NATIONAL SUMMARY GUIDANCE

FOR NURSING AND MIDWIFERY QUALITY CARE-METRICS DATA MEASUREMENT IN

MENTAL HEALTH SERVICES 2018

To be used in conjunction with the National Guideline for Nursing and Midwifery Quality Care-Metrics Data Measurement in Mental Health Services 2018 (ONMSD 2018 - 025)

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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

Contents

Figures

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 Mental Health 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 Mental Health services nationally. The quality of data is very important as it may be used to inform the delivery of care. In this regard, it is vital that services know how reliable their data actually is.

1.2 Scope

1.2.1 This summary guidance applies to all registered nurses and midwives within Mental Health 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 Mental Health Research Report (HSE 2018) and the National Guideline for Nursing and Midwifery Quality Care-Metrics Data Measurement in Mental Health Services 2018 (ONMSD 2018 -025).

1.2.4 All nurses and midwives within Mental Health 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 Mental Health Services 2018 (ONMSD 2018 - 025) 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 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 Mental Health Services 2018 (ONMSD 2018 - 025), will enable consistency in the reliability and validity of the data collection to support a standardised approach in Mental Health 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 MENTAL HEALTH SERVICES

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

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

Figure 1: Mental Health Quality Care-Metrics

2.1 Assessment Quality Care-Metric

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

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

2.2 Care Plan Quality Care-Metric

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

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

2.3 Management of Risk Quality Care-Metric

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

2.4 Management of Violence and Aggression Quality Care-Metric

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

2.5 Physical Health and Wellbeing Quality Care-Metric

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

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

2.6 Recovery Based Care Quality Care-Metric

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

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

2.7 Nursing Communication Quality Care-Metric

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

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

2.8 Medication Management Quality Care-Metric

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

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

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

15	I	**The prescription is written in block letters**
	A	Mark **Yes** if the prescription is clear, legible and written un-joined lowercase letters or block capitals. Mark **No** if prescription is not clear or legible and is not written in either un-joined lower case letters or block capitals. Mark **N/A** if no prescription documentation is utilised. Complete a Safety/Risk Form if safety concerns are present so that the prescription can be corrected (Appendix III).
16	I	**The correct legible dose of the medicine is recorded with correct use of abbreviations**
	A	Mark **Yes** if the correct dose is prescribed and is legible and abbreviations used are approved. If decimals are used, check that a zero is written in front of the decimal point when there is no other figure (e.g 0.5, 0.25). Mark **No** if the correct legible dose of the medicine is not recorded, or if unapproved abbreviations are used. Mark **N/A** if no prescription documentation is utilised. *(International Units, Micrograms, Nanograms and units must not be abbreviated)*, Check that quantities less than **1 gram** are written in **mgs** and quantities less than **1 mg** are written in **micrograms**. In cases where the dose of a drug is related to weight, ensure the weight is recorded in order to calculate correct dose.
17	I	**The route and/or site of administration is recorded**
	A	Mark **Yes** if the correct route is recorded and if applicable that the site is identified. Mark **No** if route and/ or site are not recorded. Mark **N/A** if no prescription documentation is utilised.
18	I	**The frequency of medicines administration is recorded and correct timings indicated**
	A	Mark **Yes** if the frequency is recorded and the appropriate times are either ticked or circled on the prescription chart at that time. Mark **No** if frequency is not record. Mark **No** if correct timings are not ticked/circled. Mark **N/A** if no prescription documentation is utilised.
19	I	**The minimum dose interval and/or 24 hour maximum dose is specified for all "as required" or PRN medicines**
	A	Mark **Yes** if all medicines prescribed **"as required"** states the minimum dose interval and/or the maximum 24 hour dose. Mark **No** if all medicines prescribed **"as required"** do not state the minimum dose interval and/or the maximum 24 hour dose. Mark **N/A** if medicines are not prescribed **"as required".** Mark **N/A** if no prescription documentation is utilised.

