NURSING AND MIDWIFERY QUALITY CARE-METRICS:

MIDWIFERY SERVICES RESEARCH REPORT

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NURSING & MIDWIFERY QUALITY CARE-METRICS

Office of the Nursing & Midwifery Services Director

Tús Áite do Shábháilteacht Othar
Patient Safety First

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

NURSING AND MIDWIFERY QUALITY CARE-METRICS:

MIDWIFERY SERVICES RESEARCH REPORT

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Foreword

Dear Colleagues,

As nurses and midwives, the continuous improvement of patient/client care is a central component of our ethical responsibility, professional accountability and nursing and midwifery values. Every day we engage in numerous healthcare interventions where our knowledge, clinical expertise and professional judgement guide our practice to ensure high quality, safe care delivery. Knowing however what quality nursing and midwifery care is, and how to measure it has always been a challenge, both in Ireland and internationally.

Many quality improvement approaches in healthcare tend to focus on outcomes, such as morbidity, length of stay, readmission rates, infection rates, number of medication errors and pressure ulcers. Measuring outcomes is an important indicator for healthcare and provides a retrospective view of the quality and safety of care. To determine however the quality of nursing and midwifery care, and in particular our contribution to patient safety and continuous quality improvement, we need to be able to clearly articulate and measure what it is that we do. These are the important aspects of our daily professional practice, the fundamentals of care, often referred to as our clinical care processes.

In 2016, my Office commissioned a national research study to establish from both the academic literature and the consensus of front-line nurses and midwives, the important dimensions of nursing and midwifery care that should be measured, reflecting on the processes by which we provide care, and the values underpinning our practice. The voice of nurses and midwives in this research has been the major force to communicate the professional standards for excellence in care quality. The culmination of this work has resulted in a suite of seven Quality-Care Metrics reports.

I wish to acknowledge the clinical leadership of all the nurses and midwives who contributed and engaged in this research. In particular I wish to thank the Directors of Nursing and Midwifery for their support, the Directors and Project Officers of the Nursing and Midwifery Planning and Development Units, members of the work stream working groups and the research teams of University College Dublin, University of Limerick, and the National University of Ireland Galway who guided us through the academic journey. I would also like to acknowledge the Patient Representatives for their contribution and the expert external reviewer, Professor Mary Ellen Glasgow, Dean and Professor of Nursing, Duquesne University, Pittsburgh, USA. Details of the governance structure and membership of the range of stakeholders who supported this work are outlined in the Appendices.

Finally, I wish to convey my thanks to Dr Anne Gallen for taking the national lead to co-ordinate this significant quality initiative that supports nurses and midwives at the point of care delivery to engage in continuous quality improvement and positively influence the patient/client experience.

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Interim Nursing & Midwifery Services Director
Assistant National Director
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Glossary/ Abbreviation of Terms

HSE	Health Service Executive
MDA	Misuse of Drugs Act
NMBI	Nursing and Midwifery Board of Ireland
NMPDU	Nursing and Midwifery Planning and Development Unit
ONMSD	Office of the Nursing and Midwifery Services Director
QCM	Quality Care-Metrics
SOP	Standard Operating Procedure

Acknowledgements

The Nursing and Midwifery Quality Care-Metrics Project was commissioned by the HSE Office of Nursing and Midwifery Services. The research team has worked closely with the Nursing and Midwifery Planning and Development Unit (NMPDU) Directors, Project Officers and Work-stream Working Group members. Midwives nationally have contributed greatly to the project by completing the Delphi Rounds. The research team is most grateful to all the NMPDU staff, Workstream Working Group members, Directors of Midwifery, Practice Development Coordinators, Service User and all who have helped develop this evidence-based suite of quality care process metrics and indicators for midwifery. We are particularly grateful to all the midwives who completed the surveys.

We would also like to acknowledge Professor Mary Ellen Glasgow, Duquesne University, Pittsburgh, USA, who contributed as the expert external reviewer to the research study.

Executive Summary

Background

This report presents the methods and findings of the research project, which identified and prioritised the suite of Quality Care-Metrics (QCM) and their associated indicators for midwifery care processes. To achieve this purpose, seven work streams (acute, mental health, public health nursing, children, older people services, intellectual disability and midwifery) were established within a governance structure (Appendix A) within which each stream had an Nursing and Midwifery Planning and Development Unit (NMPDU) support and Academic Steering Group (Appendix B). Governance for the overall Quality Care Metrics Project across workstreams was vested in a National Governance Steering Group (Appendix C). Each stream established an expert Working Group, which was responsible for the development of evidence based standardised Quality Care-Metrics, aligned to the delivery of quality and safe care by midwives and nurses working within that setting. The Midwifery Workstream Working Group membership was representative of all grades of staff and also geographically and service representative (Appendix D).

Aim

This study identified and prioritised the suite of Quality Care-Metrics (QCM) and their associated indicators for midwifery care processes.

Methods

The study design has four phases as follows:

Phase 1: A systematic literature review to identify midwifery care process metrics and the associated measurement indicators for same.

Phase 2: A two-round, online Delphi survey of midwives to develop consensus on the set of midwifery care process metrics to be measured.

Phase 3: A two-round online Delphi survey of midwives to develop consensus on the indicators that will be used to measure prioritised metrics.

Phase 4: A face-to-face consensus meeting with key stakeholders to review the findings and build consensus on metrics and indicators.

Results

Following the QCM Midwifery Metrics consensus meeting, 18 metrics and 93 indicators were prioritised for inclusion in the 2018 suite of Midwifery Metrics. Agreed metrics are:

1. Midwifery Plan of Care
2. Booking
3. Abdominal examination (after 24 weeks gestation) on Current or Last Assessment
4. Intrapartum Fetal Wellbeing
5. Intrapartum Fetal wellbeing cardiotocography (CTG)
6. Intrapartum Maternal wellbeing
7. Risk assessment for Venous Thromboembolism (VTE) in Pregnancy & the Puerperium
8. Immediate post birth care
9. Communication (Clinical Midwifery Handover)
10. Pain management (other than labour)
11. Infant feeding
12. Postnatal care (daily midwifery care processes)
13. Post birth discharge planning for home
14. Medication administration
15. Medication, Storage and Custody (excluding MDAs)
16. MDA Drugs
17. Intravenous fluid therapy
18. Clinical Record Keeping

Conclusion

The research process and final set of metrics and indicators presented in this report reflect the methodologically robust and rigorous process outlined. Importantly, the widespread engagement in the project by midwives of all grades and geographical areas nationally, via the work stream groups and project officers, has ensured that there is a real sense of ownership of the metrics and indicators from midwives across settings.

Recommendation

The development of this suite of process metrics and indicators for midwifery practice provides an opportunity for Ireland to take the lead internationally in generating evidence on the effectiveness of midwifery process metrics and associated indicators.

This initial work presented in this report should be followed up by a rigorous evaluation of the impact of the new suite of metrics on midwifery care processes. Designs which control insofar as possible for confounding variables such as interrupted time series studies should be considered. This should be determined prior to implementation so that opportunities for baseline assessments are not lost prior to implementation.

