NATIONAL SUMMARY GUIDANCE

FOR NURSING AND MIDWIFERY QUALITY CARE-METRICS DATA MEASUREMENT IN

OLDER PERSON SERVICES 2018

To be used in conjunction with the National Guideline for Nursing and Midwifery Quality Care-Metrics Data Measurement in Older Person Services 2018 (ONMSD 2018 - 029)

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

1.0 INITIATION OF QUALITY CARE-METRICS AT SERVICE LEVEL 6

1.1 PURPOSE 6

1.2 SCOPE 6

1.3 OBJECTIVE 6

1.4 OUTCOMES 7

2.0 METRICS, INDICATORS AND ADVICE FOR OLDER PERSON SERVICES 8

2.1 SKIN INTEGRITY QUALITY CARE-METRIC 9

2.2 ASSESSMENT AND MANAGEMENT OF PRESSURE ULCERS QUALITY CARE-METRIC 9

2.3 OPTIMISING NUTRITION AND HYDRATION QUALITY CARE-METRIC 10

2.4 PAIN ASSESSMENT AND MANAGEMENT QUALITY CARE-METRIC 12

2.5 MEDICINES PRESCRIBING QUALITY CARE-METRIC 12

2.6 MEDICINES ADMINISTRATION QUALITY CARE-METRIC 14

2.7 INFECTION PREVENTION AND CONTROL QUALITY CARE-METRIC 15

2.8 ACTIVITIES OF DAILY LIVING QUALITY CARE-METRIC 16

2.9 FALLS RISK QUALITY CARE-METRIC 16

2.10 FALLS PREVENTION QUALITY CARE-METRIC 17

2.11 CONTINENCE ASSESSMENT, PROMOTION AND MANAGEMENT QUALITY CARE-METRIC 17

2.12 FRAILTY NURSING ASSESSMENT QUALITY CARE-METRIC 18

2.13 END OF LIFE AND PALLIATIVE CARE QUALITY CARE-METRIC 19

2.14 PSYCHOLOGICAL NURSING ASSESSMENT QUALITY CARE-METRIC 19

2.15 RESPONSIVE BEHAVIOUR SUPPORT QUALITY CARE-METRIC 20

2.16 SAFEGUARDING VULNERABLE ADULTS QUALITY CARE-METRIC 21

2.17 SOCIAL ASSESSMENT QUALITY CARE-METRIC 22

2.18 ACTIVITIES (HOLISTIC) / SOCIAL ENGAGEMENT QUALITY CARE-METRIC 22

2.19 PERSON CENTRED CARE PLANNING QUALITY CARE-METRIC 23

2.20 MISUSE OF DRUGS ACT (MDA) MEDICINES QUALITY CARE-METRIC 24

2.21 MEDICINES STORAGE AND CUSTODY QUALITY CARE-METRIC 25

2.22 PERSON EXPERIENCE QUALITY CARE-METRIC 26

3.0 PROCESS FOR QUALITY CARE-METRICS DATA COLLECTION 27

3.1 PROCESS 27

3.2 SAMPLE SIZE 28

3.3 TIMING OF MONTHLY DATA COLLECTIONS 28

3.4 ACCESSING TEST YOUR CARE HSE (TYC HSE) SYSTEM 28

3.5 DATA ENTRY 30

4.0 QUALITY CARE METRICS DATA ANALYSIS 32

4.1 SCORING SYSTEM 32

4.2 REPORTING 33

5.0 QUALITY CARE METRICS ACTION PLANNING 38

5.1 ACCESSING ACTION PLANNING ON TYC HSE 38

5.2 SEVEN STEPS OF ACTION PLANNING 38

6.0 REFERENCES 42

7.0 APPENDICES 43

APPENDIX I: GLOSSARY OF TERMS AND DEFINITIONS 44

APPENDIX II ABBREVIATIONS 45

APPENDIX III IMMEDIATE SAFETY/RISK IDENTIFICATION FORM FOR NURSING AND MIDWIFERY METRICS 46

APPENDIX IV SUPPORTING EVIDENCE 48

Figures

Figure 1:	Older Persons Services Quality Care-Metrics	8
Figure 2:	Undertaking Quality Care-Metrics at Service Level	27
Figure 3:	TYC HSE System	29
Figure 4:	Data Entry: TYC HSE System	30
Figure 5:	Data Entry: TYC HSE System (1)	30
Figure 6:	Data Entry: TYC HSE System (2)	31
Figure 7:	Traffic Light Scoring System	32
Figure 8:	Scoring System	32
Figure 9:	Accessing Reports from TYC HSE	33
Figure 10:	Create your own Report	34
Figure 11:	Create your own Report; Column Heading: Month and Row Heading: Section and Question	35
Figure 12:	Create your own Report; Results; Column Heading: Month and Row Heading: Section and Question	35
Figure 13:	Create your own Report; Results; Column Heading: Location and Row Heading: Section and Question	36
Figure 14:	Create your own Report; Results; Column Heading: Month and Row Heading: Location Grouping	37
Figure 15:	Create your own Report; Results; Column Heading: Section and Row Heading: Location Grouping	37
Figure 16:	Accessing Action Planning on TYC HSE	38
Figure 17:	SMART Goals	40

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

1.2 Scope

1.2.1 This summary guidance applies to all registered nurses and midwives within Older Person 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 Older Person Research Report (HSE, 2018a) and the National Guideline for Nursing and Midwifery Quality Care-Metrics Data Measurement in Older Person Services 2018 (ONMSD 2018 -029).

1.2.4 All nurses and midwives within Older Person 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 Older Person Services 2018 (ONMSD 2018 - 029) 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 Older Person Services (ONMSD 2018 - 029), will enable consistency in the reliability and validity of the data collection to support a standardised approach in Older Person 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 AND ADVICE FOR OLDER PERSON SERVICES

