SUMMARY DOCUMENT

NATIONAL SUMMARY GUIDANCE

FOR NURSING AND MIDWIFERY QUALITY CARE-METRICS DATA MEASUREMENT IN

MIDWIFERY SERVICES 2018

To be used in conjunction with the National Guideline for Nursing and Midwifery Quality Care-Metrics Data Measurement in Midwifery Services 2018 (ONMSD 2018 - 027)

OFFICE OF THE
NURSING AND MIDWIFERY SERVICES DIRECTOR
HEALTH SERVICE EXECUTIVE

NURSING & MIDWIFERY QUALITY CARE-METRICS

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Office of the Nursing & Midwifery Services Director

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1.0 INITIATION OF QUALITY CARE-METRICS AT SERVICE LEVEL

1.1 Purpose

1.1.1 The purpose of this summary guidance is to ensure a consistent approach to the implementation of Quality Care-Metrics by the Midwifery 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 Midwifery 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 midwives and nurses within Midwifery services, who are engaged with Quality Care-Metrics in midwifery and nursing practice.

1.2.2 This summary guidance does not apply to other disciplines outside of midwifery and nursing.

1.2.3 The application of this summary guidance is aligned to the Quality Care-Metrics Midwifery Services Research Report (HSE 2018) and the National Guideline for Nursing and Midwifery Quality Care-Metrics Data Measurement in Midwifery Services 2018 (ONMSD 2018 - 027).

1.2.4 All midwives and nurses within Midwifery services, who are engaged with Quality Care-Metrics in midwifery and nursing practice, should complete the Signature Sheet in the National Guideline for Nursing and Midwifery Quality Care-Metrics Data Measurement in Midwifery Services 2018 (ONMSD 2018 - 027) 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 midwives and nurses to engage with and implement Nursing and Midwifery 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 Midwifery Services 2018 (ONMSD 2018 - 027), will enable consistency in the reliability and validity of the data collection to support a standardised approach in Midwifery services nationally.

1.4.2 Measurement of the quality of care delivered provides an assurance mechanism that captures the contribution and performance of midwives and nurses and in a way that is transparent and focuses on improvement.

2.0 METRICS, INDICATORS & ADVICE FOR MIDWIFERY SERVICES

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

Midwifery Plan of Care	Infant Feeding
Booking	Postnatal Care (daily midwifery care processes)
Abdominal Examination (after 24 weeks gestation) on Current or Last Assessment	Post Birth Discharge Planning for Home
Intrapartum Fetal Wellbeing	Medication Administration
Intrapartum Fetal Wellbeing- cardiotocography (CTG)	Medication, Storage and Custody (excluding MDA's)
Intrapartum Maternal Wellbeing	MDA Scheduled Controlled Drugs
Risk Assessment for Venous Thromboembolism (VTE) in Pregnancy & Puerperium	Intravenous Fluid Therapy
Immediate Post Birth Care	Clinical Record Keeping
Communication (clinical midwifery handover)	IMEWS Documentation Standards
Pain Management (other than labour)	IMEWS Parameters

Figure 1: Midwifery Services Quality Care-Metrics

2.1 Midwifery Plan of Care Quality Care-Metric

Midwifery Plan of Care **I** = Indicator, **A** = Data Collectors Advice, **N/A** = Not Applicable		
1	**I**	**A midwife's plan of care is evident and reflects the woman's current condition including referral where appropriate**
	A	Mark **Yes** if a midwifery plan of care is in place which reflects the woman's current condition and/or there is documented evidence that she has been referred where appropriate. Mark **No** if there is not a midwifery plan of care in place and/or there is no documented evidence that she has been referred where appropriate. **Note:** Review the plan of care for the last 72 hours.
2	**I**	**Appropriate midwifery care based on the assessment and plan is recorded**
	A	Mark **Yes** if appropriate midwifery care based on the assessment and plan is recorded within the last 72 hours. Mark **No** if appropriate midwifery care based on the assessment and plan has not been recorded within the last 72 hours.
3	**I**	**There is recorded evidence that a discussion has occurred with the woman about her care to include birth preferences**
	A	Mark **Yes** if there is recorded evidence that a discussion has occurred with the woman about her care to include birth preferences. Mark **No** if there is no recorded evidence that a discussion has occurred with the woman about her care to include birth preferences.

2.2 Booking Quality Care-Metric

Booking **I** = Indicator, **A** = Data Collectors Advice, **N/A** = Not Applicable		
1	**I**	**The woman's name and healthcare record number(HCRN)are on each page/screen**
	A	Mark **Yes** if the woman's name and HCRN are on each page/screen of the midwifery documentation. Mark **No** if any one of the components is not recorded on each page/screen of the midwifery documentation. Mark **N/A** if using MN-CMS.
2	**I**	**All previous pregnancies and outcomes are recorded**
	A	Mark **Yes** if previous pregnancies and outcomes have been recorded. Mark **No** if previous pregnancies and outcomes are not recorded. Mark **N/A** if there is no previous pregnancies.

3	I	**Past medical/surgical/family/genetic/social/medication (as appropriate) histories are recorded**
	A	Mark **Yes** if medical/surgical/genetic/social/medication (as appropriate) history is recorded. Mark **No** if history is not recorded.
4	I	**The allergy status is recorded**
	A	Mark **Yes** if any known allergies are recorded. Mark **No** if there is no status recorded or if status is left blank.
5	I	**Infection status /alert is recorded**
	A	Mark **Yes** if infection status is recorded. Mark **No** if there is no status recorded or if status is left blank.
6	I	**The blood pressure and gestation at booking is recorded**
	A	Mark **Yes** if blood pressure and gestation are recorded at booking. Mark **No** if the blood pressure and/or gestation at booking are not recorded.
7	I	**There is evidence of assessment of antenatal risk factors recorded**
	A	Mark **Yes** if there is recorded evidence of assessment of antenatal risk factors. Mark **No** if there is no recorded evidence of assessment of antenatal risk factors.
8	I	**There is recorded evidence if a blood transfusion is acceptable to the woman**
	A	Mark **Yes** if there is recorded evidence that a blood transfusion is acceptable/not acceptable to the woman. Mark **No** if there is no recorded evidence that a blood transfusion is acceptable/not acceptable to the woman.
9	I	**There is evidence of assessment for mental health illnesses recorded**
	A	Mark **Yes** if there is recorded evidence of assessment for mental health illnesses. Mark **No** if there is no recorded evidence of assessment for mental health illnesses.
10	I	**There is evidence of routine inquiry for domestic violence recorded**
	A	Mark **Yes** if there is recorded evidence of routine inquiry for domestic violence. Mark **No** if there is no recorded evidence of routine inquiry for domestic violence.
11	I	**There is evidence that infant feeding has been discussed with the woman and recorded**
	A	Mark **Yes** if there is recorded evidence that infant feeding has been discussed. Mark **No** if there is no recorded evidence of discussion regarding infant feeding.
12	I	**There is evidence that health information relating to pregnancy has been given and recorded**
	A	Mark **Yes** if there is recorded evidence that health information relating to pregnancy has been given. Mark **No**, if there is no recorded evidence of health information relating to pregnancy has been given.

2.3 Abdominal Examination (after 24 weeks gestation) on Current or Last Assessment Quality Care-Metric

ABDOMINAL EXAMINATION (AFTER 24 WEEKS GESTATION) ON CURRENT OR LAST ASSESSMENT **I** = Indicator, **A** = Data Collectors Advice, **N/A** = Not Applicable		
1	**I**	**Abdominal inspection findings are recorded**
	A	Mark **Yes** if there is recorded evidence of abdominal inspection findings on current or last assessment. Mark **No** if there is no record evidence of abdominal inspection findings on current or last abdominal assessment.
2	**I**	**Palpation-Fundal height in cms (where appropriate) is recorded**
	A	Mark **Yes** if fundal height in cms has been recorded on current or last assessment. Mark **No** if there is no recorded evidence of fundal height on current or last assessment.
3	**I**	**Palpation Lie (where appropriate) is recorded**
	A	Mark **Yes** if palpation of the fetal lie has been recorded on current or last assessment. Mark **No** if palpation of the fetal lie has not been recorded on current or last assessment. Mark **N/A** if palpation of the fetal lie is not appropriate.
4	**I**	**Palpation-Presentation (where appropriate) is recorded**
	A	Mark **Yes** if palpation of the fetal presentation (where appropriate) has been recorded. Mark **No** if palpation of the fetal presentation (where appropriate) has not been recorded. Mark **N/A** if not appropriate
5	**I**	**Palpation-Position (where appropriate) is recorded**
	A	Mark Yes if palpation of the fetal position (where appropriate) has been recorded. Mark No if palpation of the fetal position (where appropriate) has not been recorded. Mark N/A if not appropriate
6	**I**	**Palpation-Engagement (where appropriate) is recorded**
	A	Mark **Yes** if palpation of fetal engagement (where appropriate) has been recorded. Mark **No** if palpation of fetal engagement (where appropriate) has not been recorded. Mark **N/A** if not appropriate.
7	**I**	**Palpation-Fetal activity (if present) is recorded**
	A	Mark **Yes** if fetal activity (if present) has been recorded. Mark **No** if fetal activity (if present) has not been recorded. Mark **N/A** if fetal activity is not yet present.

