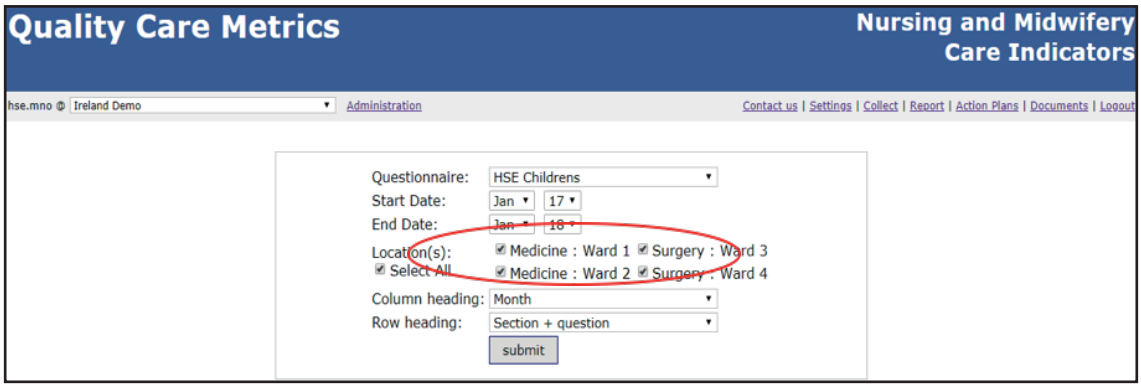

Figure 11: Create Your Own Report (1); Column Heading: Month and Row Heading: Section and Question

- This selection, **'Column Heading: Month and Row Heading: Section and Question'** supports the CMM/CNM 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 (1) 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'

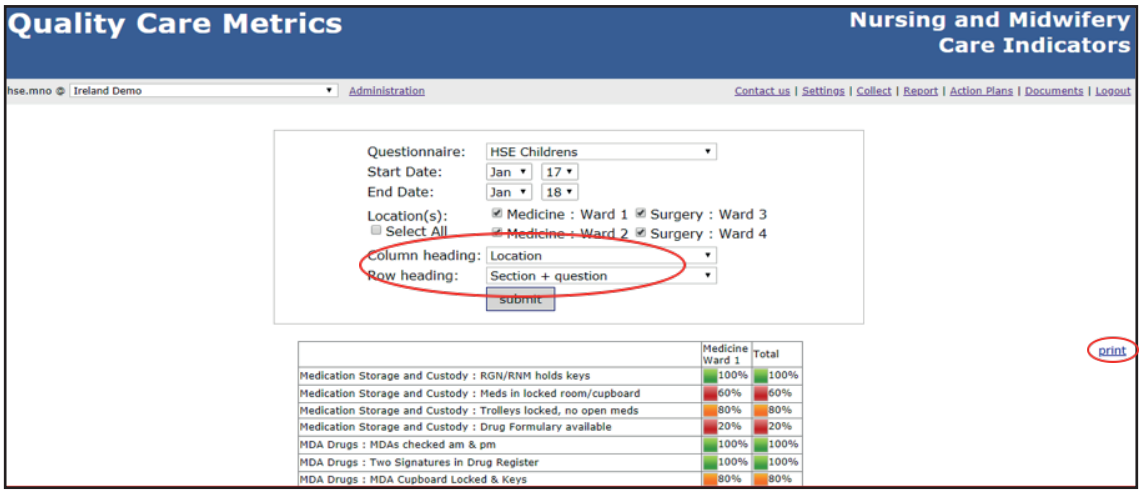

Figure 13: Create Your Own Report (2); Results; Column Heading: Location and Row Heading: Section and Question

- 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. Intellectual Disability
- Select the **start** and **end date**
- **Location** –Select **ward** or **select all** from the list
- **Column Heading** –select **month** (this puts the month (s) across the top of the page for viewing)
- **Row Heading** – select **location grouping** to show overall results for location grouping
- Click **submit** button
- A print friendly version of the report is available by clicking the 'print'

