SUMMARY DOCUMENT

NATIONAL SUMMARY GUIDANCE

FOR NURSING AND MIDWIFERY QUALITY CARE-METRICS DATA MEASUREMENT IN

INTELLECTUAL DISABILITY SERVICES 2018

To be used in conjunction with the National Guideline for Nursing and Midwifery Quality Care-Metrics Data Measurement in Intellectual Disability Services 2018 (ONMSD 2018 - 026)

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 the Intellectual Disability services.

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

1.2 Scope

1.2.1 This summary guidance applies to all registered nurses and midwives within Intellectual Disability 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 Intellectual Disability Research Report (HSE 2018) and the National Guideline for Nursing and Midwifery Quality Care-Metrics Data Measurement in Intellectual Disability Services 2018 (ONMSD 2018 -026).

1.2.4 All nurses and midwives within Intellectual Disability 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 Intellectual Disability Services 2018 (ONMSD 2018 - 026) 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 Intellectual Disability Services (ONMSD 2018 - 026), will enable consistency in the reliability and validity of the data collection to support a standardised approach in Intellectual Disability 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 INTELLECTUAL DISABILITY SERVICES

The following Nursing Quality Care-Metrics are available for Intellectual Disability services as outlined in Figure 1.

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

Figure 1: Intellectual Disability Quality Care-Metrics

2.1 Nursing Documentation Quality Care-Metric

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

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

2.2 Medicines Management Quality Care-Metric

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

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

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

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

2.3 Environment Quality Care-Metric

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

2.4 Safeguarding Quality Care-Metric

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

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

2.5 Person Centred Communication Quality Care-Metric

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

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

2.6 Physical Health Assessment Quality Care-Metric

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

2.7 Mental Health Assessment Quality Care-Metric

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

2.8 Risk Assessment and Management Quality Care-Metric

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

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

2.9 Nursing Care Plan Quality Care-Metric

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

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

2.10 Person Centred Planning Quality Care-Metric

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

2.11 Positive Behaviour Support Quality Care-Metric

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

2.12 End of Life/Palliative Care Quality Care- Metric

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

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

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 (ONMSD 2018 - 026) 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/unit they are attending, following protocols for that service, to include: obtaining permission as required entering the clinical area, dress code as per policy and adherence to infection prevention and control procedures in the clinical area/unit.

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.