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Introduction

In 2014, demand increased from Directors of Nursing & Midwifery to roll out metrics nationally. As a result, the Office of Nursing & Midwifery Services Director (ONMSD) agreed to provide the national direction and support within a guiding framework to embed a system of nursing and midwifery metrics within healthcare organisations (HSE 2015) across 7 work streams i.e., Community/Public Health, Midwifery, Acute, Older People, Mental Health, Children's and Intellectual Disability.

Overall aim

This study identified and prioritised the suite of Quality Care-Metrics (QCM) and their associated indicators for midwifery care processes.

Phase 1: Systematic Review

Aim

The systematic review sought to identify reported quality care process metrics and associated indicators across across 7 work streams i.e., Public Health Nursing, Midwifery, Acute, Older People, Mental Health, Children's and Intellectual Disability.

Methods

Inclusion criteria

Quality Care Process Metrics are defined as quantifiable measures that capture quality in terms of how (or to what extent) midwifery or nursing care is performed in relation to an agreed standard.

Quality Care Process Indicators are defined as quantifiable measures that capture what midwives or nurses are doing to provide that care in relation to a specific tool or method.

Databases Searched

Eight databases were searched systematically i.e., PubMed, Excerpta Medica database (EMBASE), PyscINFO, Applied Social Sciences Index and Abstracts (ASSIA), Cumulative Index of Nursing and Allied Health Literature (CINAHL), the Cochrane Database of Systematic Reviews (CDSR), Cochrane Central Register of Controlled Trials (CENTRAL), and the Database of Abstract of Reviews of Effects (DARE). The search strategy was "nurs*:ab,ti OR midwi*:ab,ti AND ('minimum data set':ab,ti OR indicator*:ab,ti OR metric*:ab,ti OR 'quality measure*':ab,ti) AND [english]/lim AND [2007-2017]/py." Searches were restricted to 2007-2017. No restrictions on study design, outcomes, controls, comparators or language were applied. Grey literature was obtained from both database searches and unpublished materials literature submitted from working group members or from other maternity units.

Study Selection

Studies were included if participants were (i) registered nurses or midwives working in or (ii) were persons in receipt of nursing or midwifery care within public health nursing, midwifery, acute, older people, mental health, children's and intellectual disability care services and (iii) if the study made clear reference to nursing or midwifery care processes and identified a specific quality process in use or proposed use. Citations identified from the search were screened independently by two reviewers. Any disagreements were resolved by the two reviewers, and a third reviewer consulted where necessary. At full text screening, included studies were tagged to work stream descriptors. Studies relevant to each workstream were reviewed by two reviewers from the appropriate workstream.

Data Extraction

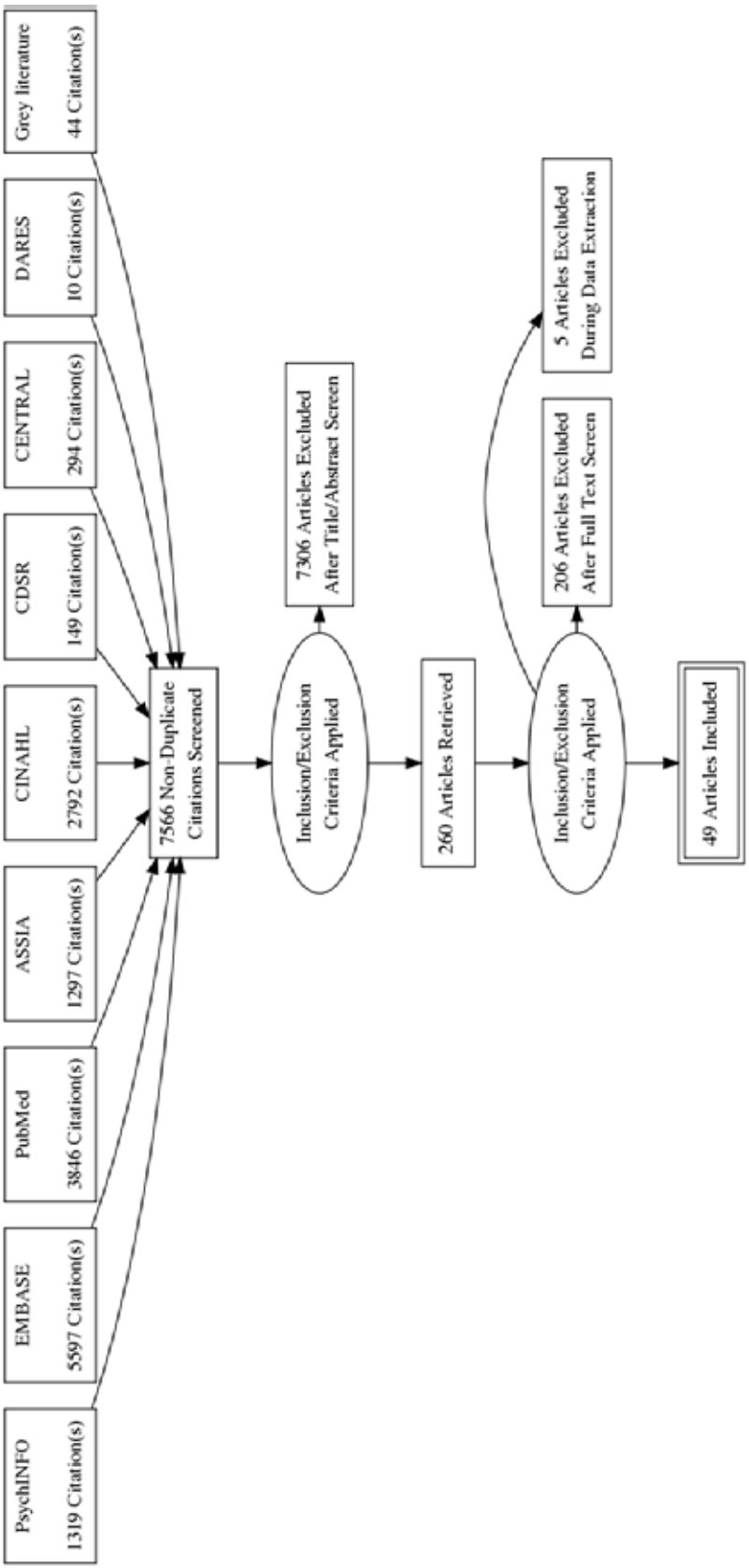
Data were abstracted onto a purposefully designed data extraction form used across all seven work streams. Data abstracted included: study aim/objective, study population, study context/setting, relevant workstream, nursing or midwifery process in current/proposed use, measure (metric/indicator) of nursing or midwifery care process, tool or method used to measure metric, and standard/statement of defined level of quality. Workstream specific data extraction was conducted by two reviewers using a purposefully designed data extraction tool.

Results

In total, 7,524 unique citations were identified across all workstreams. An additional 42 citations were identified for the midwifery workstream through grey literature searches. All citations were screened independently for inclusion by two reviewers. Of these, 260 were identified for full text screening after which 206 were excluded. These articles were then tagged depending on their relevance to each of the seven workstreams i.e., acute, children, intellectual disability, mental health, midwifery, older person, or public health nursing services. Twelve papers were tagged as relevant to the midwifery workstream; one was later excluded leaving 11 published papers included.1-11 Of the 42 citations identified through grey literature searches, 4 were excluded leaving 38. 12-49 This left 49 papers, in total, included (Figure 1). Significantly, grey literature included the previously existing suite of midwifery care process metrics from the Midwifery Standard Operating Procedure for Nursing and Midwifery Quality Care-Metrics (see Appendix E). The findings of the systematic literature review were discussed by working group members and informed the development of the first round of the Delphi survey instrument.