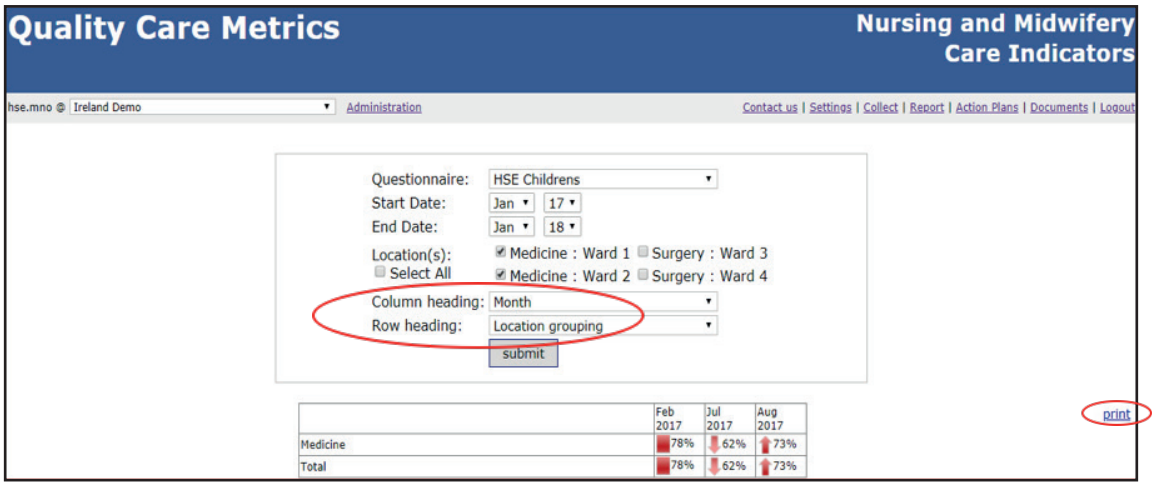

Figure 14: Create Your Own Report (3); Results; Column Heading: Month and Row Heading: Location Grouping

- 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).

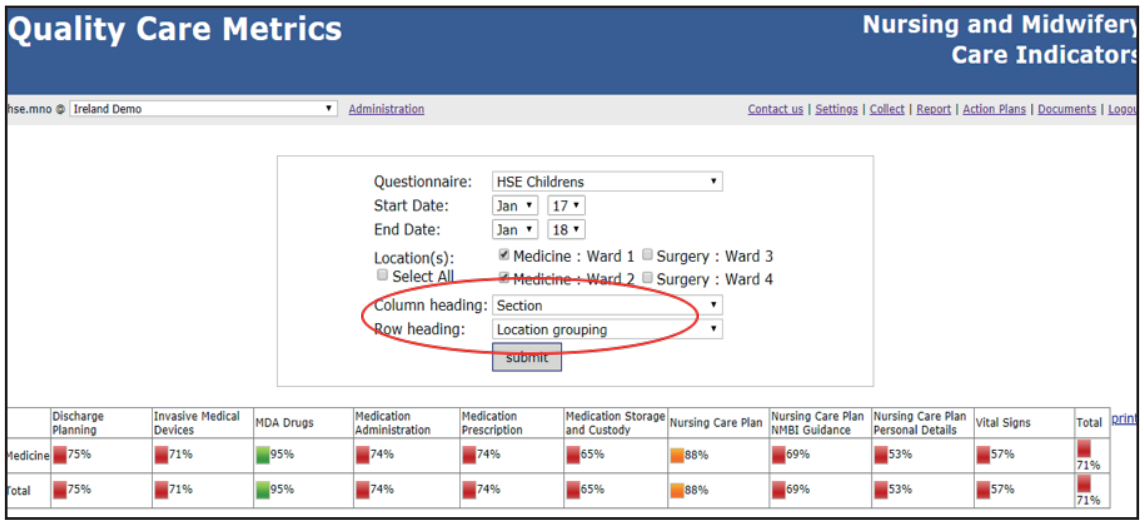

Figure 15: Create Your Own Report (3) Results; Results; Column Heading: Section and Row Heading: Location Grouping

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** Link. Click **"Action Plans"** and complete the data fields as per example below in Figure 16.

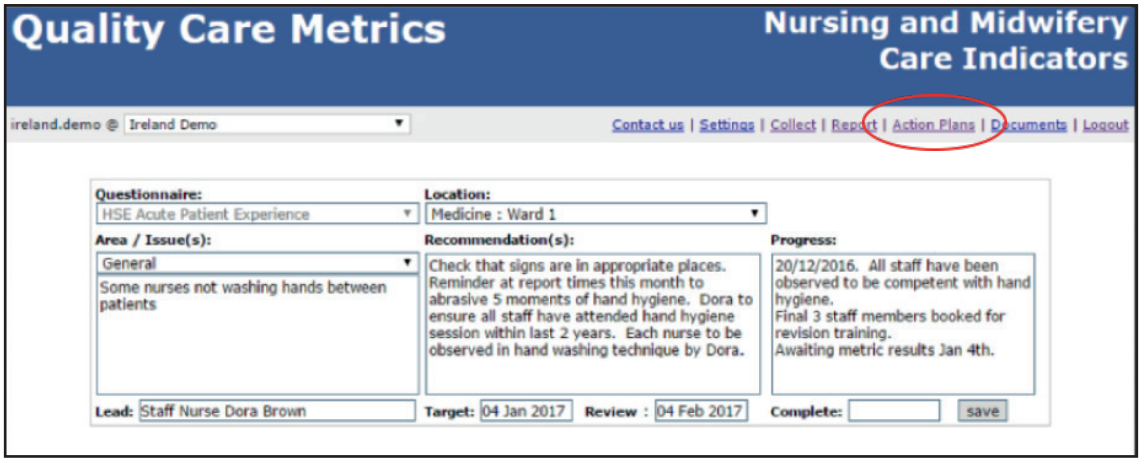

Figure 16: Accessing Action Planning on Test Your Care HSE

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

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 been done?