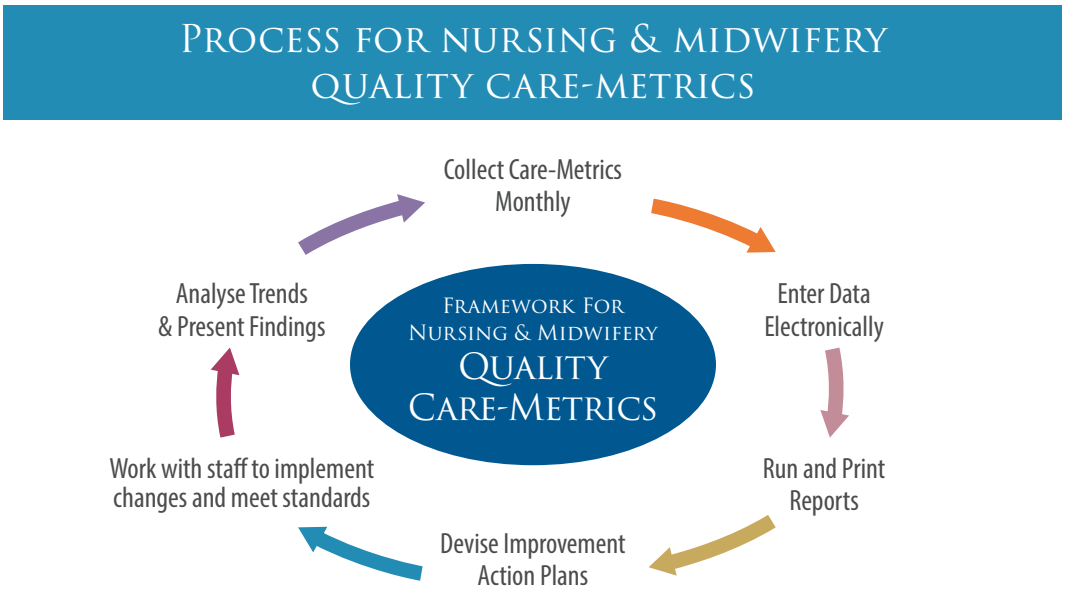

Figure 2: Undertaking Quality Care-Metrics at Service Level

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

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

- Collect only
- Collect and Report

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

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

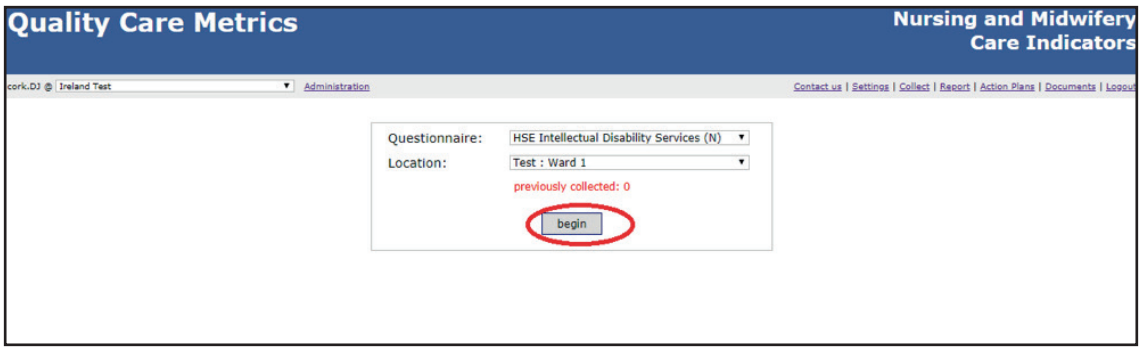

Figure 4: Data Entry: TYC HSE System

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

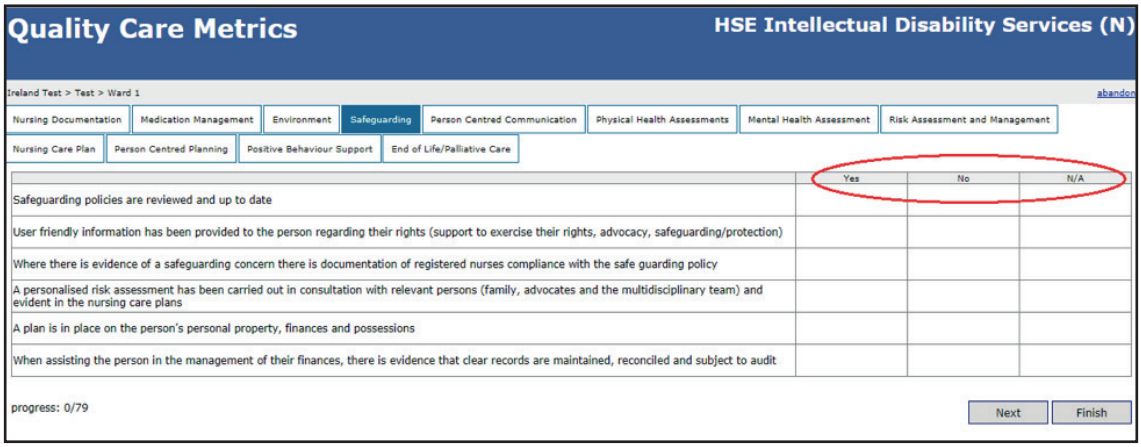

Figure 5: Data Entry: TYC HSE System (1)