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

CGA Physical Assessment

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

CGA Psychological Assessment

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

CGA Functional Assessment

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

CGA Social and Environment

17 Social Assessment
18 Activities (Holistic), Social Engagement

Post Assessment Care

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

Figure 1: Older Person Services Nursing Quality Care-Metrics

COMPREHENSIVE GERIATRIC ASSESSMENT – PHYSICAL ASSESSMENT

2.1 Skin Integrity Quality Care-Metric

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

2.2 Assessment and Management of Pressure Ulcers Quality Care-Metric

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

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

2.3 Optimising Nutrition and Hydration Quality Care-Metric

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

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

2.4 Pain Assessment and Management Quality Care-Metric

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

2.5 Medicines Prescribing Quality Care-Metric

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

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

2.6 Medicines Administration Quality Care-Metric

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

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

2.7 Infection Prevention and Control Quality Care-Metric

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

2.8 Activities of Daily Living Quality Care-Metric

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

2.9 Falls Risk Quality Care-Metric

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

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

2.10 Falls Prevention Quality Care-Metric

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

2.11 Continence Assessment, Promotion and Management Quality Care-Metric

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

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

2.12 Frailty Nursing Assessment Quality Care-Metric

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

2.13 End of Life and Palliative Care Quality Care-Metric

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

COMPREHENSIVE GERIATRIC ASSESSMENT – PSYCHOLOGICAL ASSESSMENTS

2.14 Psychological Nursing Assessment Quality Care-Metric

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

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

2.15 Responsive Behaviour Support Quality Care-Metric

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

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

2.16 Safeguarding Vulnerable Adults Quality Care-Metric

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

2.17 Social Assessment Quality Care-Metric

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

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

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

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

POST ASSESSMENT CARE

2.19 Person Centred Care Planning Quality Care-Metric

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

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

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

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

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

2.21 Medicines Storage and Custody Quality Care-Metric

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

2.22 Person Experience Quality Care-Metric

Person Experience Quality Care-Metric

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

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

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

Legislation, regulation and other publications, which are relevant to the Older Person 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 TYCHSE System using an individualised username and password.