8	**I**	**Auscultation-Fetal heart rates- Use of pinard or hand held doppler with a record of fetal heart rate in BPM**
	A	Mark **Yes** if fetal heart rate has been recorded in BPM using a pinard or hand held doppler. Mark **No** if fetal heart rate has not been recorded in BPM using a pinard or hand held doppler. Mark **N/A** if the woman is less than 24 weeks gestation.

2.4 Intrapartum Fetal Wellbeing Quality Care-Metric

INTRAPARTUM FETAL WELLBEING **I** = Indicator, **A** = Data Collectors Advice, **N/A** = Not Applicable		
1	**I**	**There is recorded evidence of fetal heart monitoring with Pinard/Doppler on initial assessment**
	A	Mark **Yes** if there is recorded evidence of fetal heart monitoring with Pinard/Doppler on initial assessment. Mark **No** if there is no recorded evidence of fetal heart monitoring with Pinard/Doppler on initial assessment. Mark **N/A** if an Intra uterine death has occurred.
2	**I**	**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**
	A	Mark **Yes** if the fetal heart rate has been recorded, at least every 15 minutes in the first stage of labour and at least every 5 minutes in the 2nd stage of labour. Mark **No** if the fetal heart rate has not been recorded, at least every 15 minutes in the first stage of labour and at least every 5 minutes in the 2nd stage of labour. Mark **N/A** if an Intra uterine death has occurred.
3	**I**	**There is recorded evidence of date and time of infant's birth in the labour record**
	A	Mark **Yes** if date and time of infant's birth is recorded in the **labour record**. Mark **No** if date and time of infant's birth is not recorded in the **labour record**.
4	**I**	**Colour and volume of liquor are recorded**
	A	Mark **Yes** if the colour and volume of liquor is recorded. Mark **No** if the colour and volume of liquor is not recorded. Mark **N/A** if membranes are intact. **Note:** Volume & Colour of liquor should be recorded at every vaginal assessment **N.B** If no liquor draining this must also be recorded.

2.5 Intrapartum Fetal Wellbeing - Cardiotocography (CTG) Quality Care-Metric

INTRAPARTUM FETAL WELLBEING-CARDIOTOCOGRAPHY (CTG) **I** = Indicator, **A** = Data Collectors Advice, **N/A** = Not Applicable		
1	**I**	**There is recorded evidence of indication for cardiotocography (CTG)**
	A	Mark **Yes** if the indication for a CTG has been recorded. Mark **No** if the indication for a CTG is not recorded. Mark **N/A** if intermittent auscultation only has been performed.
2	**I**	**The date/time is validated and recorded at the start of CTG**
	A	Mark **Yes** if both the date and time are validated and recorded at the start of CTG. Mark **No** if either the date or time is not clearly recorded at the start of CTG. Mark **N/A** if intermittent auscultation only has been performed or if using MN-CMS. **Note**: Date/time settings on CTG should be validated at commencement of every CTG.
3	**I**	**The woman's name and hospital number are recorded on the CTG by the midwife**
	A	Mark **Yes** if the woman's name and hospital number are recorded on the CTG by the midwife. Mark **No** if the woman's name or hospital number is not recorded on the CTG by the midwife. Mark **N/A** if intermittent auscultation only has been performed or if using MN-CMS.
4	**I**	**The maternal pulse is recorded on the CTG strip on commencement of the CTG tracing**
	A	Mark **Yes** if the maternal pulse is recorded on the CTG strip on commencement of the CTG tracing. Mark **No** if the maternal pulse is not recorded on the CTG strip on commencement of the CTG tracing. Mark **N/A** if intermittent auscultation only has been performed. **Note:** Maternal pulse should be recorded hourly when CTG tracing is being performed.
5	**I**	**There is recorded evidence of systematic CTG interpretation occurring hourly (baseline, variability, accelerations, decelerations, uterine activity and plan of care)**
	A	Mark **Yes** if there is recorded evidence of systematic CTG interpretation occurring hourly. Mark **No** if there is not recorded evidence of systematic CTG interpretation occurring hourly. Mark **N/A** if intermittent auscultation only has been performed.
6	**I**	**There is recorded evidence that a CTG of concern has been reviewed by the senior midwife and/or obstetrician**
	A	Mark **Yes** if there is recorded evidence that a CTG of concern have been reviewed by the senior midwife and/or obstetrician. Mark **No** if there is no recorded evidence that a CTG of concern have been reviewed by the senior midwife and/or obstetrician. Mark **N/A** if intermittent auscultation only has been performed. **Note:** CTG of concern should be escalated using the ISBAR tool.

2.6 Intrapartum Maternal Wellbeing Quality Care-Metric

INTRAPARTUM MATERNAL WELLBEING **I** = Indicator, **A** = Data Collectors Advice, **N/A** = Not Applicable		
1	**I**	**There is recorded evidence of maternal vital signs during labour based on the woman's condition**
	A	Mark **Yes** if the maternal vital signs are recorded during labour as per national/ local guidelines. Mark **No** if the maternal vital signs are not recorded during labour as per national/ local guidelines.
2	**I**	**A narrative is recorded at least hourly, to provide a record of the woman's condition**
	A	Mark **Yes** if a narrative is recorded at least hourly, to provide a record of the woman's condition. Mark **No** if a narrative has not been recorded at least hourly providing a record of the woman's condition. Mark **N/A** if a very fast labour has occurred i.e. less than 1 hour
3	**I**	**Indication for vaginal examination is recorded**
	A	Mark **Yes** if indication for vaginal examination is recorded. Mark **No** if indication for a vaginal examination is not recorded.
4	**I**	**Consent to perform vaginal examination is recorded**
	A	Mark **Yes** if consent/refusal for a vaginal examination during labour has been recorded. Mark **No** if consent/refusal for a vaginal examination during labour has not recorded. Mark **N/A** if vaginal examination has not been performed.
5	**I**	**There is recorded evidence of abdominal examination prior to vaginal examination**
	A	Mark **Yes** if there is recorded evidence of abdominal examination prior to vaginal examination. Mark **No** if there is no recorded evidence of abdominal examination prior to vaginal examination. Mark **N/A** if vaginal examination has not been performed.
6	**I**	**There is evidence of systematic record keeping of the findings of all vaginal examinations**
	A	Mark **Yes** if there is evidence of systematic record keeping of the findings of all vaginal examinations. Mark **No** if there is no evidence of systematic record keeping of the findings of all vaginal examinations. Mark **N/A** if vaginal examination has not been performed.

7	I	**There is recorded evidence of contraction assessment at least every 30 minutes**
	A	Mark **Yes** if there is a recorded evidence of uterine contraction assessment at least every 30 minutes. Mark **No** if there is no recorded evidence of uterine contraction assessment at least every 30 minutes. Mark **N/A** if admitted in the 2nd stage of labour.
8	I	**There is recorded evidence of date and time of onset of each stage of labour**
	A	Mark **Yes** if there is recorded evidence of date and time of onset of each stage of labour. Mark **No** if there is no recorded evidence of date and time of onset of each stage of labour. Mark **N/A** if admitted in the 2nd stage of labour.
9	I	**The name and designation of the person professionally requested to review the woman is recorded (as appropriate)**
	A	Mark **Yes** if the name and designation of the person professionally requested to review the woman is recorded. Mark **No** if the name and designation of the person professionally requested to review the woman is not recorded. Mark **No** if identified as "CMM"/"SHO/Reg on call" or Seen by "Doctor" or "Doctor informed". Mark **N/A** if no review was professionally requested. **Note:** A midwife making a referral or consulting with another member of the healthcare team, should clearly identify by name, the person in the record.
10	I	**Indication for amniotomy is recorded**
	A	Mark **Yes** if indication for amniotomy is recorded. Mark **No** if indication for amniotomy is not recorded. Mark **N/A** if amniotomy is not performed.
11	I	**Consent for amniotomy is recorded**
	A	Mark **Yes** if written/verbal consent for amniotomy is recorded. Mark **No** if (written/verbal) consent for amniotomy is not recorded. Mark **N/A** if amniotomy is not performed.
12	I	**Indication for administration of oxytocin is recorded**
	A	Mark **Yes** if indication for administration of oxytocin is recorded for induction or acceleration of labour. Mark **No** if indication for administration of oxytocin is not recorded for induction or acceleration of labour. Mark **N/A** if administration of oxytocin was not required.
13	I	**Consent for administration of oxytocin is recorded**
	A	Mark **Yes** if (written/ verbal) consent and for administration of oxytocin is recorded. Mark **No** if (written/verbal) consent for administration of oxytocin is not recorded. Mark **N/A** if administration of oxytocin was not required.