We identified 22 metrics from the systematic review and these metrics were included in the Phase 2, Round 1 Delphi survey instrument.

Figure 1: Study Selection Process Flow Diagram for Midwifery Work Stream



From: Moher D, Liberati A, Tetzlaff J, Altman DG, The PRISMA Group (2009). Preferred Reporting Items for Systematic Reviews and Meta-Analyses: The PRISMA Statement. PLoS Med 6(7): e1000097. doi:10.1371/journal.pmed1000097

Phases 2 & 3 Delphi studies

Aim

To conduct two, two-round Delphi surveys (phase 2 & 3) to identify and prioritise a suite of (a) metrics and (b) their indicators for use in measuring the quality of midwifery care processes.

Methods

Participants

The target population was any midwife working in any sphere of midwifery practice in the Republic of Ireland. With the support of the Office of the Nursing and Midwifery Services Director (ONMSD), Senior Clinical Managers distributed an information pack to potential participants within their respective hospital or community area. This information pack provided potential participants with information on the study, invited participation and asked those who wished to participate to complete a short form containing contact details, including their email address, and to return this form to the Senior Clinical Manager. The managers and any potential participants could also contact the research team directly to clarify any issues or seek further information about the survey and the research prior to making a decision to participate. Snowball sampling was used also, whereby participants were asked to forward the invitation to others whom they regarded as meeting the sampling criteria. Two email invitations were sent to all potential participants, one week apart.

There is an absence of guidance on optimal sample size requirements for consensus development studies such as this. We therefore estimated our required completed survey sample sizes based on that which would be required for the sample to be representative of a given total population of 1884 midwives using a 95% confidence level and a confidence interval of ± 5. Estimates indicated we required 318 completed surveys.

Phase 2: Two-round Delphi (prioritising metrics)

Round 1

The first-round metric instrument contained a short questionnaire seeking participant demographic data and the rating instrument containing 22 metrics identified in the systematic review. To facilitate the capture of metrics not identified in the systematic review, participants were invited, in this round, to add any further 'new' metrics that they considered important or relevant for inclusion in the metric dataset.

Participants were asked to rate the importance of these metrics for inclusion using a 9-point Likert scale i.e., 1-3 = not important, 4-6 = unsure of importance and 7-9 = important.

Round 2

In round 2, participants who responded to round 1 were presented again with all of the metrics after analysis of responses from round 1 (see 'Data analysis' below for details). Additional metrics identified by participants in round 1 were included in round 2. For each metric retained from round 1, the overall rating results (percentages), for each metric was presented. Participants were also sent confidential copies of their individual Round 1 survey responses and asked to re-rate the importance of each metric with knowledge of their and the overall group's previous rating for that metric. In addition, participants were asked to rate outcomes identified newly from round 1. All ratings used the same Likert-type scale used in round 1.

Data analysis

In round 2 analysis, consensus on inclusion of a metric was determined where 70% or more participants rated the metric a 7 to 9 and less than 15% of participants rated the metric a 1 to 3.

Phase 3: Two-round Delphi (prioritising indicators)

Round 1

The first-round indicator instrument contained a short questionnaire seeking participant demographic data and the rating instrument containing metrics identified in Phase 2 and the indicators for these metrics identified from the systematic review. To facilitate the capture of indicators not identified in the review, participants were invited to add any further 'new' indicators they considered important or relevant for inclusion as an indicator to measure the respective metric(s).

Participants were asked to rate the importance of these indicators for inclusion in the respective metric using a 9-point Likert scale i.e., 1-3 = not important, 4-6 = unsure of importance and 7-9 = important.

Round 2

In round 2, participants who responded to round 1 were presented again with all of the metrics and their indicators after analysis of responses from round 1 (see 'data analysis' below for details). Additional indicators identified by participants in round 1 were included in round 2. For each indicator retained from round 1, the rating results (percentages) for each were presented. Participants were sent their individual Round 1 survey responses and asked to re-rate the importance of each indicator with knowledge of their and the overall group's previous rating for that indicator. In addition, participants were asked to rate indicators identified newly from round 1. All ratings used the same Likert-type scale used in round 1.

Data analysis

In the round 2 analysis, consensus on inclusion of an indicator was determined where 70% or more participants rated the indicator a 7 to 9 and less than 15% of participants rated the indicator a 1 to 3.

Ethics

Participation in the study was voluntary. All potential participants received a study information sheet, which outlined the purpose of the study, the risks and benefits of participation, time commitment and were afforded the opportunity to ask any questions. All participants had to indicate their explicit consent to participate by clicking on an 'I agree' button at the end of the online participant information sheet before they could access the survey. Ethical approval to conduct this study was received from Research Ethics Committee at National University of Ireland, Galway on the 13th of December 2016.

Results

Phase 2: Two-round Delphi (prioritising metrics)

A total of 441 midwives expressed an interest, by email, in participating in round 1 of which 263 participated in round 1 of the metric survey. Most respondents to round 1 (see table 1) were staff midwives (34.6%, n = 91) or Clinical midwife managers (2) (24.3%, n = 64) (see Table 2). A large proportion of participants identified their grade of midwifery as 'other' (12.2%, n=32). Of these, most were either clinical skills facilitators (18.8%, n=6) or clinical placement coordinators (18.8%, n=6).

Table 1: Midwifery participants by grade: Round 1 metrics survey

GRADE	Number of Participants in Round 1	%
Staff Midwife	91	(34.6)
Clinical midwife manager (1)	18	(6.8)
Clinical midwife manager (2)	64	(24.3)
Clinical midwife manager (3)	14	(5.3)
Assistant Director of Midwifery	20	(7.6)
Director of Midwifery	8	(3.0)
Clinical Midwife Specialist	13	(4.9)
Advanced Midwife Practitioner	3	(1.1)
Other	32	(12.2)
Total	263	

Of the 263 respondents who completed round 1, 69.1% (n=183) completed Round 2. Most respondents (see Table 2) to round 2 were staff midwives (26.8%, n=49) or clinical midwife managers (grade 2) (29.5%, n=54). A large proportion of the participants in round 2 also identified their grade of midwifery as 'other' (27.5%, n=38).