20	I	**The prescription has an identifiable prescriber's signature (in ink)**
	A	Mark **Yes** if prescribers name and signature are identifiable from online signature bank/local signature bank or signature bank on the medication prescription sheet. Mark **Yes** if the signature includes NMBI Personal Identification Number (PIN)/Medical Council Number (MCN). Mark **No** if signature is not written in permanent ink. Mark **No** if PIN/MCN is not present or signature is not readily identifiable itself or from local signature bank. **Note:** The prescriber's signature can be identifiable if written clearly, if it contains an NMBI Personal Identification Number (PIN) or Medical Council Number (MCN) which is searchable online www.nmbi.ie or www.medicalcouncil.ie or there is an up to date local signature bank.
21	I	**Discontinued medicines are crossed off, dated and signed by a person with prescriber authority**
	A	Mark **Yes** if the drug is correctly crossed out and includes the full date (Day/Month/Year) it was discontinued and the signature of a prescriber who has discontinued the drug. Mark **No** if any element is not correct. Mark **No** if all discontinued drugs do not follow the standard. Mark **N/A** if there are no drugs discontinued.

2.9 Service User Experience Quality Care-Metric

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

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

Legislation, regulation and other publications, which are relevant to the Mental Health Quality Care-Metrics development, are listed in Appendix IV.

3.0 PROCESS FOR QUALITY CARE-METRICS DATA COLLECTION

3.1 PROCESS

3.1.1 The process for data collection should ensure that collection is peer to peer and that staff nurses /CNMs do not collect in the area in which they are working. Including procedures such as "inter-rater reliability" checks will support data quality.

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

3.1.3 The data collector is required to confirm that they have a working knowledge of the guideline as appropriate to each metric, to ensure accuracy, standardisation and consistency in the interpretation of the metric – as outlined in Section 2.0.

3.1.4 Data collectors should be mindful of the clinical area they are attending, following protocols for that service, to include: obtaining permission as required entering the clinical area, dress code as per policy and adherence to infection prevention and control procedures in the clinical area.

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

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

PROCESS FOR NURSING & 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 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 the Settings options on the TYC HSE toolbar and entering a password of choice. Username and passwords should not be shared as they are unique to users and allow access to either data entry or reporting or both. The home page of the TYC HSE System is illustrated in Figure 3.

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

- **Collect:** Data Entry (to enter the Quality Care-Metric responses for each clinical area)
- **Report:** Reporting on the results of the Quality Care-Metric responses per clinical area
- **Action Plans:** This section gives access to an online Action Plan to address scores under 100% as deemed appropriate by each manager
- **Documents:** This section contains supporting documentation including the National Guidelines for each Quality Care-Metric and the templates for data collection

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

- Collect only
- Collect and Report

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

3.5 Data Entry

3.5.1 The TYC HSE System will open automatically on the data entry screen (Collect). If this does not occur, the data collector/user should click the **Collect** link in the middle of the toolbar on the top right of screen.

3.5.2 A drop down menu (Figure 4) is utilised to select the questionnaire of choice and also the location where it is being undertaken. To undertake data entry:

- Select the relevant questionnaire
- Select the relevant location
- Select **"Begin"**; once selected, the number of times data has been accessed and saved this month will be displayed