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

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

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

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

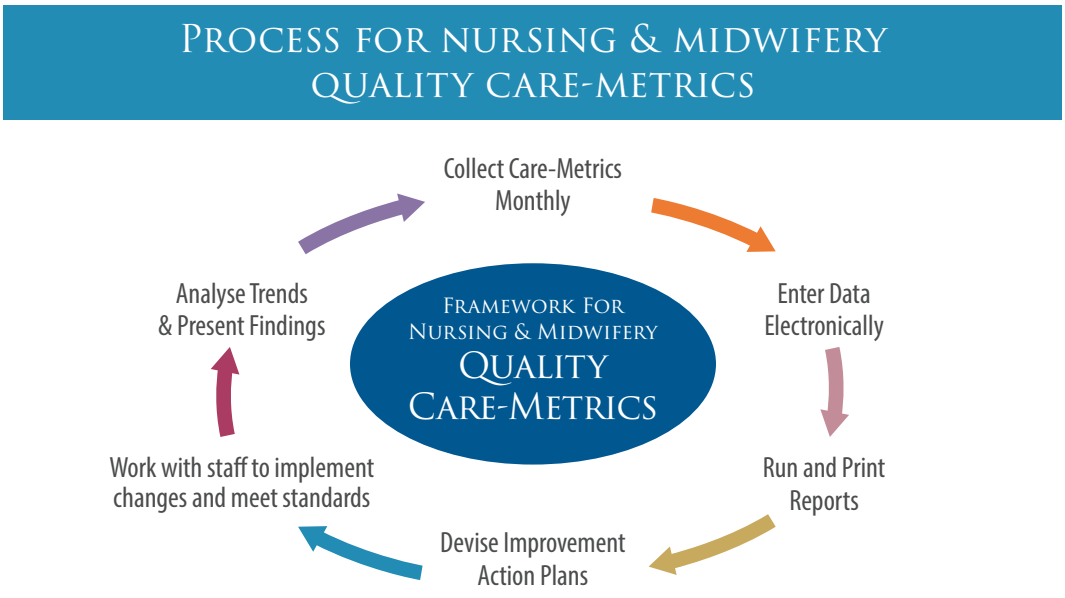


Figure 2: Undertaking Quality Care-Metrics at Service Level

3.2 Sample Size

3.2.1 Sample Size Selection in Ward/Unit Based Areas

- Based on total bed capacity, samples of 25% of patient/service user records are randomly selected per month from each ward/unit/location/network. Following guidance from the HSE Quality Improvement Division, it is recommended that a minimum of 5 data collections per month for each ward/unit/location/network are conducted.
- Where the bed capacity or occupancy for a particular ward/unit/location/network is fewer than 5, it is recommended that Quality Care-Metrics data is collected from all patient/service user records per month.
- Where a sample of 25% of patients/service users exceeds 10, it is recommended that the number of data collections per month should equal 10.

3.2.2 Sample Size Selection in Caseload Based Services

- In services such as operating theatres, procedure areas, labour suites or day service areas the monthly sample recommended is 10 cases per month. Similarly in Public Health Nursing Areas, the sample caseload should be 10 cases per network each month.

3.3 Timing of Monthly Data Collections

3.3.1 Data may be collected anytime between the first and the last day of each month. Data entered will automatically be entered in the current month.