Table 2: Midwifery Participants by Grade at Close of Round 2

GRADE	Number of Participants per Grade	%
Staff Midwife	49	(26.8)
Clinical Manager (1)	8	(4.4)
Clinical Manager (2)	54	(29.5)
Clinical Manager (3)	8	(4.4)
Assistant Director of Midwifery	17	(9.3)
Director of Midwifery	9	(4.9)
Other	38	(27.5)
Total	183	

Of the 22 metrics included in Round 1, participants rated 21 metrics as important for inclusion in the suite. In addition, 9 metrics were newly identified by participants. These plus the 21 metrics were carried forward to Round 2. In Round 2, participants rated all 30 metrics as important for inclusion in the suite. These 30 metrics were discussed in detail by the Working Group. Of the 30 metrics, three i.e., 'Women's Experience', 'Irish-Maternity Early Warning Score (I-MEWS)' and 'Invasive Medical Devices' were identified as having a separate process either underway or planned for which indicators were and would be developed. Therefore, these were not included in Phase 3 of the project within which indicators to measure adherence to the metrics were developed. In addition, 8 metrics were judged to overlap with other metrics. The remaining 19 metrics were carried forward to Phase 3 and later to the face to face consensus meeting along with participants suggestions for where metrics may overlap.

Phase 3: Two-round Delphi-Developing Consensus on Prioritised Indicators

A total of 217 midwives participated in the round 3 survey. Most respondents (see Table 3) were staff midwives (30.0%, n=65) and clinical midwife managers (grade 2) (25.4%, n=55).

Table 3: Midwifery Participants by Grades at Close of Round 3

GRADE	Number of Participants in Round 1	%
Staff Midwife	65	(30.0)
Clinical Manager (1)	13	(6.0)
Clinical Manager (2)	55	(25.4)
Clinical Manager (3)	15	(6.9)
Assistant Director of Midwifery	17	(7.8)
Director of Midwifery	12	(5.5)
Clinical Midwife Specialist	6	(2.7)
Advanced Midwife Practitioner	3	(1.4)
Other	31	(14.3)
Total	217	

Of the 217 midwives who completed round 3, 69.6% (n=151) completed Round 4. Most respondents (Table 4) to Round 4 were staff midwives (25.89%, n=39) and clinical midwife managers (grade 2) (19.9%, n=30). A large proportion of participants (19.2%, n=29) identified their grade of midwifery as 'other', which consisted largely of clinical placement coordinators (20.7%, n=6).

Table 4: Midwifery Participants by Grades at Close of Round 4

GRADE	Number of Participants per Grade	%
Staff Midwife	39	(25.8)
Clinical Manager (1)	13	(8.6)
Clinical Manager (2)	30	(19.9)
Clinical Manager (3)	6	(4.0)
Assistant Director of Midwifery	15	(9.9)
Director of Midwifery	8	(5.3)
Clinical Midwife Specialist	8	(5.3)
Advanced Midwife Practitioner	3	(2.0)
Other	29	(19.2)
Total	151	

Of the 109 indicators included in round 3, participants rated all as important for inclusion in the midwifery metrics suite. In addition, 1 indicator was newly identified by participants. In Round 4, participants rated the 110 indicators as important for inclusion in the suite. Following detailed review and discussion by the working group, 7 indicators were judged to lack clarity, were potentially ambiguous and were removed. The remaining 103 indicators (and the associated 19 metrics), were carried forward to the face to face consensus meeting.

Phase 4
Consensus meeting

This phase consisted of a face-to-face meeting with key stakeholders (midwives) to review the findings from the Delphi surveys and build consensus on metrics and respective indicators. In total, 19 midwives participated in the face to face consensus meeting. Each of the 19 maternity units in Ireland had a midwifery representative and participants represented all grades of midwives.

At the consensus meeting, participants were provided with paper copies of the list of 19 metrics and 103 indicators following Round 4 of the Delphi survey as well as the percentage rating for each metrics and indicator. Participants were also provided with a Judgement Framework Tool (see Table 5), adapted from Flenady et al. (2016) to guide participants in judging if the metric/indicator was appropriate for inclusion in the final suite of metrics. Consensus meeting participants voted YES or NO on whether each metric and indicator should be included in the final suite using an electronic voting app. Metrics and indicators were required to be voted YES by 70% or more participants to be included in the final suite of metrics and indicators.

Table 5: Nursing and Midwifery Quality Care-Metrics Judgement Framework Tool

DOMAIN	
01	**PROCESS FOCUSED** The metrics/ indicator contributes clearly to the measurement of nursing or midwifery care processes.
02	**IMPORTANT** The data generated by the metric/indicator will likely make an important contribution to improving nursing or midwifery care processes.
03	**OPERATIONAL** Reference standards are developed for each metric or it is feasible to do so. The indicators for the respective metric can be measured.
04	**FEASIBLE** It is feasible to collect and report data for the metric/indicator in the relevant setting.

(adapted from Flenady et al. 2016)

At the conclusion of the consensus meeting 18 metrics with 93 associated indicators were agreed to be included in the suite of final suite of Midwifery Quality Care-Metrics (see Table 6). In addition, three metrics i.e., 'Women's Experience', 'Irish-Maternity Early Warning Score (I-MEWS)' and 'Invasive Medical Devices' were identified as having a separate national process either underway or planned for which indicators were or would be developed. Therefore, these were not included in the final suite agreed within this project.

Table 6: Agreed Metrics and Indicators Following Midwifery Consensus Meeting

METRIC (N=18)		INDICATORS
Midwifery Plan of Care	1	A midwife's plan of care is evident and reflects the woman's current condition including referral where appropriate
	2	Appropriate midwifery care based on the assessment and plan is reordered
Booking	1	The woman's name and healthcare record number are on each page/screen
	2	All previous pregnancies and outcomes are recorded
	3	Past medical/surgical/family/genetic/social/medication (as appropriate) histories are recorded
	4	The allergy status is recorded
	5	Infection status /alert is recorded
	6	The blood pressure, and gestation at booking is recorded
	7.	There is evidence of assessment of antenatal risk factors recorded
	8	Whether a blood transfusion is acceptable to the woman is recorded
	9	There is evidence of assessment for mental health illnesses recorded
	10	There is evidence of routine inquiry for domestic violence recorded
	11	There is evidence that infant feeding has been discussed with the woman and recorded
	12	There is evidence that health information relating to pregnancy has been given and recorded
Abdominal examination *(after 24 weeks gestation) on Current or Last Assessment*	1	Abdominal inspection findings are recorded
	2	Palpation-Fundal height in cms (where appropriate) is recorded
	3	Palpation-Lie is recorded
	4	Palpation-Presentation (where appropriate) is recorded
	5	Palpation-Position (where appropriate) is recorded
	6	Palpation-Engagement (where appropriate) is recorded
	7	Palpation-Fetal activity (if present) is recorded
	8	Auscultation-Fetal heart rates-Use of Pinard or hand held Doppler with a record of fetal heart rate in beats per minute (BPM)
Intrapartum Fetal Wellbeing	1	There is recorded evidence of fetal heart monitoring with Pinard/Doppler on initial assessment
	2	When using intermittent auscultation, the fetal heart is recorded at least every 15 minutes in the 1st stage of labour and at least every 5 minutes in the 2nd stage of labour
	3	There is recorded evidence of date and time of infant's birth in the labour record
	4	Colour and volume of liquor are recorded
Intrapartum Fetal wellbeing cardiotocography *(CTG)*	1	There is recorded evidence of indication for cardiotocography (CTG)
	2	The date/time is validated and recorded at the start of CTG
	3	The woman's name and hospital number are recorded on the CTG by the midwife
	4	The maternal pulse is recorded on the CTG strip on commencement of the CTG tracing
	5	There is recorded evidence of systematic CTG interpretation occurring hourly (baseline, variability, accelerations, decelerations, uterine activity and plan of care)
	6	There is recorded evidence that CTGs of concern have been reviewed by the senior midwife and/or obstetrician