14	I	**There is recorded evidence that oxytocin infusion has been reduced or stopped when uterine tachysystole is present**
	A	Mark **Yes** if there is recorded evidence that oxytocin infusion has been reduced or stopped when uterine tachysystole is present i.e. when contraction frequency has exceeded 5 in 10 minutes. Mark **No** if there is no recorded evidence that oxytocin infusion has been reduced or stopped when uterine tachysystole is present i.e. when contraction frequency has exceeded 5 in 10 minutes. Mark **N/A** if administration of oxytocin was not required or if there is no evidence of tachysystole.
15	I	**Where a CTG is of concern, there is recorded evidence that the oxytocin infusion was reduced or discontinued and a medical review was undertaken**
	A	Mark **Yes** where a CTG is of concern, there is recorded evidence that the oxytocin infusion was reduced or discontinued and a medical review was undertaken. Mark **No** if a CTG is of concern and there is no recorded evidence that the oxytocin infusion was reduced or discontinued or if a medical review was not undertaken. Mark **N/A** if administration of oxytocin was not required.
16	I	**There is recorded evidence of findings from assessment for perineal trauma**
	A	Mark **Yes** if there is recorded evidence of findings from assessment for perineal trauma. Mark **No** if there is no recorded evidence of findings from assessment for perineal trauma. Mark **N/A** if there was no perineal trauma.
17	I	**Where perineal repair was necessary and was performed by a midwife, there is recorded evidence of a repair**
	A	Mark **Yes** if a perineal repair was necessary and has been performed by a midwife, evidence of the repair is recorded. Mark **No** if a perineal repair was necessary and was performed by a midwife, but there is no recorded evidence of the repair. Mark **N/A** if there was no perineal trauma or the repair was performed by a Doctor.
18	I	**There is recorded evidence of estimated blood loss at birth**
	A	Mark **Yes** if there is recorded evidence of estimated blood loss at birth. Mark **No** if there is no record evidence of estimated blood loss at birth.
19	I	**The date, time and method of birth are recorded**
	A	Mark **Yes** if the date, time and method of birth are all recorded. Mark **No** if the date, time and method of birth are not all recorded.

2.7 Risk Assessment for Venous Thromboembolism (VTE) in Pregnancy and Puerperium Quality Care-Metric

RISK ASSESSMENT FOR VTE IN PREGNANCY AND PUERPERIUM **I** = Indicator, **A** = Data Collectors Advice, **N/A** = Not Applicable		
1	**I**	**There is recorded evidence of venous thromboembolism (VTE) assessment on admission**
	A	Mark **Yes** if there is recorded evidence of VTE assessment on each admission. Mark **No** if there is no recorded evidence of VTE assessment on each admission.
2	**I**	**There is recorded evidence of VTE assessment postnatally**
	A	Mark **Yes** if there is recorded evidence of VTE assessment postnatally. Mark **No** if there is no recorded evidence of VTE assessment postnatally.

2.8 Immediate Post Birth Care Quality Care-Metric

IMMEDIATE POST BIRTH CARE **I** = Indicator, **A** = Data Collectors Advice, **N/A** = Not Applicable		
1	**I**	**Maternal vital signs are recorded on the IMEWS chart, prior to transfer to the postnatal ward**
	A	Mark **Yes** if all elements of the maternal vital signs are recorded on the IMEWS chart, prior to transfer to the postnatal ward. Mark **No** if all elements of the maternal vital signs are not recorded on the IMEWS chart, prior to transfer to the postnatal ward.
2	**I**	**Maternal urinary output is recorded**
	A	Mark **Yes** if the first urinary void is recorded. Mark **No** if the first urinary void is not recorded.
3	**I**	**Skin to skin contact is recorded**
	A	Mark **Yes** if skin to skin contact is recorded or it is recorded that the woman has refused skin to skin contact. Mark **No** if skin to skin contact is not recorded. Mark **N/A** if the neonate has been transferred to a neonatal unit immediately post birth.
4	**I**	**Breast feeding initiation time is recorded for a woman who chooses to breastfeed**
	A	Mark **Yes** if breastfeeding initiation time is recorded for a woman who chooses to breastfeed. Mark **No** if breastfeeding initiation time is not recorded for a woman who chooses to breastfeed. Mark **N/A** if the woman is artificial feeding or the neonate has been transferred to the neonatal unit or if the neonate is stillborn.

5	I	**Neonatal condition at birth (live, neonatal death, fetal death) is recorded**
	A	Mark **Yes** if the neonates condition at birth of is recorded. Mark **No** if the neonates condition at birth is not recorded.
6	I	**Findings of initial systematic examination of the new born is recorded**
	A	Mark **Yes** if the findings of the initial systematic examination of the new born are recorded. Mark **No** if the findings of the initial systematic examination of the new born are not recorded. Mark **N/A** if the neonate has been transferred to a neonatal unit immediately post birth or if the neonate is stillborn.

2.9 Communication (Clinical Midwifery Handover) Quality Care-Metric

COMMUNICATION (CLINICAL MIDWIFERY HANDOVER) **I** = Indicator, **A** = Data Collectors Advice, **N/A** = Not Applicable		
1	I	**Mother- Identification of risk factors in handover is recorded**
	A	Mark **Yes** if identification of risk factors for the mother, is recorded at handover. Mark **No** if identification of risk factors for the mother, is not recorded at handover. Mark **N/A** if there are no risk factors for the mother identified or if using MN- CMS.
2	I	**Baby- Confirmation of identity band checking is recorded**
	A	Mark **Yes** if there is confirmation of the baby's identity band checked and recorded. Mark **No** if there is not confirmation of the baby's identity band checked and recorded.
3	I	**Baby- Gender of new born is recorded**
	A	Mark **Yes** if the gender of the baby has been recorded. Mark **No** if the gender of the baby has not been recorded.
4	I	**Baby- Security tag is recorded as present and active**
	A	Mark **Yes** if the baby security tag is present/recorded and activated. Mark **No** if both these elements are not all present/recorded and activated.

2.10 Pain Management- (other than Labour) Quality Care-Metric

Pain Management- (other than Labour) **I** = Indicator, **A** = Data Collectors Advice, **N/A** = Not Applicable		
1	**I**	**Woman's response to actions taken to reduce pain are recorded**
	A	Mark **Yes** if the woman's response to analgesia within the last 24 hours is recorded. Mark **No** if the woman's response analgesia within the last 24 hours is not recorded. Mark **N/A** if the woman did not require pain management.

2.11 Infant Feeding Quality Care-Metric

Infant Feeding **I** = Indicator, **A** = Data Collectors Advice, **N/A** = Not Applicable		
1	**I**	**Method of infant feeding is recorded**
	A	Mark **Yes** if the method of infant feeding is recorded at least daily (may change from birth and over subsequent days). Mark **No** if the method of infant feeding is not recorded at least daily. Mark **N/A** if neonatal death or still birth has occurred.
2	**I**	**Assessment of effectiveness of baby feeding is recorded**
	A	Mark Yes if assessment of effectiveness of baby feeding is recorded at least daily. Mark No if assessment of effectiveness of baby feeding is not recorded at least daily.
3	**I**	**The actions taken if feeding is ineffective are recorded**
	A	Mark **Yes** if the actions taken of ineffective feeding are recorded. Mark **No** if the actions taken of ineffective feeding are not recorded. Mark **N/A** if the baby is feeding effectively.