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

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

3.4 Accessing Test Your Care HSE System

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

Figure 3: TYC HSE System

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

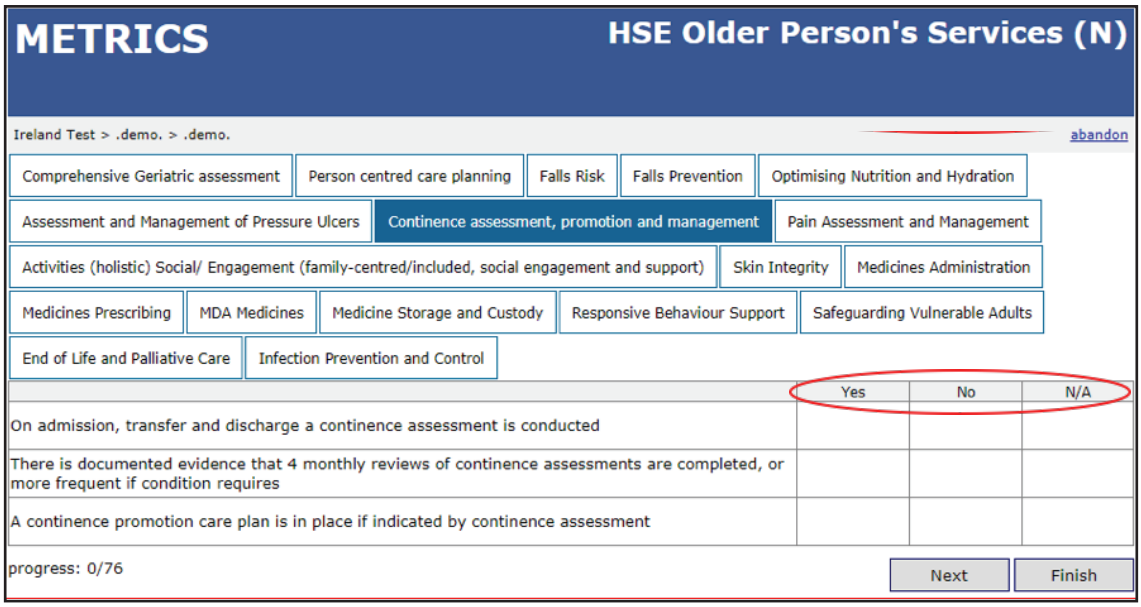


Figure 5: Data Entry: TYC HSE System (1)

- 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

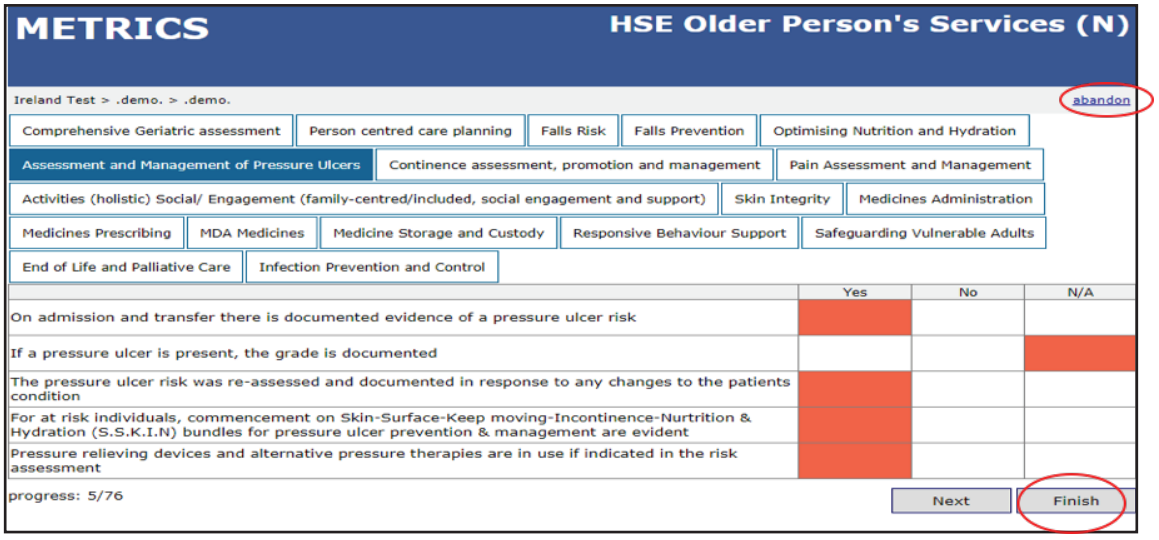


Figure 6: Data Entry: TYC HSE System (2)

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.