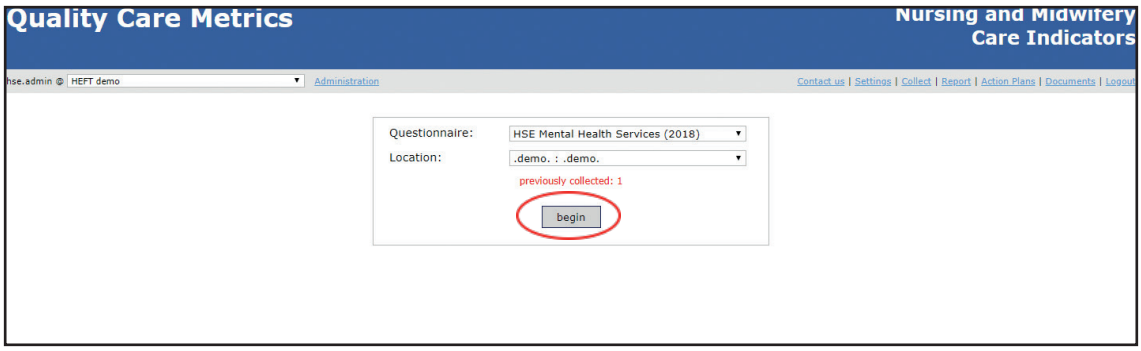

Figure 4: Data Entry: TYC HSE System

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

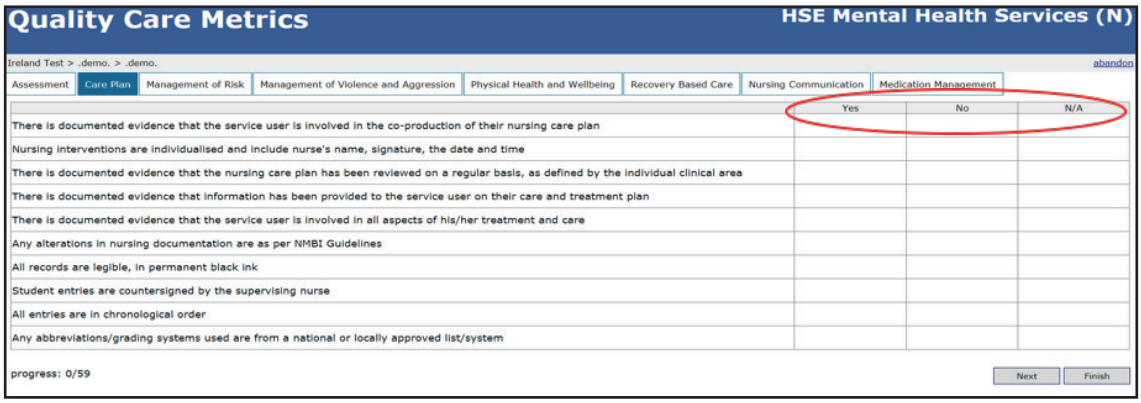

Figure 5: Data Entry: TYC HSE System (1)

- Select the appropriate response for each question, on completing a section the user should click the **Next** button
- **Yes** answer has a score of 10/10
- **No** answer has a score of 0/10
- **N/A** answer does not have a score and doesn't affect the overall result
- Once all questions have been answered, click the **Finish** button to save and the data entered for that patient/service user will be uploaded to the server
- At any time the user can **abandon** the current collection; however abandoned collections are not saved or included in the reports

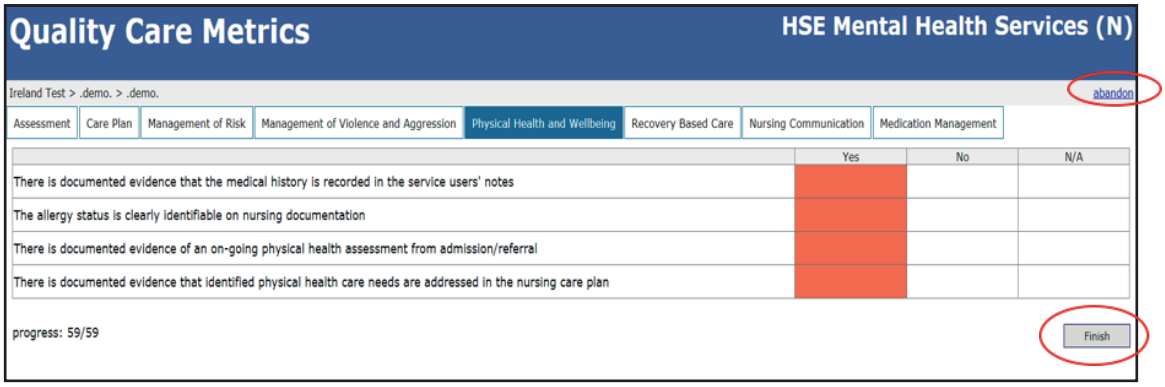

Figure 6: Data Entry: TYC HSE System (2)

4.0 QUALITY CARE-METRICS DATA ANALYSIS

4.1 Scoring System

4.1.1 Scores are illustrated easily using a Traffic Lights Scoring System which highlights areas of improvement, areas of risk and areas of excellence (Figure 7). Areas of good practice are demonstrated using green lights. Areas requiring some improvement are displayed with amber lights and areas requiring immediate attention and Action Plans are shown using red lights.

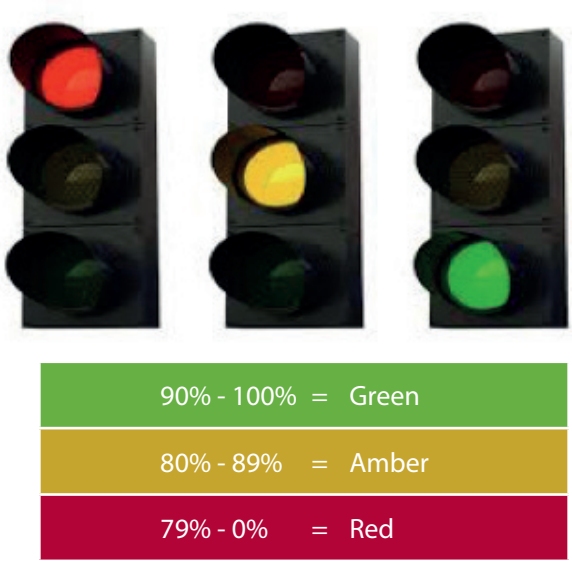

Figure 7: Traffic Light Scoring System

4.1.2 The highlighted score will be colour coded as illustrated in Figure 7. 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 direction illustration only).