Intrapartum Maternal wellbeing	1	There is recorded evidence of recording of maternal vital signs during labour according to the woman's condition
	2	A narrative is recorded at least hourly, to provide a record of the woman's condition
	3	Indication for vaginal examination is recorded
	4	Consent to perform vaginal examination is recorded
	5	There is recorded evidence of abdominal examination prior to vaginal examination.
	6	There is evidence of systematic record keeping of the findings of all vaginal examinations
	7	There is recorded evidence that a discussion has occurred with the woman about her care to include birth preferences
	8	There is recorded evidence of contraction assessment at least every 30 minutes
	9	There is recorded evidence of date and time of onset of each stage of labour
	10	The name and designation of the person professionally requested to review the woman is recorded (as appropriate)
	11	Indication for amniotomy is recorded
	12	Consent for amniotomy is recorded
	13	Indication for administration of oxytocin is recorded
	14	Consent for administration of oxytocin is recorded
	15	There is recorded evidence that oxytocin infusion has been reduced or stopped when uterine tachystystole is present
	16	Where a CTG is of concern, there is recorded evidence that the oxytocin infusion was reduced or discontinued and a medical review was undertaken
	17	There is recorded evidence of findings of assessment for perineal trauma
	18	Where perineal repair is necessary and is performed by midwife, there is recorded evidence of repair
	19	There is recorded evidence of estimated blood loss at birth
	20	The date, time and method of birth are recorded
Risk assessment for Venous Thromboembolism (VTE) in Pregnancy & the Puerperium	1	There is recorded evidence of venous thromboembolism (VTE) assessment on admission
	2	There is recorded evidence of VTE assessment postnatally
Immediate post birth care	1	Maternal vital signs are recorded on the IMEWS chart, prior to transfer to the postnatal ward
	2	Maternal urinary output is recorded
	3	Skin to skin contact is recorded
	4	Breast feeding initiation time is recorded for a woman who chooses to breastfeed
	5	Neonatal condition at birth (live, neonatal death, fetal death) is recorded
	6	Findings of initial systematic examination of the newborn is recorded
Communication *(Clinical Midwifery Handover)*	1	Mother- Identification of risk factors in handover is recorded
	2	Baby- Confirmation of identify band checking is recorded
	3	Baby- Gender of newborn is recorded
	4	Baby- Security tag is recorded as present and active
Pain management *(other than labour)*	1	Woman's response to actions taken to reduce pain are recorded
Infant feeding	1	Method of infant feeding is recorded
	2	Assessment of effectiveness of baby feeding is recorded
	3	The actions taken if feeding is ineffective are recorded

Postnatal care *(daily midwifery care processes)*	1	There is recorded evidence of ongoing postnatal education being offered to the woman
	2	There is recorded evidence of daily assessment of the mother (as per national health care record/local policy)
	3	There is recorded evidence of how well the woman is coping postnatally
	4	There is recorded evidence of daily assessment of the neonate (as per national health care record/local policy)
Post birth discharge planning for home	1	Discharge date and time are recorded
	2	The name of midwife completing discharge is recorded
	3	The destination of the woman is recorded on discharge
	4	Referral for professional skilled services (e.g. lactation consultant, physio, social work, speciality clinic, if required) is recorded
	5	There is recorded evidence of neonatal pulse oximetry screening having been performed (if appropriate)
	6	There is recorded evidence of discharge advice/discussion on health and wellbeing of self and baby
Medication administration	1	The allergy status is clearly identifiable on the front page of prescription chart.
	2	All prescribed medication is administered in accordance with local and national policies, procedures, protocols and guidelines (PPPGs)
Medication, Storage and Custody *(excluding MDAs)*	1	A registered midwife is in possession of the keys for medicinal product storage
	2	All medicinal products are stored in a locked cupboard or locked room
MDA Drugs	1	MDA drugs are checked & signed at each changeover of shifts by midwifery staff
	2	Two signatures are entered in the MDA drug register for each administration of an MDA drug
	3	The MDA drug cupboard is locked and keys for MDA cupboard are held by designated midwife
	4	MDA drug keys are kept separate from other medication keys
Intravenous fluid therapy	1	Fluid balance charts are completed accurately and totalled
Clinical Record Keeping	1	All entries are dated and timed (using 24 hour clock)
	2	All written records are legible, in permanent ink and signed
	3	All entries are in chronological order
	4	All abbreviations/grading systems are from a national or local approved list/ system
	5	Alterations/corrections are as per HSE standards and recommended practices for healthcare records management
	6	Recorded care provided by midwifery students is countersigned by a registered midwife

Additional metrics agreed to be included with indicators identified from external sources. NB: Indicators will be taken from said external sources.

- Women's Experience Quality Care-Metric To be measured with **HIQA/HSE National Women's Experience Survey** when developed.
- Invasive Medical Devices to be recorded as part of **peripheral lines and urinary catheters care bundles**.
- **IMEWS/Observation** To be recorded in new IMEWS Guideline Audit Tool.

Conclusion

The research process and final set of metrics and indicators presented in this report reflect the methodologically robust and rigorous process outlined. Importantly, the widespread engagement in the project by midwives of all grades and geographical areas nationally, via the work stream groups and project officers, has ensured that there is a real sense of ownership of the metrics and indicators from midwives across settings.

Recommendations

The development of this suite of process metrics and indicators for midwifery practice provides an opportunity for Ireland to take the lead internationally in generating evidence on the effectiveness of midwifery process metrics and associated indicators.

This initial work presented in this report should be followed up by a rigorous evaluation of the impact of the new suite of metrics on midwifery care processes. Designs which control insofar as possible for confounding variables such as interrupted time series studies should be considered. This should be determined prior to implementation so that opportunities for baseline assessments are not lost prior to implementation.