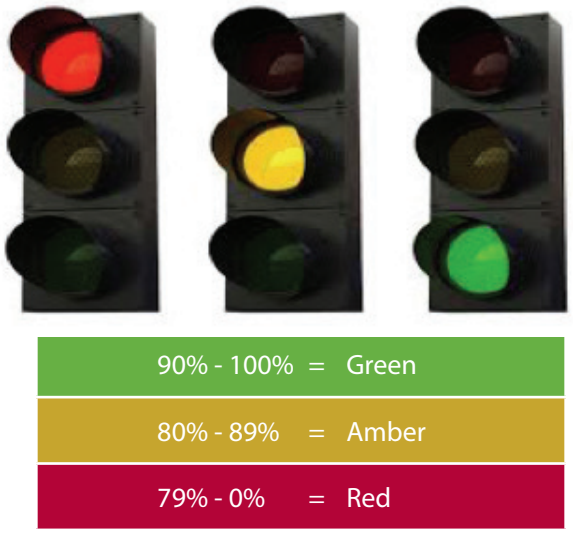


Figure 7: Traffic Light Scoring System

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)

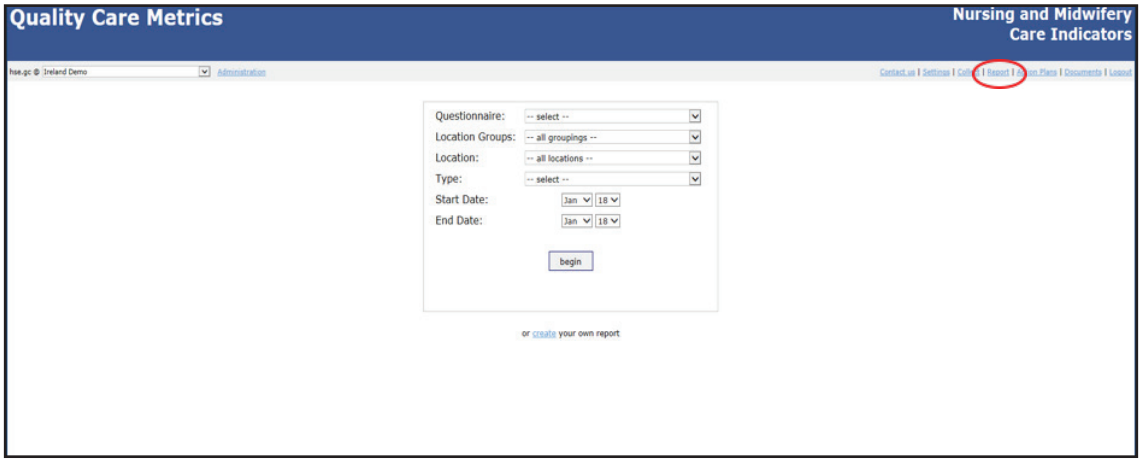


Figure 9: Accessing Reports from TYC HSE

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'