2.12 Postnatal Care (daily midwifery care processes) Quality Care-Metric

POSTNATAL CARE (DAILY MIDWIFERY CARE PROCESSES) **I** = Indicator, **A** = Data Collectors Advice, **N/A** = Not Applicable		
1	**I**	**There is recorded evidence of on-going postnatal education being offered to the woman**
	A	Mark **Yes** if there is recorded evidence of on-going postnatal education being offered to the woman. Mark **No** if there is no recorded evidence of on-going postnatal education being offered to the woman.
2	**I**	**There is recorded evidence of daily assessment of the mother (as per national health care record/local policy)**
	A	Mark **Yes** if there is recorded evidence of daily assessment of the mother. Mark **No** if there is no recorded evidence of daily assessment of the mother.
3	**I**	**There is recorded evidence of how well the woman is coping postnatally**
	A	Mark **Yes** if there is recorded evidence of how well the woman is coping postnatally. Mark **No** if there is no recorded evidence of how well the woman is coping postnatally.
4	**I**	**There is recorded evidence of daily assessment of the neonate (as per national health care record/local policy)**
	A	Mark **Yes** if there is recorded evidence of daily assessment of the neonate. Mark **No** if there is no recorded evidence of daily assessment of the neonate. Mark **N/A** if the neonate has been transferred to a neonatal unit or was a still birth.

2.13 Post Birth Discharge Planning for Home Quality Care-Metric

POST BIRTH DISCHARGE PLANNING FOR HOME **I** = Indicator, **A** = Data Collectors Advice, **N/A** = Not Applicable		
1	**I**	**Discharge date and time are recorded**
	A	Mark **Yes** if discharge date and time are recorded. Mark **No** if discharge date and time are not recorded.
2	**I**	**The name of midwife completing discharge is recorded**
	A	Mark **Yes** if the name of midwife completing discharge is recorded. Mark **No** if the name of midwife completing discharge is not recorded.
3	**I**	**The destination of the woman is recorded on discharge**
	A	Mark **Yes** if the destination of the woman is recorded on discharge. Mark **No** if the destination of the woman is not recorded on discharge.

4	**I**	**Referral for professional skilled services (e.g. lactation consultant, physio, social work, speciality clinic, if required) is recorded**
	A	Mark **Yes** if referral for professional skilled services is recorded. Mark **No** if referral for professional skilled services is not recorded. Mark **N/A** if referral was not required.
5	**I**	**There is recorded evidence of neonatal pulse oximetry screening having been performed (if appropriate)**
	A	Mark **Yes** if there is recorded evidence of neonatal pulse oximetry screening having been performed. Mark **No** if there is no recorded evidence of neonatal pulse oximetry screening having been performed. Mark **N/A** if neonatal pulse oximetry screening was not appropriate.
6	**I**	**There is recorded evidence of discharge advice/discussion on health and wellbeing of self and baby**
	A	Mark **Yes** if there is recorded evidence of discharge advice/discussion on health and wellbeing of self and baby. Mark **Yes** if there is recorded evidence of discharge advice/discussion on health and wellbeing of Mother, when infant is not being discharged or in the event of a still birth. Mark **No** if there is no recorded or incomplete evidence of discharge advice/discussion on health and wellbeing of self and baby.

2.14 Medication Administration Quality Care-Metric

MEDCIATION MANAGEMENT **I** = Indicator, **A** = Data Collectors Advice, **N/A** = Not Applicable		
1	**I**	**The allergy status is clearly identifiable on the front page of the maternal medication record**
	A	Mark **Yes** if the allergy status is clearly identifiable on the front page of the maternal medication record. Mark **No** if the allergy status is not stated or if it is left blank on the maternal medication chart. Mark **N/A** if using MN-CMS.
2	**I**	**The individual's medication documentation provides details of individual's legible name and health care record number**
	A	Mark **Yes** if Name and Healthcare Record Number (HCRN) are on each page. Where organisations do not use HCRN, Date of Birth (DOB) is a valid identifier. Mark **No** if all sheets do not have two identification details. Mark **No** if detachable prescription sheets do not have details. Mark **No** if name/HCRN/DOB is not legible. Mark **N/A** if using MN-CMS.

3	I	**The individua's identification band (ID) has correct and legible name and healthcare record number**
	A	Mark **Yes** if Name and Healthcare Record Number (HCRN) are on ID Band and legible. Mark **No**, if the patient's ID band has incorrect or illegible name/HCRN/or if the patient is not wearing an ID. band.
4	I	**Prescribed medication not administered has an omission code entered**
	A	Mark **Yes** if omission codes are used and prescription page contains the initials of the midwife omitting the drug, check, within the last 72 hours. Mark **No** if no omission code is used for drug/s not administered, within the last 72 hours. Mark **No** if no omission code is not initialled by the Midwife when a drug/s is not administered, within the last 72 hours. Mark **N/A** if all medicines are administered and there is no requirement for an omission code, within the last 72 hours. **Note:** All medications should be initialled at time of administration or when they were due.
5	I	**The individual's locker and bedside/ or surrounding environment are free of unsecured prescribed medicinal products**
	A	Mark **Yes** if bed space (top of locker/ bed table/or surrounding area) does not have any medications. Mark **No** if medications are found on the individuals locker/bedside table/ or surrounding area. Mark **N/A** for medicinal products exempt from this (mycostatin or corsodyl mouth washes/ patient's own inhaler necessary for pre identified patients).
6	I	**The generic name is used for each medicine prescribed**
	A	Mark **Yes** if medication is prescribed using generic name. Mark **Yes** if stated generic name and requested proprietary (Brand) name to be administered. Mark **No** if propriety (Brand) name only is used. Mark **N/A** if using MN-CMS.
7	I	**The medication record is written in block letters**
	A	Mark **Yes** if all medicines are written in block letters or are written in clear, legible and written un-joined lowercase letters. Mark **No** if not written in capital letters or if not written in clear, legible and written un-joined lowercase letters. Mark **N/A** if using MN-CMS. **Note:** Complete a Safety/Risk form if safety concerns are present, so that the medication record can be corrected.
8	I	**The correct legible dose of the medicine is recorded and not abbreviated**
	A	Mark **Yes** if the correct dose is prescribed and is legible and abbreviations used are approved. If decimals are used, check that a zero is written in front of the decimal point when there is no other figure (e.g. 0.5, 0.25). Mark **No** if the correct legible dose of the medicine is not recorded, or if unapproved abbreviations are used. Mark **N/A** if no prescription documentation is utilised or if using MN-CMS. Note: *(International Units, Micrograms, Nanograms and units must not be abbreviated)*, Check that quantities less than **1 gram** are written in **mgs** and quantities less than **1 mg** are written in **micrograms**. In cases where the dose of a drug is related to weight, ensure the weight is recorded in order to calculate correct dose.

9	I	**The Route and/or Site of Administration is recorded**
	A	Mark **Yes** if the correct route is stated and if applicable that the site is identified. Mark **No** if route and site are not stated. Mark **N/A** if using MN-CMS.
10	I	**The frequency of administration is recorded & correct timings indicated**
	A	Mark **Yes** if the frequency is recorded and the appropriate times are either ticked or circled on the medication record at that time. Mark **No** if correct timings are not ticked/circled. Mark **N/A** if using MN-CMS.
11	I	**The minimum dose interval and/or 24 hour maximum dose is specified for all "as required" or PRN drugs**
	A	Mark **Yes** if all medicines prescribed **"as required"** states the minimum dose interval and/or the maximum 24 hour dose. Mark **No** if all medicines prescribed **"as required"** do not state the minimum dose interval and/or the maximum 24 hour dose. Mark **N/A** if medicines are not prescribed "as required" or if using MN-CMS.
12	I	**The prescription has a legible Prescriber's Signature (in ink)**
	A	Mark **Yes** if prescribers name and signature are identifiable from online signature bank/local signature bank or signature bank on the medication prescription sheet. Mark **Yes** if the signature includes NMBI Personal Identification Number (PIN)/Medical Council Number (MCN). Mark **No** if signature is not written in permanent ink. Mark **No** if PIN/MCN is not present or signature is not readily identifiable itself or from local signature bank. Mark **N/A** if using MN-CMS. **Note:** The prescribers' signature can be identifiable if written clearly, if it contains an NMBI Personal Identification Number (PIN) or Medical Council Number (MCN) which is searchable online www.nmbi.ie or www.medicalcouncil.ie or there is an up to date local signature bank.
13	I	**Discontinued medicine/s are crossed off, dated and signed by prescriber**
	A	Mark **Yes** if the medicine/s is correctly crossed out and includes the full date (Day/Month/Year) it was discontinued and the signature of the prescriber who has discontinued the drug. Mark **No** if any element is not correct. Mark **No** if all discontinued medicine/s do not follow the standard. Mark **N/A** if there are no drugs discontinued or if using MN-CMS.