- 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

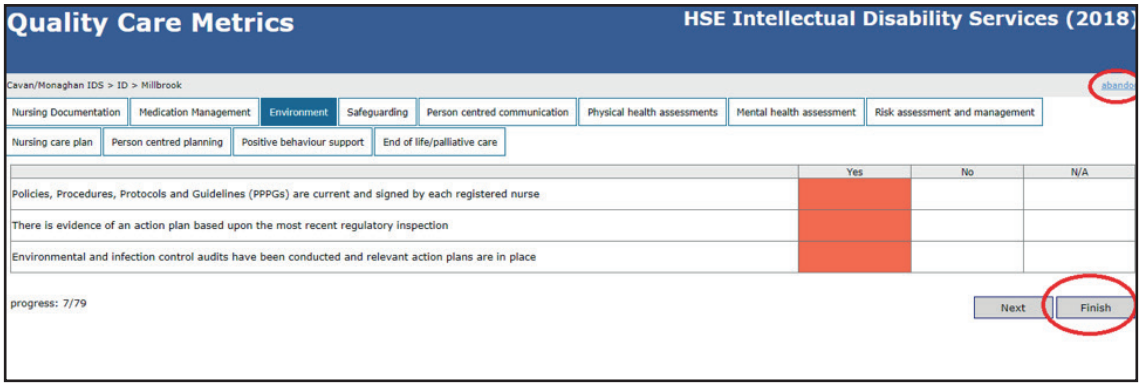

Figure 6: Data Entry: TYC HSE System (2)

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. The arrows will be coloured according to the score achieved and so could be any of the 3 colours green, amber or red (Figure 8 is for arrow illustration only).

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

Figure 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)