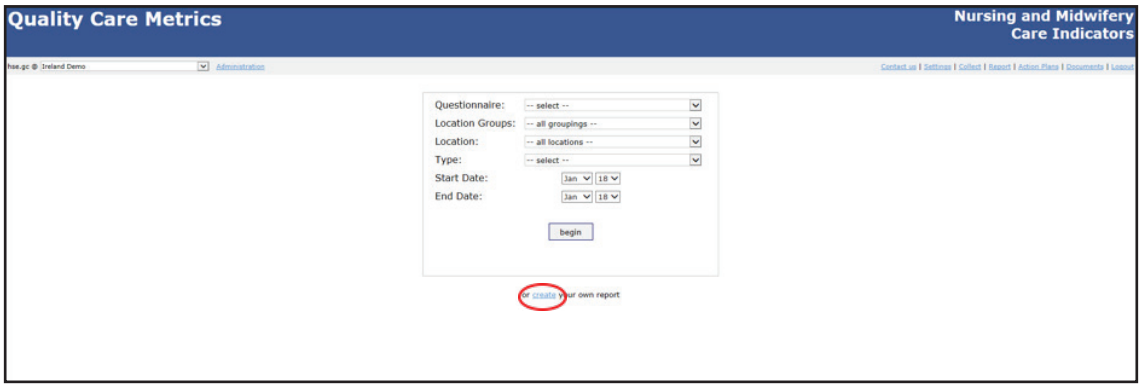


Figure 10: Create your own Report

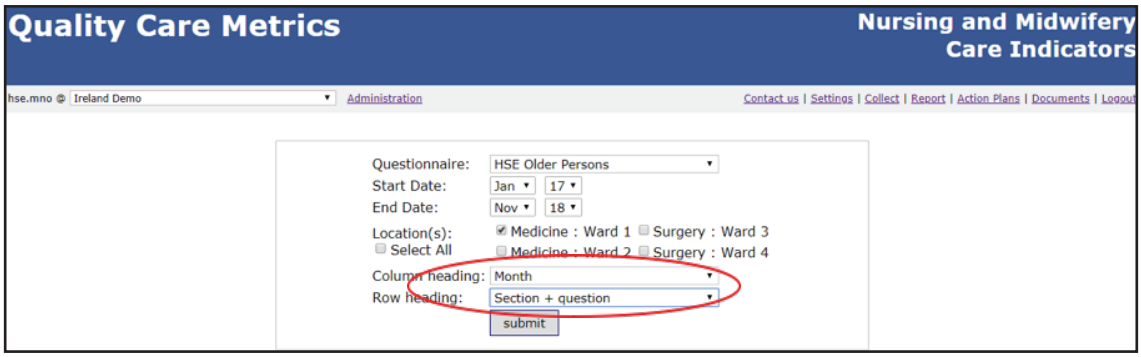


Figure 11: Create your own Report; Column Heading: Month and Row Heading: Section and Question

- 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'

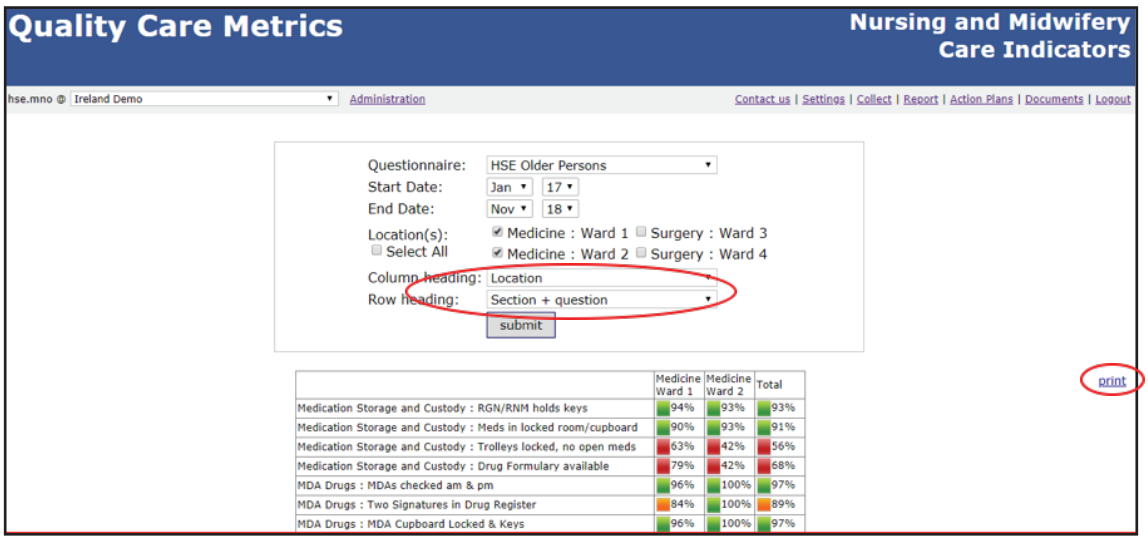


Figure 13: Create your own Report; Results; Column Heading: Location and Row Heading: Section and Question

- 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'