2.15 Medication Storage and Custody (excluding MDAs) Quality Care-Metric

MEDICATION STORAGE AND CUSTODY (EXCLUDING MDAs) **I** = Indicator, **A** = Data Collectors Advice, **N/A** = Not Applicable		
1	**I**	**A registered midwife is in possession of the keys for medicinal product storage**
	A	Mark **Yes** if keys are held by a midwife on their person. Mark **No** if a midwife is not holding the keys.
2	**I**	**All medicinal products are stored in a locked cupboard or locked room**
	A	Mark **Yes** if cupboard and fridge is locked or the room is locked. Mark **No** if medicinal products are accessible in an unlocked cupboard, fridge or room. **Note:** All cupboards/trolleys/fridges containing medication MUST be locked. As numerous staff may have passkeys to access clinical rooms but should not have access to medication once in that room.

2.16 MDA Scheduled Controlled Drugs Quality Care-Metric

MDA SCHEDULED CONTROLLED DRUGS **I** = Indicator, **A** = Data Collectors Advice, **N/A** = Not Applicable		
1	**I**	**Misuse Drugs Act (MDA) Drugs are checked & signed at each changeover of shifts by midwifery staff**
	A	Mark **Yes** if MDA Scheduled Controlled Drugs Register has two signatures for members of day staff and night staff on changeover shifts in last 72 hours. Mark **No** if duty roster does not verify names of who were on these specific shifts. **Note:** Where there is no night shift, Mark **Yes** if checked and signed at beginning of shift and end of shift.
2	**I**	**Two signatures are entered in the MDA Drugs register for each administration of an MDA drug**
	A	Mark **Yes** if MDA drugs register has two signatures for each MDA Scheduled Controlled drugs administered within the last 72 hours. Mark **No** if MDA Scheduled Controlled drugs register does not have two signatures for each MDA Scheduled Controlled drug administered within the last 72 hours. Mark **N/A** if unit does not store MDA Scheduled Controlled drugs currently or no MDA Scheduled Controlled drug has been administered within the last 72 hours.
3	**I**	**The MDA Drugs cupboard is locked and keys for MDA Drugs cupboard are held by designated midwife**
	A	Mark **Yes** if the MDA Scheduled Controlled Drugs cupboard is locked and the keys are held by the designated midwife. Mark **No** if MDA Scheduled Controlled Drugs cupboard is not locked. Mark **No** if designated midwife does not know who has the MDA Scheduled Controlled Drugs keys.

4	I	**MDA Drug keys are kept separate from other medication keys**
	A	Mark **Yes** if MDA Scheduled Controlled Drugs keys are separate from other sets of keys, as MDA Scheduled Controlled Drugs and other drug cupboard/trolley keys should not travel as one set. Mark **No** if MDA Scheduled Controlled Drugs keys are not separate. Mark **N/A** if unit does not store MDA Scheduled Controlled Drugs currently.

2.17 Intravenous Fluid Therapy Quality Care-Metric

INTRAVENOUS FLUID THERAPY **I** = Indicator, **A** = Data Collectors Advice, **N/A** = Not Applicable		
1	I	**Fluid balance charts are completed accurately and totalled**
	A	Mark **Yes** if the fluid balance chart of a woman, is completed accurately and totalled (input, output and balance) within a 24 hour period. Mark **No** if the fluid balance chart of a woman, is not completed accurately and totalled (input, output and balance) within a 24 hour period. Mark **N/A** if the woman is not on a fluid balance chart.

2.18 Clinical Record Keeping Quality Care-Metric

CLINICAL RECORD KEEPING QUALITY **I** = Indicator, **A** = Data Collectors Advice, **N/A** = Not Applicable		
1	I	**All entries are dated and timed (using 24 hour clock)**
	A	Mark **Yes** if all entries are dated and timed using the 24 hour clock, check entries for the last 72 hours. Mark **No** if all entries are not dated and timed using the 24 hour clock, check entries for the last 72 hours. Mark **N/A** if using MN-CMS.
2	I	**All written records are legible, in permanent ink and signed**
	A	Mark **Yes** if all entries within the last 72 hours are legible and written in permanent ink and signed. Mark **No** if all entries within the last 72 hours are not legible or not written in permanent ink and signed. Mark **N/A** if using MN-CMS.

3	I	**All entries are in chronological order**
	A	Mark **Yes** if all entries in the midwifery documentation within the last 72 hours are in chronological order or if the reason for any variance from this is documented. Mark **No** if any entries within the last 72 hours are not in chronological order or if any variances have not been documented. Mark **N/A** if using MN-CMS.
4	I	**All abbreviations/grading systems are from a national or local approved list/system**
	A	Mark **Yes** if any abbreviations/grading systems are used in entries within the last 72 hours is from a national or locally approved list/system. Mark **No** if abbreviations used in entries within the last 72 hours are not from a national or locally approved list/system. Mark **N/A** if abbreviations are not used in any entries within the last 72 hours.
5	I	**Alterations/corrections are as per HSE standards and recommended practices for healthcare records management**
	A	Mark **Yes** if alterations/corrections in midwifery documentation, within the last 72 hours are as per HSE standards and recommended practices for healthcare records management. Mark **No** if alterations/corrections in midwifery documentation, within the last 72 hours are not as per HSE standards and recommended practices for healthcare records management. Mark **N/A** if no alterations have been made within the last 72 hours or if using MN-CMS.
6	I	**Recorded care provided by midwifery students is countersigned by a registered midwife**
	A	Mark **Yes** if all student midwives entries within the last 72 hours are countersigned by the supervising midwife. Mark **No** if any student midwife entries within the last 72 hours are not countersigned. Mark **N/A** if there are no entries by a student midwife within the last 72 hours.

2.19 Irish Maternity Early Warning System (IMEWS) Documentation Standards Quality Care-Metric

IMEWS STANDARDS DOCUMENTATION **I** = Indicator, **A** = Data Collectors Advice, **N/A** = Not Applicable		
1	**I**	**The addressograph (or details) are recorded on both sides of the IMEWS chart**
	A	Mark **Yes** if the addressograph (or details) are recorded on both sides of the chart. Mark **No** if the addressograph (or details) are not recorded on both sides of the chart.
2	**I**	**The booking blood pressure, gestation at booking, booking BMI and large BP cuff are recorded**
	A	Mark **Yes** if the booking blood pressure, gestation at booking, booking BMI and large BP cuff are recorded. Mark **No** if any one of the elements is not recorded.
3	**I**	**Date and time of the observations are recorded**
	A	Mark **Yes** if both the date (day/month/year) and time of the observations are recorded. Mark **No** if both the date (day/month/year) and time of the observations have not been recorded. Mark **N/A** if using MN-CMS.
4	**I**	**Time is recorded using the 24 hour clock**
	A	Mark **Yes** if the time is recorded using the 24 hour clock. Mark **No** if the time is not recorded or if the time is not recorded using a 24 hour clock. Mark **N/A** if using MN-CMS.
5	**I**	**Each entry is initialled**
	A	Mark **Yes** if each entry is initialled Mark **No** if each entry is not initialled. Mark **N/A** if using MN-CMS.
6	**I**	**The ISBAR tool was used to document the escalation of care**
	A	Mark **Yes** if the ISBAR tool was used to document the escalation of care Mark **No** if the ISBAR tool was not used to document the escalation of care. Mark **N/A** if escalation of care was not required.