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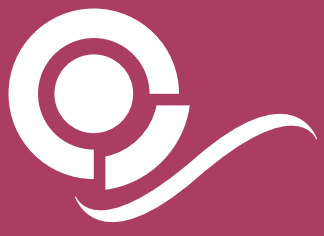
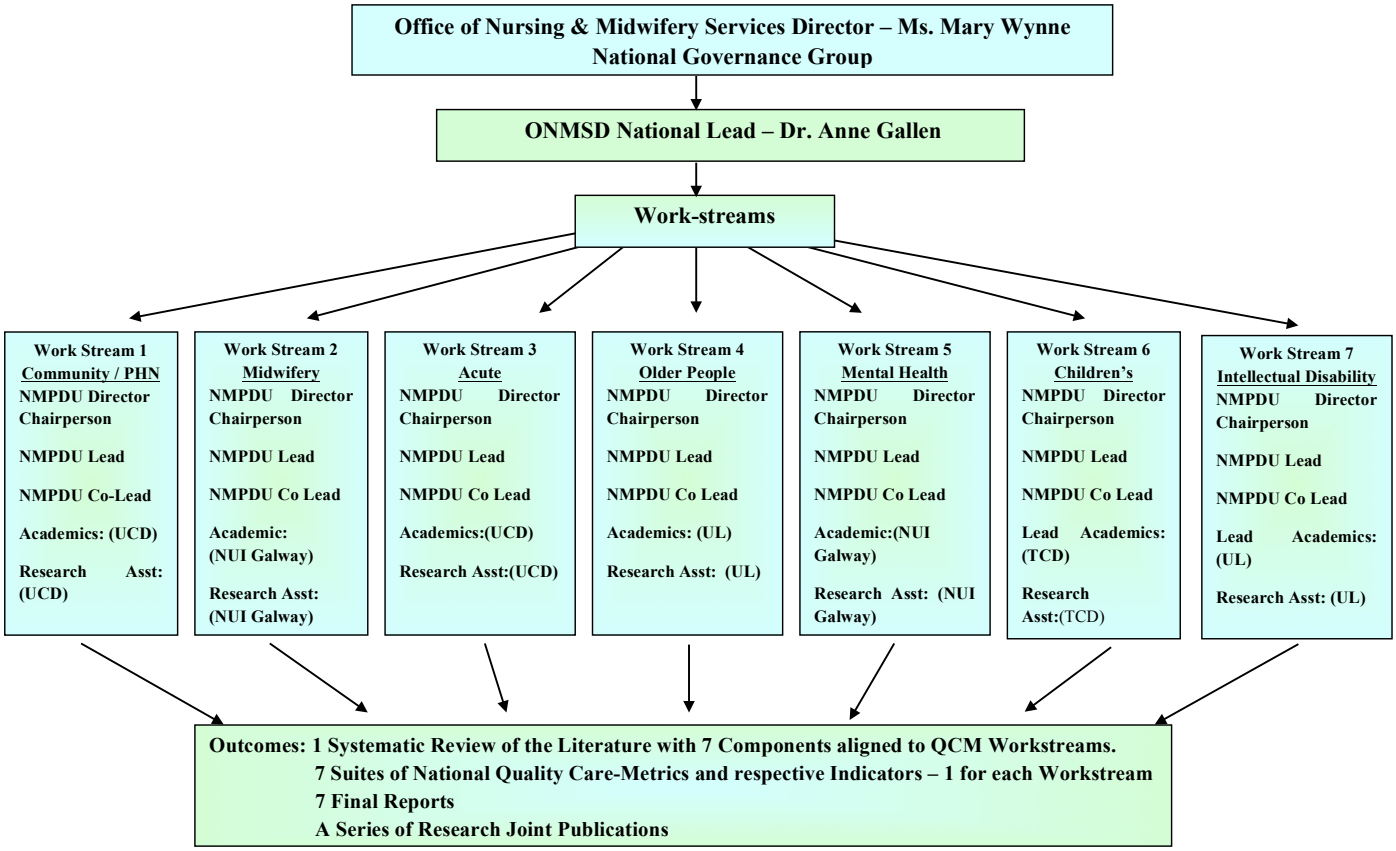
Appendices



NURSING & MIDWIFERY
QUALITY
CARE-METRICS

Appendix A:
Nursing and Midwifery Quality Care-Metrics Governance Flow Chart



Appendix B:
Nursing & Midwifery Quality Care-Metrics – Academic & NMPD Steering Group Membership

OFFICE OF NURSING & MIDWIFERY SERVICE DIRECTOR	**Ms. Mary Wynne,** HSE, Interim Nursing and Midwifery Services Director & Assistant National Director, Office of the Nursing & Midwifery Services Director
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ADMINISTRATION	**Ms. Anita Gallagher,** NMPDU, HSE, North West

Appendix C:
Nursing & Midwifery Quality Care-Metrics – National Governance Steering Group Membership

Chairperson	**Ms. Mary Wynne,** HSE, Interim Nursing and Midwifery Services Director & Assistant National Director, Office of the Nursing & Midwifery Services Director
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QCM NMPD Project Officers Representative	**Ms. Gillian Conway,** QCM Project Officer, NMPDU, HSE West/Mid-West
Hospital Group Chief Nurse Representatives / IADNAM DON/M Representatives: • Acute Care • Midwifery • Children's Nursing • Older Persons	**Ms. Julie Nohilly,** Director of Nursing, Galway University Hospital **Ms. Mary Brosnan,** Director of Midwifery & Nursing, The National Maternity Hospital, Adjunct Associate Professor, UCD School of Nursing, Midwifery and Health Systems, **Ms. Suzanne Dempsey,** Chief Director of Nursing, Children's Hospital Group **Ms. Georgina Bassett,** National Leadership & Innovation Centre for Nursing and Midwifery NLIC, Office of the Nursing & Midwifery Services Director ONMSD
Area Director of Mental Health Nursing Representative	**Ms. Catherine Adams,** Office of the Area Director of Nursing, Mid-West Mental Health Services
Director of Public Health Nursing	**Ms. Mary B Finn-Gilbride,** Director Public Health Nursing, HSE South, Upper George's Street, Wexford
Director of Nursing Intellectual Disability	**Ms. Theresa O'Loughlin,** Oakridge Children's Services Manager, Daughters of Charity Disability Support Services
HSE Quality Improvement Division Representative	**Dr. Jennifer Martin,** Quality Improvement Division Lead on Measurement for Improvement, Stewart's Hospital, Dublin
HSE ICT Representative	**Mr. Pat Kelly,** Corporate IT Delivery Director, Office of the CIO
INMO Representative	**Ms. Martina Harkin-Kelly,** President, Irish Nurses & Midwives Organisation
PNA Representative	**Ms. Aisling Culhane,** Research and Development Advisor, Psychiatric Nurses Association
SIPTU Representative	**Ms. Aideen Carberry,** Assistant Organiser, SIPTU Health Division
Patient Representative	**Ms. Anne Harris,** Development & Case Support - Southern Area, SAGE (Support & Advocacy Service)
Secretary to the Group	**Ms. Anita Gallagher,** HSE, NMPDU, North West

Appendix D:
Nursing & Midwifery Quality Care-Metrics – Midwifery Workstream Working Group Membership

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NMPD CO-LEAD	**Ms. Gillian Conway,** QCM Project Officer, NMPDU , HSE West/Mid-West
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SERVICE USER REPRESENTATIVE	**Ms. Marie Cregan** **Ms. SheilaSugrue,** ONMSD, HSE **Dr. Linda Biesty,** Lecturer in Midwifery, National University of Ireland Galway **Ms. Rebecca, O'Donovan,** A/National Breast Feeding Coordinator **Ms. Olive Long,** Director of Midwifery, Cork University Maternity, Hospital **Ms. Rosaline O'Donovan,** Ass Director of Midwifery, Cork University Maternity, Hospital **Ms. Katie Bourke,** Assistant Director of Midwifery, Cork University Maternity, Hospital **Ms. Kate Lyons,** Clinical Skills Facilitator, Cork University Hospital **Ms. Anna Maria Verling,** Bereavement, Loss Midwife, Cork University Maternity, Hospital **Ms. Sinead Heaney,** Director of Midwifery, South Tipperary University Hospital **Ms. Breda Crotty,** Clinical Midwife Manager 3, Waterford University Hospital **Ms. Janet Murphy,** Registered Advance Midwife Practitioner, Waterford University Hospital **Ms. Ann Holly,** Practice Development Coordinator, Kerry University Hospital **Ms. Mary Brosnan,** Director of Midwifery, National Maternity Hospital **Ms. Luicille Sheehy,** Clinical Practice Development Coordinator, National Maternity Hospital