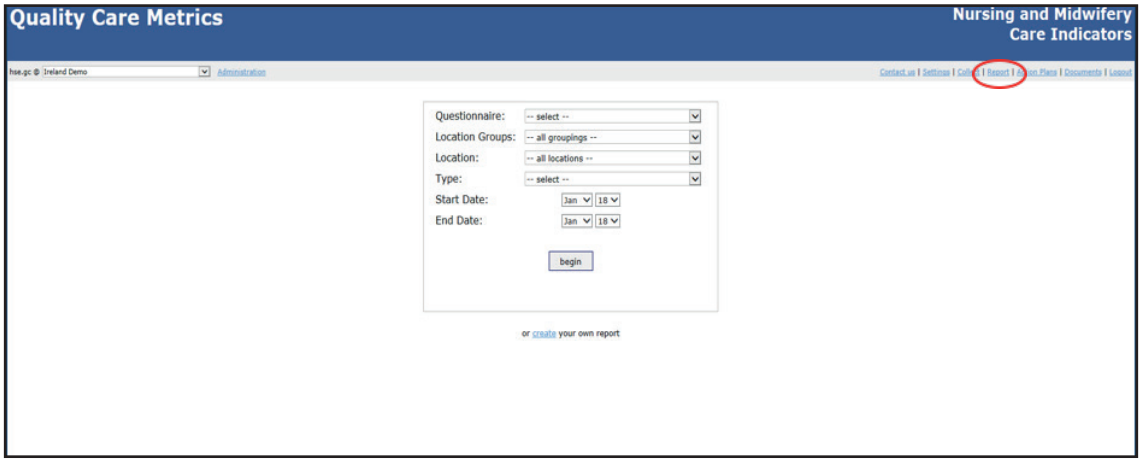

Figure 9: Accessing Reports from TYC HSE

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

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

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

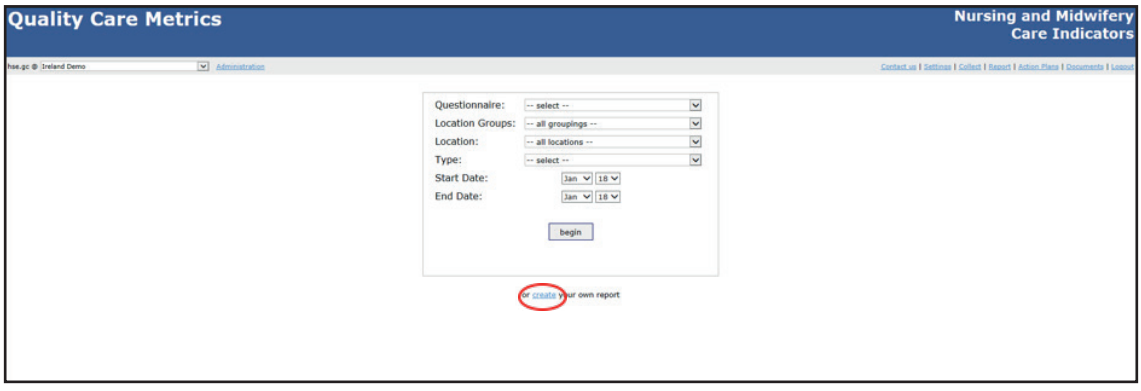

Figure 10: Create your own Report

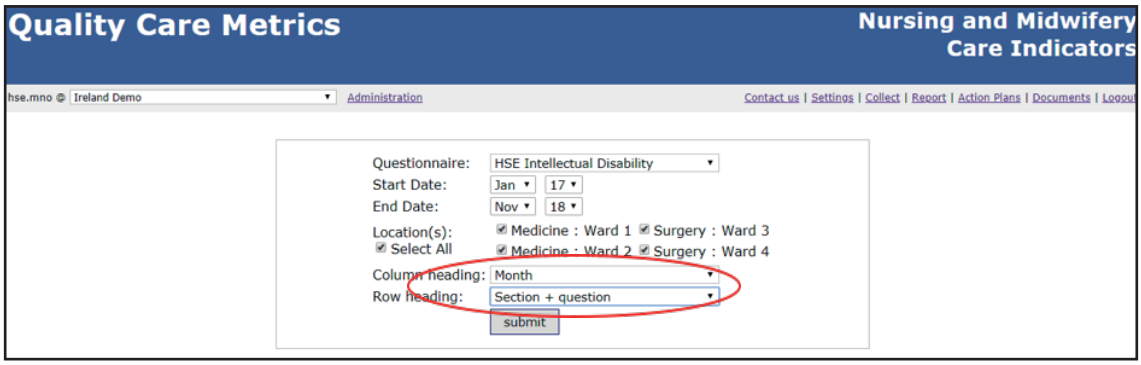

Figure 11: Create your own Report; Column Heading: Month and Row Heading: Section and Question