2.20 Irish Maternity Early Warning System (IMEWS) Parameters Quality Care-Metric

IMEWS PARAMETERS **I** = Indicator, **A** = Data Collectors Advice, **N/A** = Not Applicable		
1	**I**	**Respiratory rate is documented numerically**
	A	Mark **Yes** respiratory rate is recorded numerically. Mark **No** respiratory rate is not recorded numerically. **Note:** Check all records within the last 72 hrs.
2	**I**	**Respiratory rate is documented in the appropriate box**
	A	Mark **Yes** respiratory rate is recorded in the appropriate box. Mark **No** respiratory rate is not recorded in the appropriate box. **Note:** Check all records within the last 72 hrs.
3	**I**	**SpO2 (if applicable) is documented numerically**
	A	Mark **Yes** if SpO2 (if applicable) is recorded numerically. Mark **No** if SpO2 (if applicable) is not recorded numerically. Mark **N/A** if SpO2 is not applicable. **Note:** Check all records within the last 72 hrs.
4	**I**	**SpO2 (if applicable) is documented in the appropriate box**
	A	Mark **Yes** if SpO2 (if applicable) is recorded in the appropriate box. Mark **No** if SpO2 (if applicable) is not recorded in the appropriate box. Mark **N/A** if SpO2 is not applicable. **Note:** Check all records within the last 72 hrs.
5	**I**	**Temperature is documented numerically**
	A	Mark **Yes** if temperature is recorded numerically. Mark **No** if temperature is not recorded numerically. **Note:** Check all records within the last 72 hrs.
6	**I**	**Temperature is documented in the appropriate box**
	A	Mark **Yes** the woman's temperature is recorded in the appropriate box. Mark **No** if the woman's temperature is not recorded in the appropriate box. **Note:** Check all records within the last 72 hrs.
7	**I**	**Maternal heart rate is documented numerically**
	A	Mark **Yes** if maternal heart rate is recorded numerically. Mark **No** if maternal heart rate is not recorded numerically. **Note:** Check all records within the last 72 hrs.
8	**I**	**Maternal heart rate is documented in the appropriate box**
	A	Mark **Yes** if maternal heart rate is recorded in the appropriate box. Mark **No** if maternal heart rate is not recorded in the appropriate box. **Note:** Check all records within the last 72 hrs.

9	I	**Systolic blood pressure is documented numerically**
	A	Mark **Yes** if Systolic blood pressure is recorded numerically. Mark **No** if Systolic blood pressure is not recorded numerically. **Note:** Check all records within the last 72 hrs.
10	I	**Systolic blood pressure is documented in the appropriate box**
	A	Mark **Yes** if systolic blood pressure is recorded in the appropriate box. Mark **No** if systolic blood pressure is not recorded in the appropriate box. **Note:** Check all records within the last 72 hrs.
11	I	**Diastolic blood pressure is documented numerically**
	A	Mark **Yes** if diastolic blood pressure is recorded numerically. Mark **No** if diastolic blood pressure is not recorded numerically. **Note:** Check all records within the last 72 hrs.
12	I	**Diastolic blood pressure is documented in the appropriate box**
	A	Mark **Yes** if diastolic blood pressure is recorded in the appropriate box. Mark **No** if diastolic blood pressure is not recorded in the appropriate box. **Note:** Check all records within the last 72 hrs.
13	I	**Urinalysis is documented**
	A	Mark **Yes** if urinalysis is recorded. Mark **No** if urinalysis is not recorded. **Note:** Check all records within the last 72 hrs.
14	I	**Pain score is documented**
	A	Mark **Yes** if pain score is recorded. Mark **No** if pain score is not recorded. **Note:** Check all records within the last 72 hrs.
15	I	**AVPU is recorded**
	A	Mark **Yes** if AVPU is recorded. Mark **No** AVPU is not recorded. **Note:** Check all records within the last 72 hrs.
16	I	**Total Yellow Zone is correct on every entry**
	A	Mark **Yes** if the total yellow zone is correct on every entry. Mark **No** if the total yellow zone is not correct on every entry. **Note:** Check all records within the last 72 hrs and if using MN-CMS check that the IMEWS total is recorded
17	I	**Total Pink Zone is correct on every entry**
	A	Mark **Yes** if the total pink zone is correct on every entry. Mark **No** if the total pink zone is not correct on every entry. **Note:** Check all records within the last 72 hrs and if using MN-CMS check that the IMEWS total is recorded

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

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

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 midwives /CMMs 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 Midwifery/ Nursing. Authorisation is given to enter data on the TYC HSE System using an individualised username and password.

3.1.3 The data collector is required to confirm that they have a working knowledge of the guideline (ONMSD 2018 - 027) 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

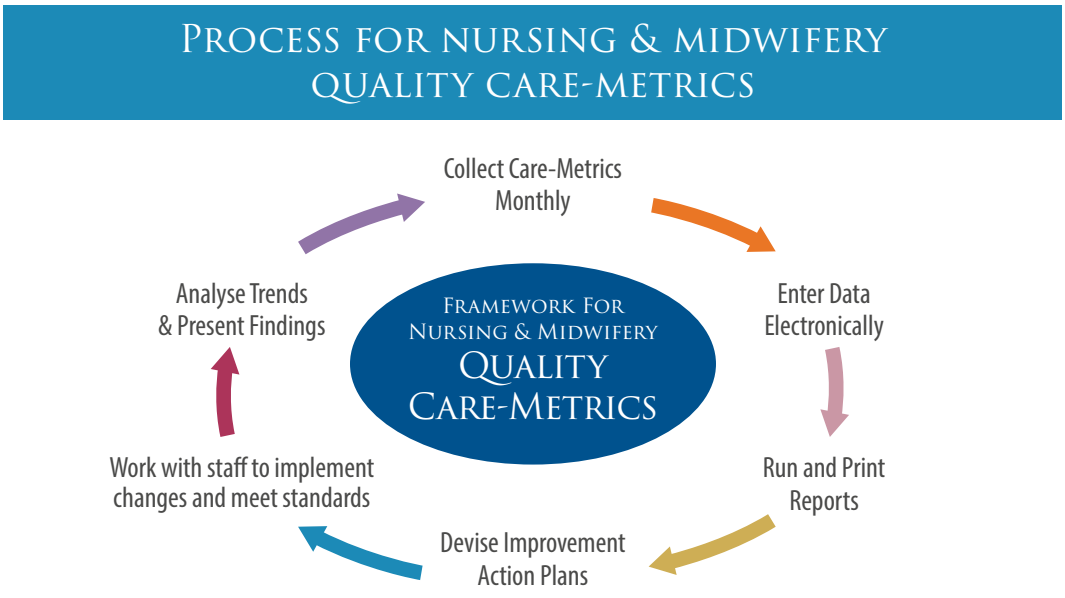


Figure 2: Undertaking Quality Care-Metrics at Service Level

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

3.3 Timing of Monthly Data Collections

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

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

3.3.3 Data collectors are only required to examine the care records for the 72 hours preceding data collection.

3.4 Accessing Test Your Care HSE 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 Nursing and Midwifery 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 Nursing and Midwifery Quality Care-Metrics Project Officer who arranges the issuing of passwords.

Figure 3: TYC HSE System

3.4.2 To access the TYC HSE System, users log on to the Internet browser and open the website **http://www.testyourcarehse.com**. Users enter a username and password and click the login button. The TYC HSE system disseminates the initial username and password to the user via two emails. Passwords can then be changed by the user by going to the Settings options on the TYC HSE toolbar and entering a password of choice. Username and passwords should not be shared as they are unique to users and allow access to either data entry or reporting or both. The home page of the TYC HSE System is illustrated in Figure 3.

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

- **Collect:** Data Entry (to enter the Nursing and Midwifery Quality Care-Metric responses for each clinical area)
- **Report:** Reporting on the results of the Nursing and Midwifery 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 Nursing and Midwifery Quality Care-Metric and the templates for data collection

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

- Collect only
- Collect and Report

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

3.5 Data Entry

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

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

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

Figure 4: Data Entry: TYC HSE System

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

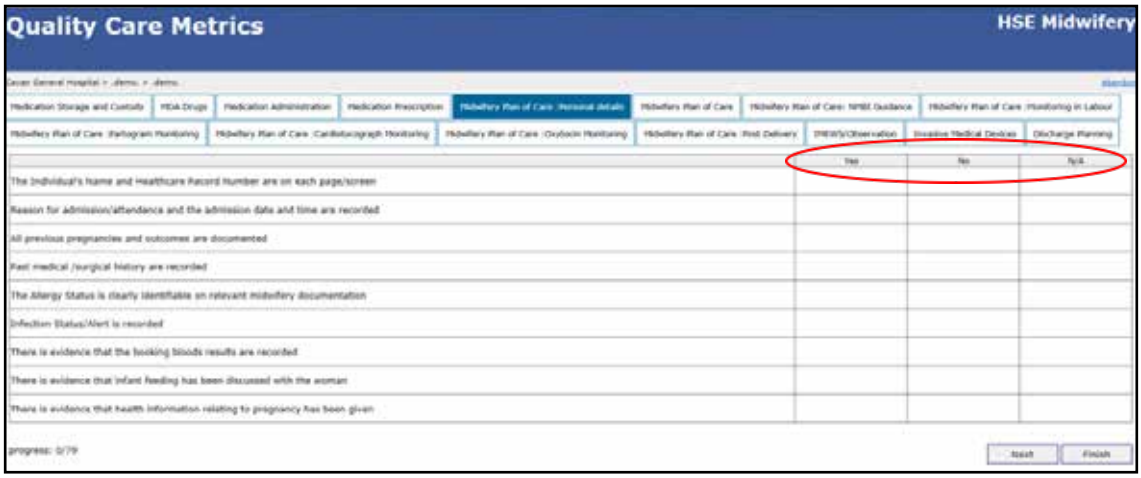


Figure 5: Data Entry: TYC HSE System (1)