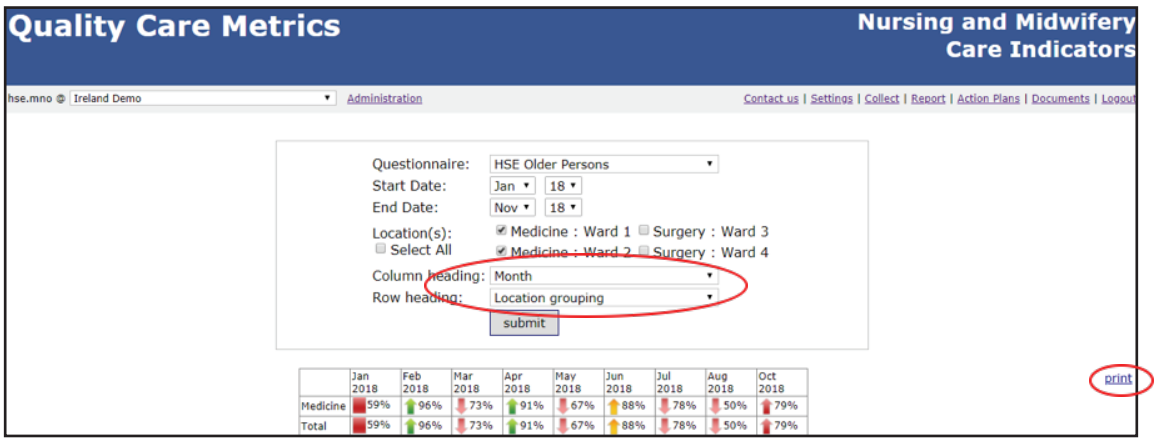


Figure 14: Create your own Report; Results; Column Heading: Month and Row Heading: Location Grouping

- 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).

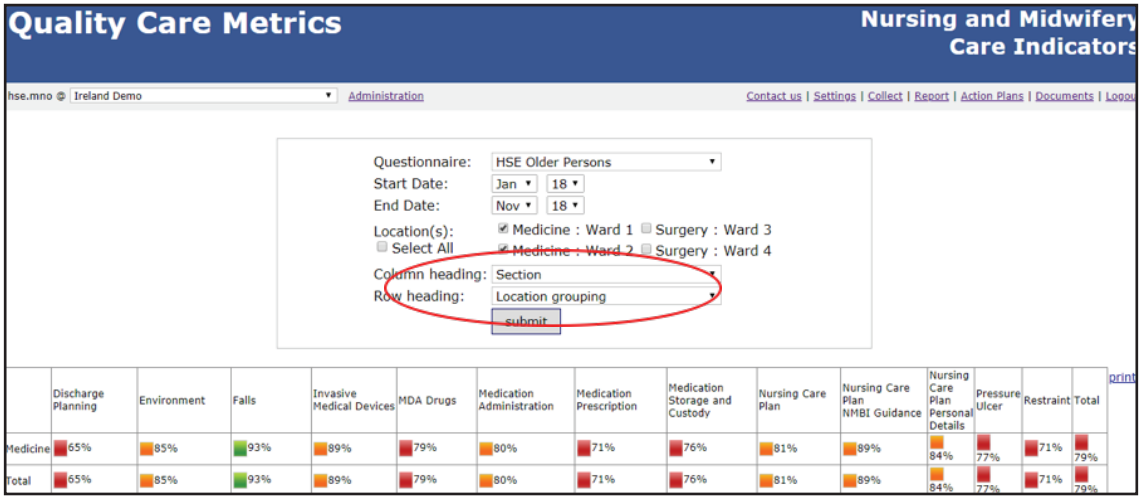


Figure 15: Create your own Report; Results; Column Heading: Section and Row Heading: Location Grouping