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

Figure 8: Scoring System

4.2 Reporting

4.2.1 Reports are created to assist in the systematic measuring of quality of Nursing and Midwifery clinical care processes. Reports identify and acknowledge services that are delivering safe, quality care and agreed standards and identify opportunity for quality improvements.

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

4.2.3 When new services are being configured, it is important 'Location Groupings' are discussed with the Nominated Service Lead. This option facilitates collective reporting for senior managers if required, however, individual locations may be adequate for reporting requirements.

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

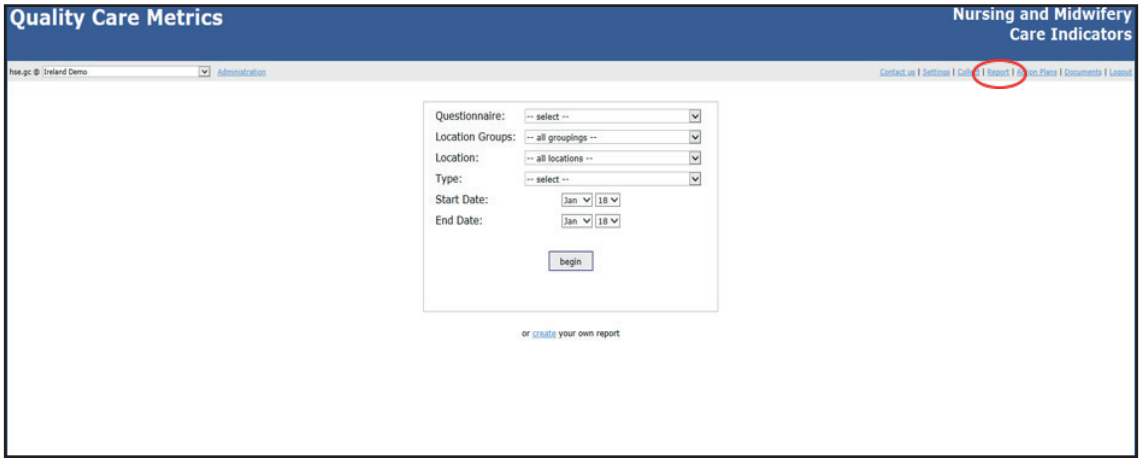

Figure 9: Accessing Reports from TYC HSE

4.2.5 Summary Report: A common report is the 'Summary Report' which gives an overall score for each metric and the results can be exported into excel/word etc. if needed. This report can also provide details on the specific metrics by drilling into the relevant month in addition to identifying trends.

- **Questionnaire** – Select the relevant questionnaire e.g. Mental Health, Acute, Theatre, Children's, Public Health
- **Location Groups** – Select groupings such as Acute, Community, CAMHS or if a particular group is not required, select all
- **Location** – Select the name of the ward, unit or theatre or all locations to get an overall hospital /care facility/network score
- **Type** –Select Summary

4.2.6 Collection Summary Report: A common report is the 'Collection Summary Report' which gives an overall view of collections and the results can be exported into excel/word etc. if needed. This report can also provide details on the specific metrics by drilling into either the number of collections or the relevant month.

- **Questionnaire** – Select the relevant questionnaire e.g. Mental Health, Acute, Theatre, Children's, Public Health
- **Location Groups** – Select groupings such as Acute, Community, CAMHS or if a particular group is not required, select all
- **Location** – Select the name of the ward, unit or theatre or all locations to get an overall hospital /care facility/network score
- **Type** –Select Summary

4.2.7 Create your own Report (1): if a more detailed report is required to ascertain precisely which indicators within a metric scored low, the 'Create your own report' option may be used (Figure 10 and 11).