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Ms. Margaret Quigley, Director of Midwifery, University Maternity Hospital, Limerick
Ms. Mary Doyle, Midwifery Practice Development Coordinator, University Maternity Hospital, Limerick
Ms. Helen Coe, Community Midwife, University Maternity Unit, Limerick
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Ms. Ann Bowers, Acting Practice Development Coordinator, Coombe Hospital

Ms. Maureen Revilles, Interim Director of Midwifery, Midlands Regional Hospital, Portlaoise
Ms. Helen Murphy, Director of Midwifery, University Hospital, Galway

Appendix E:
Existing Midwifery Metrics at the Start of Quality Care-Metrics Process

METRIC	INDICATORS
MEDICATION STORAGE AND CUSTODY	• A registered midwife is in possession of the keys for Medicinal Product Storage • All Medicinal products are stored in a locked cupboard or locked room. • 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 Drug Formulary is available on all Med Trolleys.
MDA DRUGS	• MDA drugs are checked & signed at each changeover of shifts by midwifery staff. (By member of Day Staff & Night Staff). • Two signatures are entered in the MDA Drug Register for each administration of an MDA drug. • The MDA Drug cupboard is locked and keys for MDA cupboard are held by designated Midwife. • MDA drug keys are kept separate from other medication keys.
MEDICATION ADMINISTRATION	• The Individual's prescription documentation provides details of individual's legible name and health care record number. • The Individuals' identification band has correct and legible name and healthcare record number or photo ID is in use. • The Allergy Status is clearly identifiable on the front page of the prescription chart. • Prescribed Medication not administered have an omission code entered. • The individuals' locker and bedside/ or surrounding environment are free of unsecured prescribed medicinal products.
MEDICATION PRESCRIPTION	• The Generic name is used for each drug prescribed • The Start date is recorded • The Prescription is written in capital letters • The correct legible Dose of the drug is recorded and not abbreviated • The Route and/or Site of Administration is recorded • The Frequency of Administration is recorded & correct timings indicated • The minimum dose interval and/or 24-hour maximum dose is specified for all "as required" or PRN drugs • The Prescription has a legible Prescriber's Signature (in ink) • Discontinued drugs are crossed off, dated and signed by prescriber.

MIDWIFERY PLAN OF CARE: PERSONAL DETAILS	• The Individuals Name and Healthcare Record Number are on each page/screen. • Reason for admission/attendance is recorded and the admission date and time are Recorded. • All previous pregnancies and out comes are documented. • Past medical/surgical history are recorded • The Allergy Status is clearly identifiable on relevant nursing documentation. • Infection Status /Alert is recorded. • There is evidence that the booking bloods results are recorded. • There is evidence that infant feeding has been discussed with the woman. • There is evidence that health information relating to pregnancy has been given.
MIDWIFERY PLAN OF CARE	• A Midwife's plan of Care is evident and reflects the individuals' current condition. • All risk assessments have been completed within the set time frames as per local policy. • When a woman is considered high risk, there is documented evidence that she is referred to the appropriate medical team/ obstetric team/service. • Midwives Interventions are individualised, dated, timed and signed. • Timely Evaluation of the Midwife's plan of care is evident and has been updated accordingly.
NMBI GUIDANCE	• All entries are dated and timed (24-hour clock). • All written records are legible, in permanent ink and signed. • All entries are in chronological order. • All abbreviations/grading systems are from a national or local approved list/system. • Alterations/corrections are as per NMBI Guidance. • Student midwives' entries are countersigned by the supervising midwife.
MONITORING IN LABOUR	• Indication and Consent to perform vaginal examinations are recorded. • Indication and consent for type of fetal monitoring is documented • There is evidence of fetal heart monitoring with Pinard/doptone/ doppler on initial Assessment. • Birthplans are dated and timed and signed by attending midwife. • The name and designation of the person professionally requested to review the woman is documented. • A narrative is recorded at least hourly, to provide a record of the woman's condition
PARTOGRAM MONITORING	• The partogram was commenced on diagnosis of labour onset. • Maternal blood pressure, pulse and temperature are recorded on the partogram. • The fetal heart is recorded every 15 minutes in the first stage of labour and every 5 minutes in the 2nd stage. • The frequency of uterine activity was recorded for 10 minutes at least every 30 minutes up to time of birth.

CTG MONITORING	• The date/time is validated at the start of the CTG. • The woman's name and hospital number are recorded on the CTG strip by the midwife. • The maternal pulse is recorded on the CTG strip on commencement of the procedure. • There is documented evidence that a pathological CTG pattern was reviewed by the Senior midwife and Registrar. • The date, time and method of birth are recorded at the end of the trace and the CTG is stored securely either electronically or at the back of chart securely.
OXYTOCIN MONITORING	• Indication and consent for use of oxytocin is recorded. • Oxytocin infusion has been reduced when contraction frequency has exceeded 5 in 10 Minutes. • For a pathological CTG there is evidence that the oxytocin infusion was discontinued and a medical review was undertaken.
MIDWIFERY PLAN OF CARE: POST DELIVERY	• Maternal observations, temperature, pulse, BP, respirations were recorded on the Early Warning Chart, prior to transfer to the postnatal ward. • Uterine involution, blood loss, condition of perineum and urinary out put are documented. • Skin to skin contact is recorded. • Infant temperature is recorded. • Breast-feeding initiation time is recorded for a woman who chooses to breastfeed.
IMEWS/OBSERVATION	• The woman's name, date of birth and healthcare record number are on both sides of the observation chart. • Observations are dated, timed and signed. • The booking blood pressure and gestation at booking is recorded. • The IMEWS are recorded using the 24 hour clock for each entry. • In each entry, Respiratory Rate, Temperature, Maternal heart rate, systolic and diastolic blood pressure, SPO2, urinalysis, pain score and AVPU are recorded. • In each entry, the IMEWS is completed and totalled correctly • There is evidence that the care was escalated to the appropriate level as per escalation protocol (Team/On Call SHO/Registrar/ Consultant as appropriate). • There is evidence of an increase in the frequency of monitoring and recording of vital signs in response to the detection of abnormal physiology. • 24hr cumulative balances are evident on all fluid balance charts.
INVASIVE MEDICAL DEVICES	• An assessment of the insertion site is recorded daily on care plan. • The Clinical Indication for insertion of the indwelling urinary catheter is recorded.
DISCHARGE PLANNING	• There is evidence that the woman has been given information on reasons for presenting to hospital outside of appointment times. • There is documented evidence that discharge advise has been discussed with the Woman. • A Predicted Date of Discharge is documented.