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

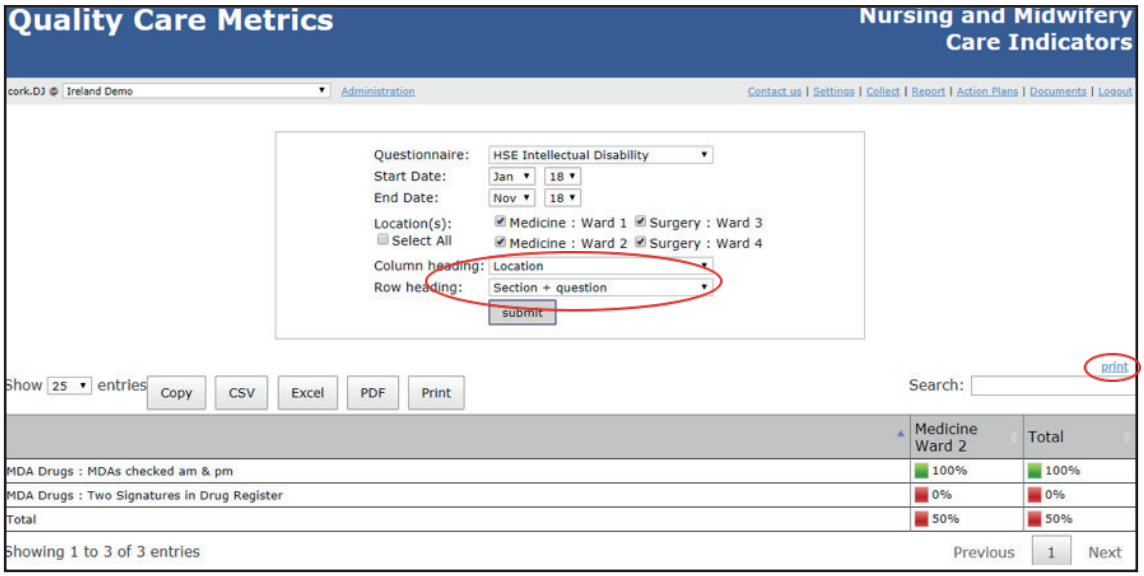

Figure 13: Create your own Report; Results; Column Heading: Location and Row Heading: Section and Question

- This selection, **'Column Heading: Location and Row Heading: Section and Question'** supports the CNM 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'

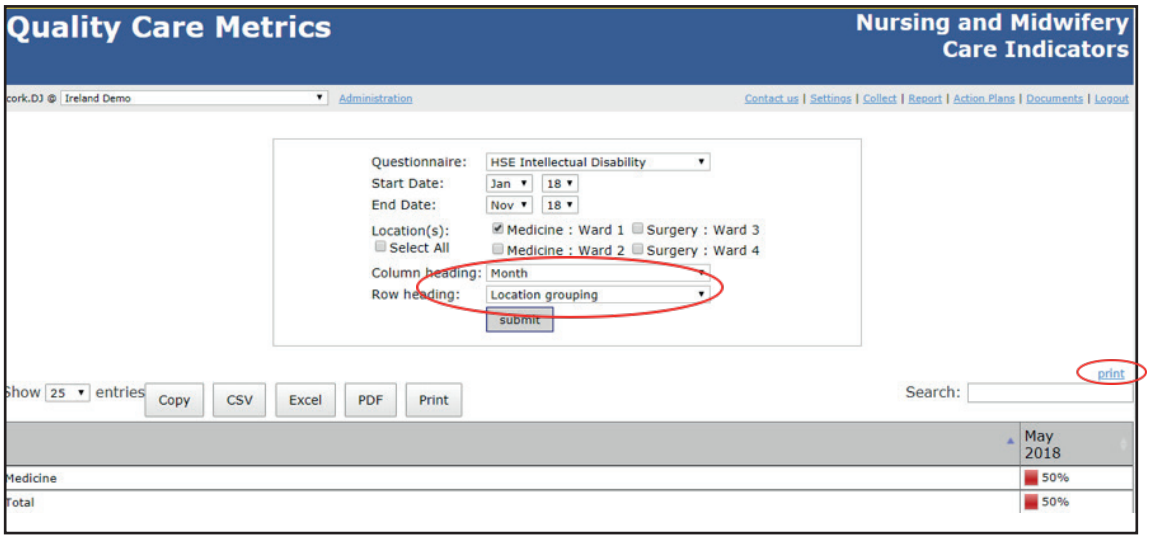

Figure 14: Create your own Report; Results; Column Heading: Month and Row Heading: Location Grouping

- 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).