- Once in Report tab click on **Create your own report**
- **Questionnaire** – Select the relevant questionnaire e.g. Mental Health, Acute, Theatre, Children's, Public Health
- Select the **start** and **end date**
- **Location** –Select ward from the list
- **Column Heading** –select 'month'(this puts the month(s) across the top of the page for viewing)
- **Row Heading** – select **Section and question** to show results for each question (indicator) within a metric
- Click **submit** button
- A print friendly version of the report is available by clicking the 'print'

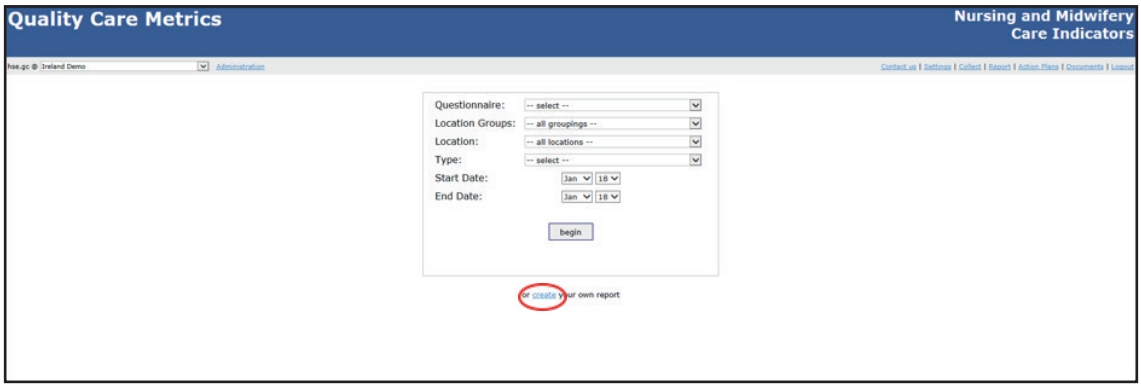

Figure 10: Create your own Report

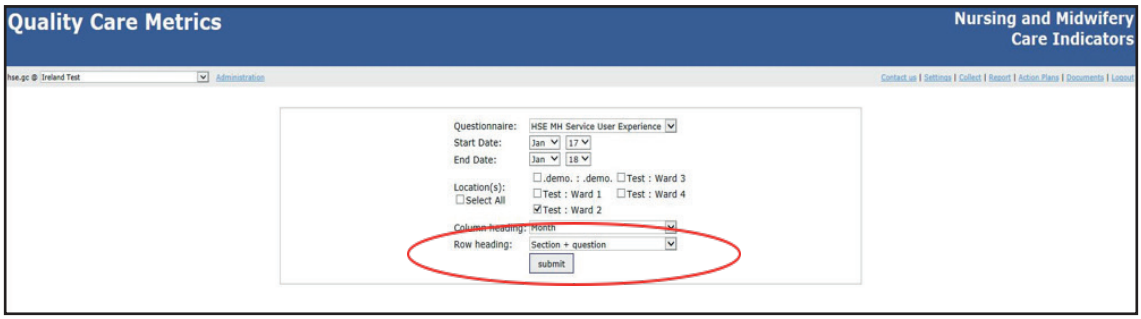

Figure 11: Create your own Report; Column Heading: Month and Row Heading: Section and Question

- This selection, **'Column heading: Month and Row Heading: Section and Question'** supports the CNM/CMM to investigate what areas of good practice require recognition and what areas need improvements (Figure 12).

	Jan 2018	Mar 2018	Jun 2018
Medication Storage and Custody : RGN/RNM holds keys	100%	100%	100%
Medication Storage and Custody : Meds in locked room/cupboard	100%	100%	100%
Medication Storage and Custody : Trolleys locked, no open meds		100%	100%
Medication Storage and Custody : Drug Formulary available	100%	100%	100%
MDA Drugs : MDAs checked am & pm	100%	100%	100%
MDA Drugs : Two Signatures in Drug Register	100%	100%	100%
MDA Drugs : MDA Cupboard Locked & Keys	100%	100%	100%
MDA Drugs : MDA Keys Separate	100%	100%	100%
Medication Administration : Name and HCRN	0%	60%	100%

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

4.2.8 Create your own Report (2): if a more detailed report is required to compare locations (wards / units) across a service the 'Create your own report' option may also be used (Figure 10 and 13).