WOMEN'S EXPERIENCE QUALITY CARE-METRIC	1. Are you satisfied with the cleanliness of the ward? 2. Have you observed the midwives perform hand hygiene? 3. Have you received adequate information from midwives about your medication? 4. Have midwives given you enough privacy when being examined or treated? 5. Do midwives treat you with respect and dignity on this ward? 6. Do you feel your pain has been managed appropriately 7. When using the Midwife Call bell/buzzer, is it answered within the appropriate timeframe? 8. Have midwives on the ward talked to you about going home? 9. Would you recommend this hospital/service to your family or friends?

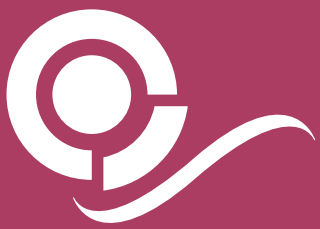
Appendix F:
Description of Nursing & Midwifery Grades

Grade	Description
Staff Nurse / Staff Midwife / Registered Nurse Community / Registered Midwife Community	Relates to a nurse or midwife registered in the general, midwifery, children's, psychiatric or intellectual disability division of the professional register of the Nursing & Midwifery Board of Ireland. The role includes assessing, planning, implementing and evaluation of care to the highest professional and ethical standards within the model of care relevant to the care setting. Generally reports to a Clinical Nurse/Midwife Manager grade and is professionally accountable to nursing/midwifery management levels.
Public Health Nurse (PHN)	Registered in the PHN division of the professional register of the Nursing & Midwifery Board of Ireland. Works as a member of the primary care team and provides a range of nursing and midwifery services to people of all ages in the community. Reports to the Assistant Director of Public Health Nursing
Clinical Nurse/ Midwife Manager 1 (CNM/CMM 1)	Registered in the general, midwifery, children's, psychiatric or intellectual disability division of the professional register of the Nursing & Midwifery Board of Ireland. Provides clinical and professional leadership and development to the nursing/midwifery team. Responsible for the management and delivery of care to the optimum standard within the designated area of responsibility. Generally reports to the Clinical Nurse/Midwife Manager 2 or 3 grades, depending on the structure of the organisation, and is professionally accountable to the Assistant Director or Director of Nursing/Midwifery.
Clinical Nurse/ Midwife Manager 2 (CNM/CMM2)	Registered in the general, midwifery, children's, psychiatric or intellectual disability division of the professional register of the Nursing & Midwifery Board of Ireland. Responsible for the management of a nursing/midwifery team and the service delivery within a specific area. Generally reports to a Clinical Nurse/ Midwife Manager 3 or Assistant Director of Nursing/Midwifery grade, and is professionally accountable to the Assistant Director or Director of Nursing/ Midwifery.
Clinical Nurse/ Midwife Manager 3 (CNM/CMM 3)	Registered in the general, midwifery, children's, psychiatric or intellectual disability division of the professional register of the Nursing & Midwifery Board of Ireland. Usually responsible for more than one clinical area within the organisation. The role incorporates resource management and the continuing professional leadership of nursing and midwifery teams. Reports to the Assistant Director or Director of Nursing/Midwifery.

Clinical Nurse/ Midwife Specialist (CNSp/CMSp)	Registered in the general, midwifery, children's, psychiatric or intellectual disability division of the professional register of the Nursing & Midwifery Board of Ireland. Works in a clinical area of speciality practice which requires the application of specially focused knowledge and skills for safe care delivery. The specialist practice encompasses a major clinical focus. A level 8 postgraduate qualification and experience in the clinical specialist field are required for appointment. Reports to the Assistant Director or Director of Nursing/ Midwifery/PHN.
Community Mental Health Nurse (CMHN)	Registered in the psychiatric division of the professional register of the Nursing & Midwifery Board of Ireland. Works in a community area of speciality practice which requires the application of specially focused knowledge and skills for safe care delivery. The specialist practice encompasses a major clinical focus. A level 8 postgraduate qualification and experience in the clinical specialist field are required for appointment. Reports professionally and is operationally accountable to the Area Director of Nursing.
Clinical Skills Facilitator	Registered in the general, midwifery, children's, psychiatric or intellectual disability division of the professional register of the Nursing & Midwifery Board of Ireland. Provides clinical support, education and guidance to nurses, midwives and students to support them to achieve/maintain their required clinical skills and competencies.
Practice Development Co-ordinator (PDC)	Registered in the general, midwifery, children's, psychiatric or intellectual disability division of the professional register of the Nursing & Midwifery Board of Ireland. Works at the grade of an Assistant Director of Nursing/Midwifery/ PHN with a specific focus on the development of nursing/midwifery practice. Reports to the Director of Nursing/Midwifery/Public Health Nursing
Advanced Nurse/Midwife Practitioner (AN/MP)	Registered in the AN/MP professional register of the Nursing & Midwifery Board of Ireland. Uses advanced nursing/midwifery knowledge and critical thinking skills as an autonomous practitioner to deliver optimum care through caseload management of acute and chronic illness. The role is an expert in clinical practice, educated to Master's level 9 or above and reports professionally to the Director of Nursing/Midwifery/PHN.
Assistant Director of Nursing/ Midwifery/ Public Health Nursing (ADON/M/PHN)	Registered in the general, midwifery, children's, psychiatric or intellectual disability division of the professional register of the Nursing & Midwifery Board of Ireland. Manages the service delivery function and the nursing and midwifery teams within the area of responsibility. The role encompasses strategic planning and development. Reports to the Director of Nursing / Midwifery / Public Health Nursing
Director of Nursing/ Midwifery/ Public Health Nursing (DON/M/PHN)	Registered in the general, midwifery, children's, psychiatric or intellectual disability division of the professional register of the Nursing & Midwifery Board of Ireland. Responsible for all of the nursing and midwifery teams within the specific organisation. Works as part of the senior management team to achieve the organisational goals. Reports operationally to the General Manager/CEO. In acute hospital care the professional reporting relationship is to the Chief Director of Nursing/Midwifery.

Nurse / Midwife Lecturer /Educator / Tutor / Specialist Co-ordinator	Registered on the Nurse Tutor division of the professional register of the Nursing & Midwifery Board of Ireland. Normally employed within an educational institution with responsibility for the delivery of nursing and midwifery education at undergraduate, postgraduate or continuing professional development level.
Director of Centre of Nursing/ Midwifery Education (CNME)	Registered on the general, midwifery, children's, psychiatric or intellectual disability division of the professional register of the Nursing & Midwifery Board of Ireland. Responsible for overseeing the delivery of continuing professional development education, training and development to enable registered nurses, midwives and healthcare assistants to maintain and develop knowledge, skills and competence.
Director of Nursing & Midwifery Planning and Development Unit (NMPDU)	Registered on the general, midwifery, children's, psychiatric or intellectual disability division of the professional register of the Nursing & Midwifery Board of Ireland. Leads and manages a nursing and midwifery team within a designated regional area to provide strategic, professional, practice, education and clinical leadership to enable the future development of nursing and midwifery services
Nursing & Midwifery Planning & Development Officer (NMPD Officer)	Registered on the general, midwifery, children's, psychiatric or intellectual disability division of the professional register of the Nursing & Midwifery Board of Ireland. The role is to support and enhance healthcare delivery through the development of nursing and midwifery in acute hospital and/or community healthcare organisations.

Notes



NURSING & MIDWIFERY QUALITY CARE-METRICS

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