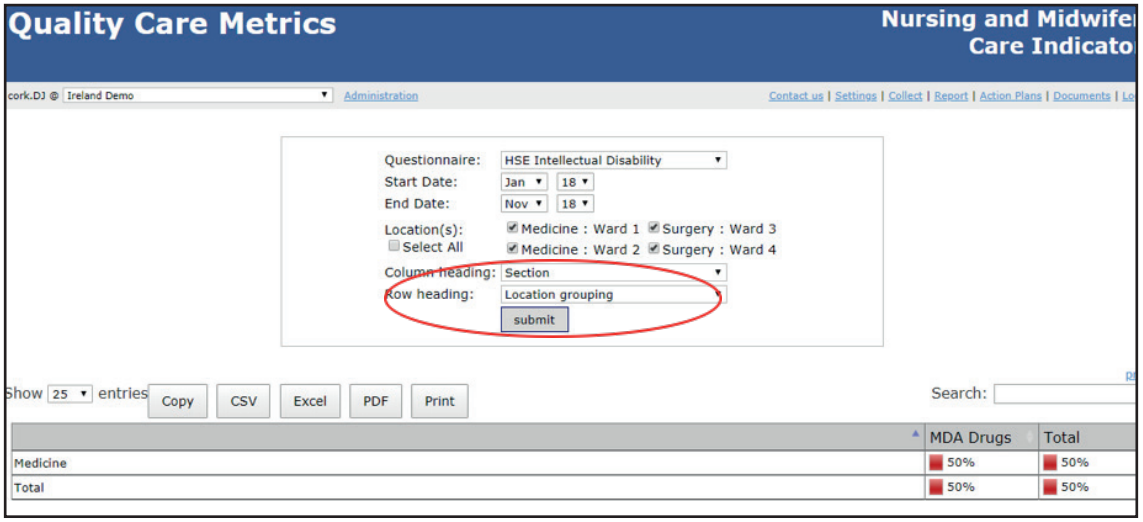

Figure 15: Results; Column Heading: Section and Row Heading: Location Grouping

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.

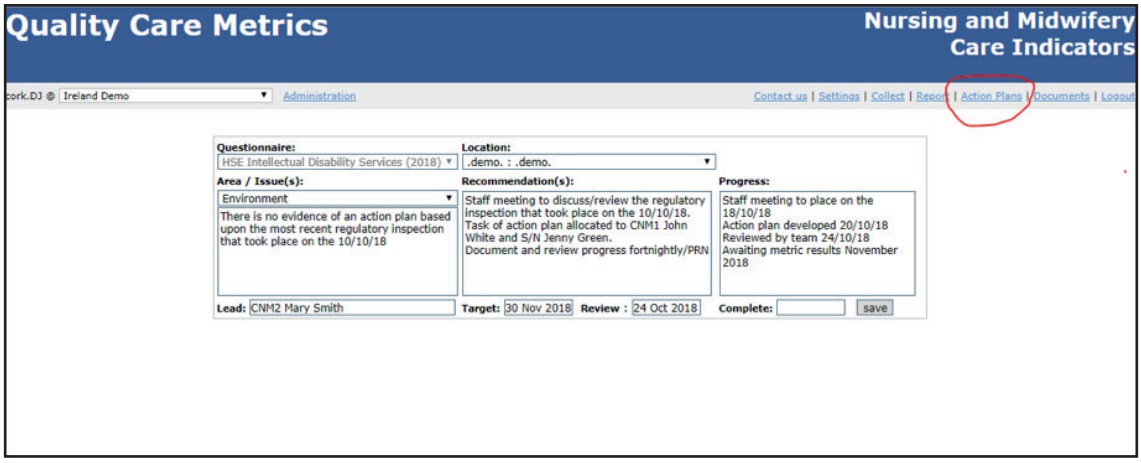

Figure 16: Accessing Action Planning on Test Your Care HSE

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

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

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: Intellectual Disability Research Report.* Dublin: Health Services Executive.

Health Service Executive (HSE). (2018g) *National Guideline for Nursing and Midwifery Quality Care Metrics Data Measurement in Intellectual Disability Services.* Dublin: Health Services Executive.

McHugh, M. L. (2012) *Interrater 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 Intellectual Disability Services 2018 (ONMSD 2018 -026).

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 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
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.

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 Intellectual Disability 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-Metric Data Measurement in Intellectual Disability Services 2018 (ONMSD 2018 - 026)

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

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

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

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

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

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

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

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

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

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

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

NURSING & MIDWIFERY

QUALITY CARE-METRICS

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

Health Service Executive
Dr. Steevens' Hospital
Dublin 8
Ireland

www.hse.ie/go/onmsd