- Once in Report tab click on **Create your own report**
- **Questionnaire** – Select the relevant questionnaire for the relevant service
- Select the **start** and **end date**
- **Location** –Select ward from the list
- **Column Heading** –select 'location' or 'location grouping'(this puts the location (s) or the location grouping (s) across the top of the page for viewing)
- **Row Heading** – select **Section and question** to show results for each question (indicator) within a metric
- Click **submit** button
- A print friendly version of the report is available by clicking the 'print'

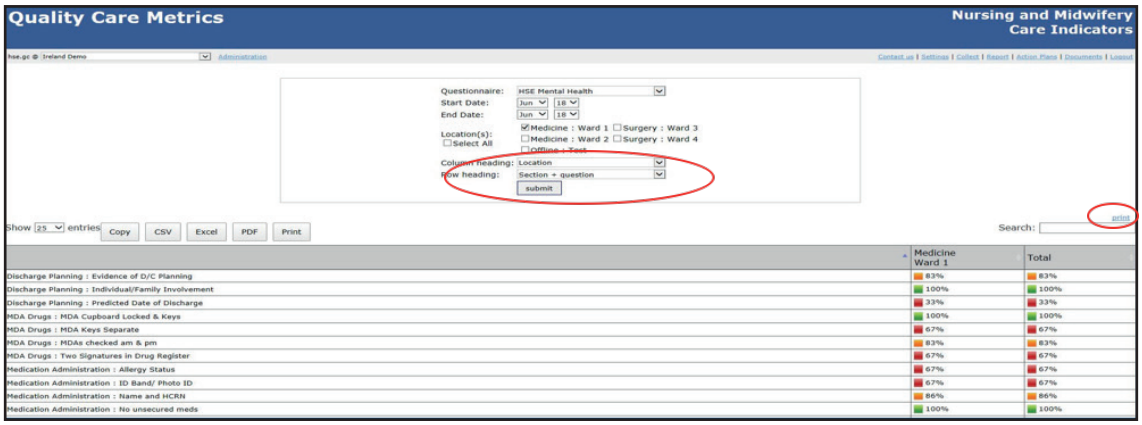

Figure 13: Create your own Report; Results; Column Heading: Location and Row Heading: Section and Question

- This selection, **'Column heading: Location and Row Heading: Section and Question'** supports the CNM/CMM to compare indicators in each area for shared learning (Figure 13).

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

- Once in Report tab click on **Create your own report**
- **Questionnaire** – Select the relevant questionnaire e.g. Mental Health, Acute, Children's, Public Health
- Select the **start** and **end date**
- **Location** –Select **ward** or **select all** from the list
- **Column Heading** –select **month** (this puts the month (s) across the top of the page for viewing)
- **Row Heading** – select **location grouping** to show overall results for location grouping
- Click **submit** button
- A print friendly version of the report is available by clicking the 'print'

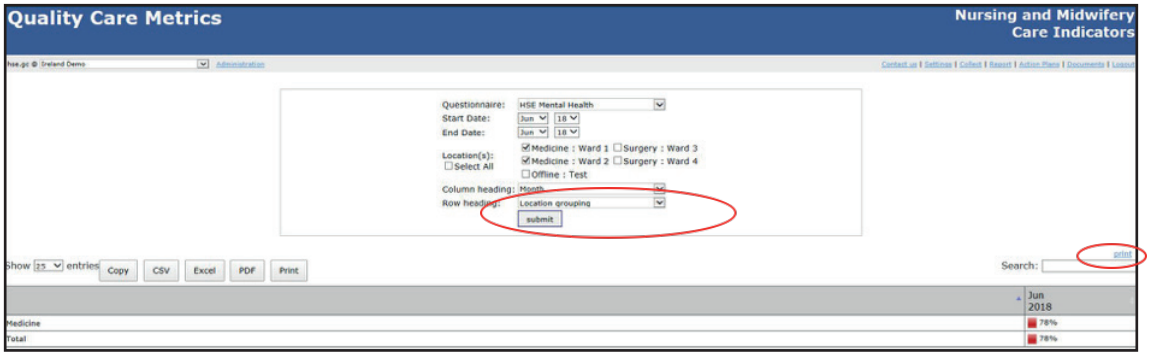

Figure 14: Create your own Report; Results; Column Heading: Month and Row Heading: Location Grouping

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

Alternatively, for more detail in relation to each metric, select **section** in the **Column Heading** – (this puts the metrics across the top of the page for viewing) (Figure 15).