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

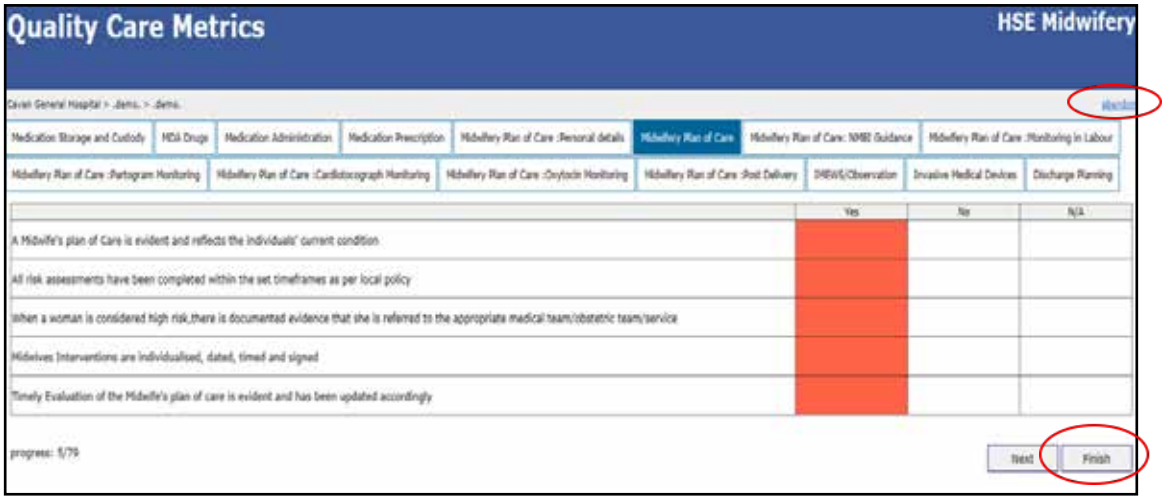


Figure 6: Data Entry: TYC HSE System (2)

4.0 QUALITY CARE-METRICS DATA ANALYSIS

4.1 Scoring System

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

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

Figure 7: Traffic Light Scoring System

4.1.2 The highlighted score will be colour coded as illustrated in Figure 7. The arrows will be coloured according to the score achieved and so could be any of the 3 colours green, amber or red. (Figure 8 is for arrow 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. Midwifery, Acute, Theatre, Children's, Public Health
- **Location Groups** – Select groupings such as antenatal, labour, postnatal or if a particular group is not required, select all
- **Location** – Select the name of the ward, unit or theatre or all locations to get an overall hospital /care facility/network score
- **Type** –Select Summary

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

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

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

- Once in Report tab click on **Create your own report**
- **Questionnaire** – Select the relevant questionnaire e.g. Midwifery, 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'

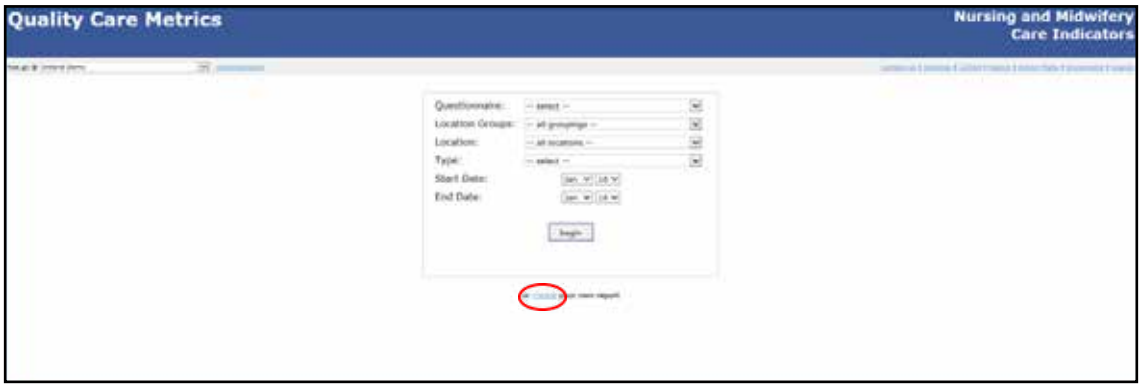


Figure 10: Create your own Report

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 CMM/CNM to investigate what areas of good practice require recognition and what areas need improvements (Figure 12).

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

Figure 12: Create your own Report: 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'

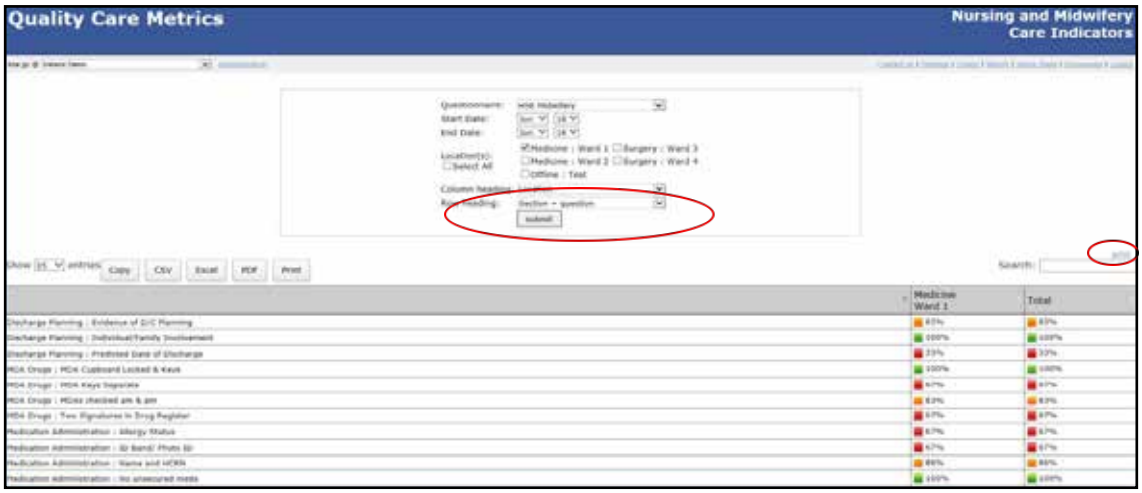


Figure 13: Create your own Report: Results; Column Heading: Location and Row Heading: Section and Question

- This selection, **'Column Heading: Location and Row Heading: Section and Question'** supports the CMM/CNM to compare indicators in each area for shared learning (Figure 22).

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. Midwfiery
- 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'

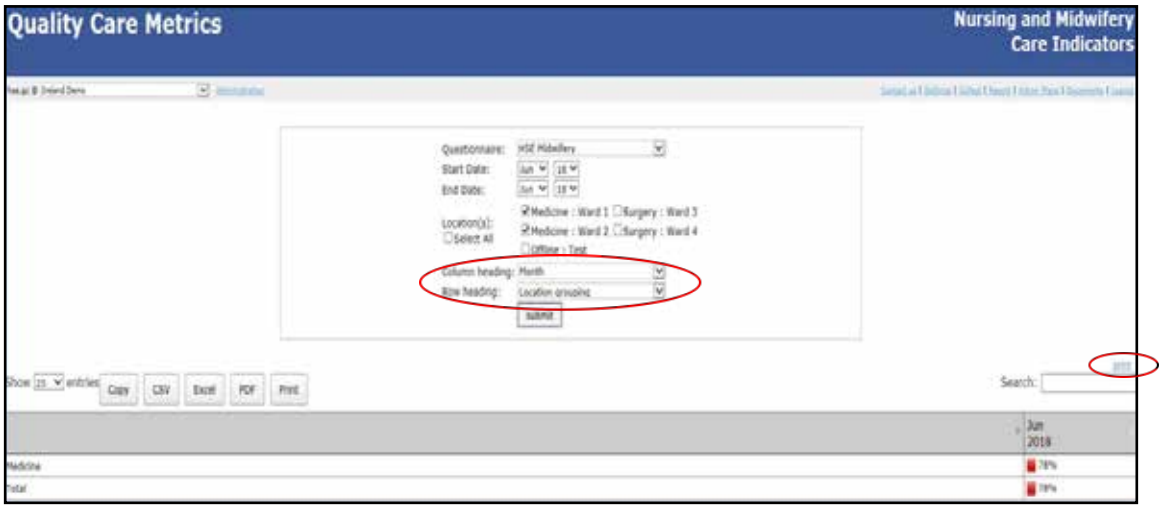


Figure 14: Create your own Report: Results; Column Heading: Month and Row Heading: Location Grouping

- This selection, **'Column Heading: Month and Row Heading: Location Grouping'** supports the ADoM/ADoN 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).