5.2.7 Step 7; Share what Works

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

6.0REFERENCES

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

Health Service Executive (HSE). (2018a) *Nursing and Midwifery Quality Care-Metrics: Children's Services Research Report*. HSE Office of Nursing and Midwifery Services Director

Health Service Executive (HSE) (2018) National Guideline for Nursing and Midwifery Quality Care-Metrics Data Measurement in Children's Services 2018 (ONMSD 2018 - 028). Available online at: https://www.hse.ie/eng/about/who/onmsd/safecare/qcm/qcm-pppgs.html

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 Childrens Services 2018 (ONMSD 2018 - 028)

7.0 APPENDICES

Appendix I
GLOSSARY OF TERMS AND DEFINITIONS

Appendix II
ABBREVIATIONS

Appendix III
IMMEDIATE SAFETY/RISK IDENTIFICATION FORM FOR NURSING AND MIDWIFERY METRICS

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 2018a).

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 2018a).

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

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
ED	Emergency Department
GP	General Practitioner
HIQA	Health Information and Quality Authority
HCRN	Healthcare Record Number
HSE	Health Service Executive
ID	Identification Band
MCN	Medical Council Number
MR	Modified Release
NMBI	Nursing and Midwifery Board of Ireland
ONMSD	Office of the Nursing and Midwifery Services Director
PEWS	Pediatric Early Warning Score
PIN	Personal Identification Number
PPE	Personal Protective Equipment
PPPG	Policies, Procedures, Protocols and Guidelines
PRN	Pro re nata (as required)
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.

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

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

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 Children's Quality Care-Metrics developmentare listed here.

The complete list of references can be accessed in the National Guideline for Nursing and Midwifery Quality Care-Metrics Data Measurement in Children's Services 2018 (ONMSD 2018 - 028).

- *National Standards for Safer Better Healthcare.* (HIQA, 2012)
- *General Guidance on the National Standards for Safer Better Healthcare.* (HIQA, 2012a)
- *Hygiene Services Assessment Scheme.* (HIQA, 2006)
- *National Framework for Developing Policies, Procedures, Protocols and Guidelines (PPPGs).* (HSE, 2016a)
- *Integrated Care Guidance: A Practical Guide to Discharge and Transfer from Hospital.* Version 2, (HSE, 2014)
- *National Consent Policy. National Consent Advisory Group.* (HSE, 2014a)
- *Standards and Recommended Practices for Healthcare Records Management.* Version 3, (HSE, 2011)
- *Code of Practice for Healthcare Records Management-Abbreviations.* (HSE, 2010)
- *Nurses and Midwives Act.* (Government of Ireland, 2011)
- *Guidance to Nurses and Midwives on Medication Management.*(ABA, 2007)
- *Standards for Registered Nurses and Midwives on Medication Administration.* (NMBI, 2018) DRAFT
- *Scope of Nursing and Midwifery Practice Framework.* (NMBI, 2015)
- *Code of Professional Conduct and Ethics for Registered Nurses and Registered Midwives.* (NMBI, 2014)
- *Recording Clinical Practice Guidance to Nurses and Midwives.* (NMBI, 2014a)
- *Dalkey, N. & Helmer, O.* (1963) An experimental application of the Delphi method to the use of experts.
- Flenady, et al. (2016) *eRegistries: indicators for the WHO Essential Interventions for reproductive, maternal,newborn and child health. BMC Pregnancy and Childbirth,*
- Hsu, C.C. (2007) *The Delphi Technique: Making Sense of Consensus.*
- *Jagosh, J.,et al.(2012) Uncovering the benefits of participatory research: implications of a realist review for health research andpractice.*
- *Maben, J., et al. (2012) High Quality Care Metrics for Nursing*
- *Nolan, M., et al. (1998) Evidence-based care: can we overcome the barriers?*
- *Stetler, C.B., et al. (2006) The Role of Formative Evaluation in Implementation Research and the QUERI Experience.*
- *Upton, D. & Upton, P. (2005) Nurses' attitudes to evidence-based practice: impact of a national policy.*

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
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