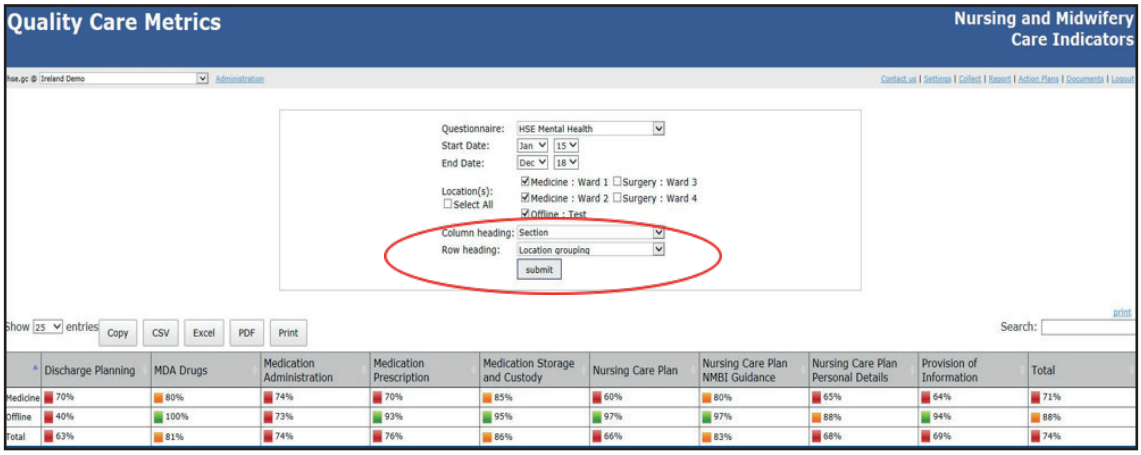

Figure 15: Create your own Report; Results; Column Heading: Section and Row Heading: Location Grouping

5.0 QUALITY CARE-METRICS ACTION PLANNING

5.1 ACCESSING ACTION PLANNING ON TEST YOUR CARE HSE

5.1.1 Action Plan Reporting is available for each location to keep an electronic record of Action Plans arising from measurement of the metrics. Action plans are completed by going to the top right hand corner and selecting the Action Plans Link. Click **"Action Plans"** and complete the data fields as per example below in Figure 16.

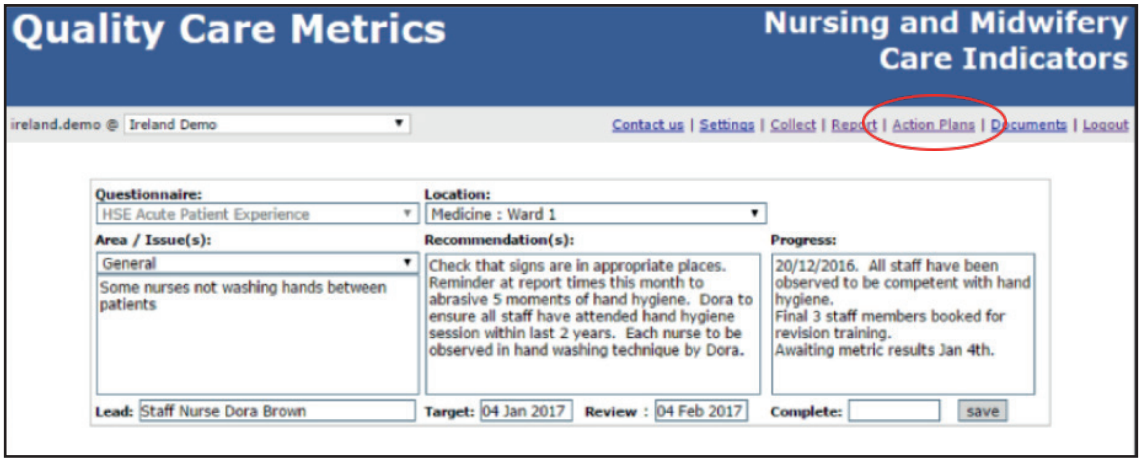

Figure 16: Accessing Action Planning on TYC HSE

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

5.2 SEVEN STEPS OF ACTION PLANNING

- Understanding Quality Care-Metrics results
- Communicating and discussing Quality Care-Metrics results
- Developing focused Action Plans in response to Quality Care-Metrics results
- Communicating Action Plans and deliverables
- Implementing Action Plans
- Accessing progress and evaluating the impact
- Sharing what works