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

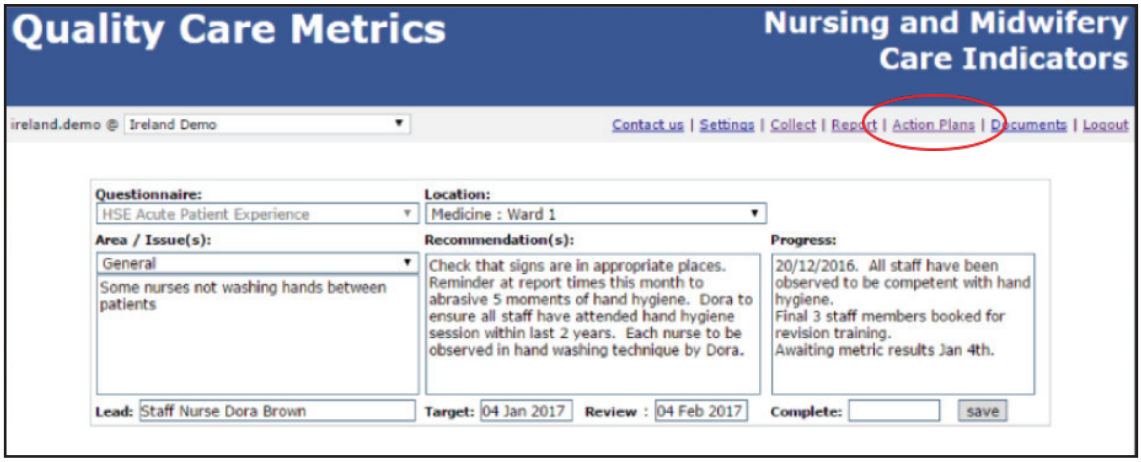


Figure 16: Accessing Action Planning on Test Your Care HSE

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

5.2 SEVEN STEPS OF ACTION PLANNING

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

5.2.1 Step 1; Understanding Quality Care-Metrics Results

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

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

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

5.2.3 Step 3; Writing the Action Plan

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

Figure 17: SMART Goals

5.2.4 Step 4; Communicate the Action Plan

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

5.2.5 Step 5; Implement the Action Plan

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

5.2.6 Step 6; Assess your Progress

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

5.2.7 Step 7; Share what Works

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

6.0REFERENCES

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

Health Service Executive (HSE) (2018) National Guideline for Nursing and Midwifery Quality Care-Metrics Data Measurement in Older Person Services 2018 (ONMSD 2018 - 029). Available online at: www.hse.ie/onmsd/

Health Service Executive (HSE) (2018a) *Nursing & Midwifery Quality Care Metrics: Older Person Research Report.* 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 Older Person Services 2018 (ONMSD 2018 -029)

7.0 APPENDICES

Appendix I
GLOSSARY OF TERMS AND DEFINITIONS

Appendix II
ABBREVIATIONS

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

Appendix IV
SUPPORTING EVIDENCE

Appendix I
Glossary of Terms and Definitions

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

Inter-rater Reliability:
Measurement of the extent to which data collectors (raters) assign the same score to the same variable (indicator) is called inter-rater reliability (McHugh 2012). Two data collectors collect the same sample data independently and then compare scores.

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

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

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

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

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

Appendix II
Abbreviations

ADoN/ADoM	Assistant Director of Nursing/Assistant Director of Midwifery
CNM/CMM	Clinical Nurse Manager/Clinical Midwife Manager
DOB	Date of Birth
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 Older Person 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 Older Person Services 2018 (ONMSD 2018 - 029)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

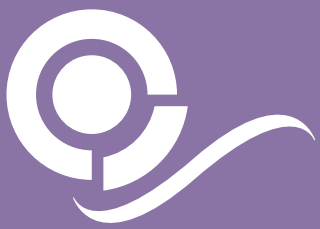
Responsive behaviour support	
Relevant literature	(Brühl et al 2007) (Butler Maher et al 2012) (Chen et al 2011) (Feil at al. 2007) (Guideline on delivery of dementia care ND) (Imhof et al 2012) (Nakrem et al 2009) (Terrell et al 2009)
Standard	NA

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

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

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

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



NURSING & MIDWIFERY

QUALITY CARE-METRICS

DECEMBER 2018

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www.hse.ie/go/onmsd