5.2.1 Step 1; Understanding Quality Care-Metrics Results

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

5.2.2 Step 2; Communicating and Discussing Results - Holding Team Meeting/Huddle

- Bring the *detailed report* to the team meeting/huddle
- *Choose* what to tackle first - There may be several questions/indicators that require attention, however the team will need to determine priority areas first
- *Be specific* - Identify specific tasks and activities that are required to address the area requiring improvement
- *Extra resources* – Identify external resources (outside my unit) required to tackle this e.g. expertise, education, equipment
- *Timeframes:* Assign realistic timeframes to each specific task or activity
- *Be collaborative* – ask staff to highlight issues which may be causing low scores /poor care on this issue. Ask - What makes it difficult for staff to do it this way/ carry out this check…?
- *Lead person* -Identify who on the team will be responsible for leading on the Action Plan and encouraging the team
- What might block this plan?-*Identify* potential obstacles that may be encountered when trying to implement change and try to understand resistance

5.2.3 Step 3; Writing the Action Plan

- Having identified what areas (metric/indicator) to tackle - be SMART as guided by Figure 17
- Use plain English
- Address one issue per Action Plan otherwise the Action Plan can become unfocussed and confusing to follow
- State clearly what the team is expected to do - the identified actions should be precise in what needs to be done and the changes that need to be made
- Write a plan that relates directly to the individual workplace and that is under the team's area of influence
- Be realistic with identified target dates

Figure 17: SMART Goals

5.2.4 Step 4; Communicate the Action Plan

- Make sure the nursing team are informed about the Action Plan
- Print off current Action Plans and display on notice board or communication board or Quality Improvement board
- Discuss after all hand-overs one day per week (…each Tuesday discuss what Action Plans are on-going – 5 minutes) to keep it on the ward/unit agenda

5.2.5 Step 5; Implement the Action Plan

- Vital - taking *action* makes the real difference.
- Changes do not have to be major or require significant resources
- Make Action Plans small and manageable

5.2.6 Step 6; Assess your Progress

- Ask staff how they are getting on with this change
- Don't wait for the next metric result …. Keep an eye to see if the change is being carried out
- Fill in the progress part of the Action Plan
- If the change has worked, tell staff
- If the change has not worked – ask why?
- Were the changes outlined in the Action Plan not carried out?
- Were the 'wrong changes' planned - was there something different that could have done?

5.2.7 Step 7; Share what Works

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

6.0REFERENCES

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: Mental Health Research Report*. Dublin: Health Service Executive.

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

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

Please note 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 Mental Health Services 2018 (ONMSD 2018 - 025)

7.0 APPENDICES

Appendix 1
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 and Midwifery Metrics:
Nursing and Midwifery metrics are agreed standards of measurement for nursing and midwifery care, where the care can be monitored against agreed standards and benchmarks (Foulkes 2011).

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

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

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

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

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
GP	General Practitioner
HCRN	Healthcare Record Number
MCN	Medical Council Number
MHC	Mental Health Commission
NMBI	Nursing and Midwifery Board of Ireland
ONMSD	Office of the Nursing and Midwifery Services Director
PIN	Personal Identification Number
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 Mental Health Quality Care-Metrics development are listed below.

The complete list of references can be accessed in the National Guideline for Nursing and Midwifery Quality Care-Metrics Data Measurement in Mental Health Services 2018 (ONMSD 2018 - 025)

- *Accreditation for Inpatient Mental Health Services (AIMS) Standards for Inpatient Wards – Working-Age Adults.* 4th Edition, (Cresswell & Beavon 2010)
- *Assisted Decision Making* (Capacity) Act. (2015)
- *National Standards for Residential Services for Children and Adults with Disabilities.* (HIQA 2013)
- *National Standards for Safer Better Healthcare.* (HIQA 2012)
- *General Guidance on the National Standards for Safer Better Healthcare.* (HIQA 2012a)
- *National Quality Standards for Residential Care Settings for Older People in Ireland.* (HIQA 2009)
- *Hygiene Services Assessment Scheme.* (HIQA 2006)
- *Nursing & Midwifery Quality Care-Metrics: Mental Health Research Report.* (HSE 2018)
- *A National Framework for Recovery in Mental Health Services. A National Framework for Mental Health Service Providers to support the Delivery of a Quality, Person Centred Service.* (HSE 2017)
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NURSING & MIDWIFERY

QUALITY CARE-METRICS

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