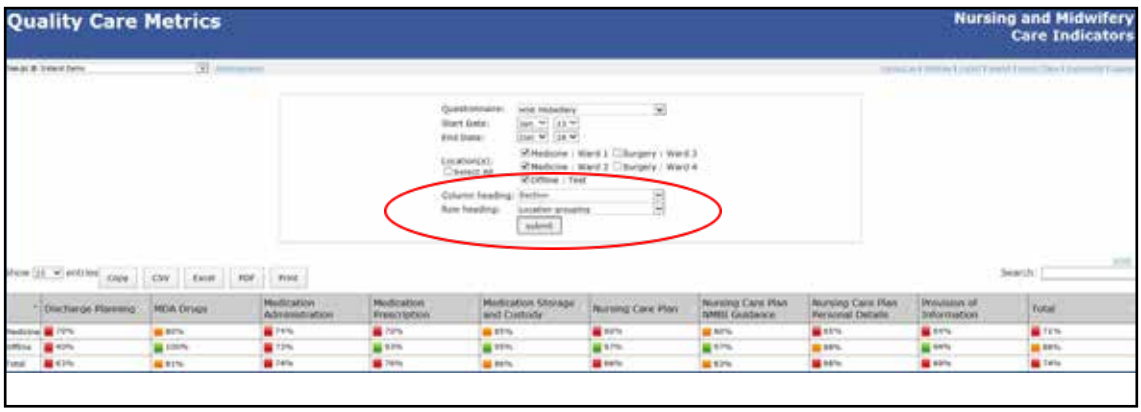


Figure 15: Create your own Report: Results; Column Heading: Section and Row Heading: Location Grouping

5.0 QUALITY CARE-METRICS ACTION PLANNING

5.1 Accessing Action Planning on TYC HSE

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

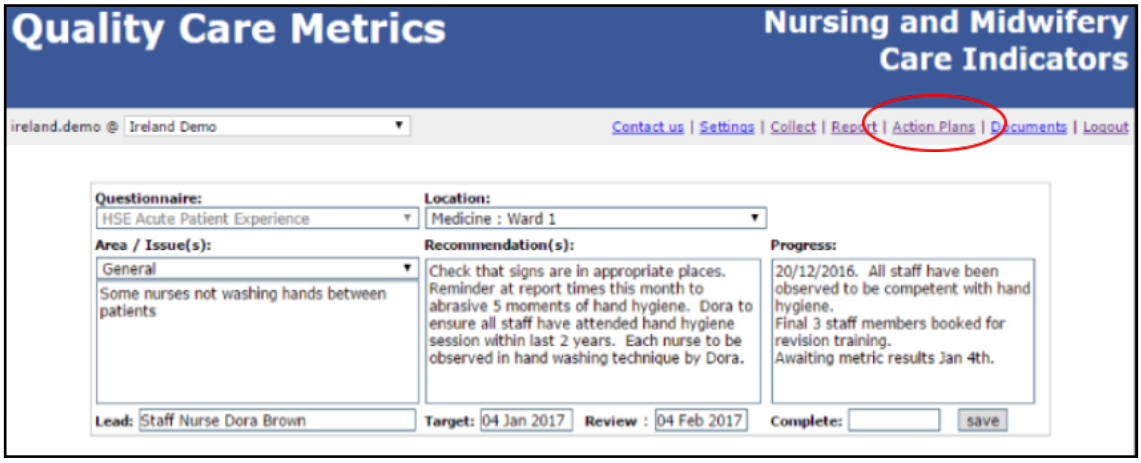


Figure 16: Accessing Action Planning on Test Your Care HSE

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

5.2 Seven Steps of Action Planning

- Understanding Nursing and Midwifery Quality Care-Metrics results
- Communicating and discussing Nursing and Midwifery 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 Nursing and Midwifery 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 CMM/CNM colleagues at meetings
- Be honest about the parts that were hard/didn't work
- Get ideas from action plans from other areas already completed

6.0REFERENCES

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

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

Health Service Executive (HSE). (2018b) *Nursing & Midwifery Quality Care-Metrics: Mental Health Research Report.* Dublin: Health Service Executive.

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

Please note the full references for the Supporting Evidence (Appendix IV) are available in the National Guideline for Nursing and Midwifery Quality Care-Metrics Data Measurement in Midwifery Services 2018 (ONMSD 2018 - 027)

7.0 APPENDICES

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

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

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

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

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

Appendix II
Abbreviations

ADoM/ADoN	Assistant Director of Midwifery/Assistant Director of Nursing
AVPU	Alert-Voice-Pain-Unresponsive
BMI	Body Mass Index
BPM	Beats per Minute
CMM/CNM	Clinical Midwife Manager/Clinical Nurse Manager
DOB	Date of Birth
HIQA	Health Information and Quality Authority
HCRN	Healthcare Record Number
HSE	Health Service Executive
ID	Identification Band
IMEWS	Irish Maternity Warning Score
ISBAR	Identify-Situation-Background-Assessment-Recommendation
MCN	Medical Council Number
MN-CMS	Maternal & Newborn Clinical Management System
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
PRN	Pro re nata (as required)
QCM	Quality Care-Metrics
TYC HSE	Test Your Care Health Service Executive
SpO2	Peripheral Capillary Oxygen Saturation

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 midwife/nurse manager or midwife/nurse 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 midwife/nurse manager or midwife/nurse in charge prior to the formal report findings of the Metric. It is the responsibility of the clinical midwife/nurse 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 Midwife Manager/ADoM of the issue in a timely fashion and outline to the CMM/ADoM 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 CMM or Midwife in Charge informed of Safety/Risk Issue:	

To be completed By CMM or Midwife in Charge		
Name of Unit Midwifery Manager/ ADoM informed of Safety/Risk Issue		
Please sign to confirm the relevant CMM/ADoM has been informed and record date informed.	**Date:**	**Signature of CMM/Midwife 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 Midwifery Services 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 Midwifery Services 2018 (ONMSD 2018 - 027)

Metric	Summary	Supporting literature	Indicators
Midwifery Plan of Care	Midwife guidance on initial; assessment and care planning including referral	NMBI Practice Standards for Midwives (2015, Standard 4)	A midwife's plan of Care is evident and reflects the woman's current condition including referral where appropriate Appropriate midwifery care based on the assessment and plan is documented.
Booking	Midwifery specific care processes at the initial antenatal booking visit	DOH (2014) The Irish Maternity Early Warning System (IMEWS) National Clinical Guideline No. 4. NICE (2008) Antenatal care for uncomplicated pregnancies, Clinical guideline [CG62] Grier G, Geraghty S. (2015) Intimate partner violence and pregnancy: How midwives can listen to silenced women. British Journal of Midwifery, 23:6, 412-416. NMBI Practice Standards for Midwives (2015, Standard 1). Institute of Obstetricians and Gynaecologists and Health Service Executive (20120 Antenatal routine enquiry regarding violence in the home. Clinical practice guideline: Dublin.	The woman's name and Healthcare Record Number are on each page/screen All previous pregnancies and out comes are documented. Past medical/surgical/family/genetic/ social/medication (as appropriate) histories are recorded The Allergy Status is recorded Infection Status /Alert is recorded The blood pressure and gestation at booking is recorded. There is evidence of assessment of antenatal risk factors Whether a blood transfusion is acceptable to the woman is recorded There is evidence of assessment for mental health illnesses There is evidence of routine inquiry for domestic violence There is evidence that infant feeding has been discussed with the woman There is evidence that health information relating to pregnancy has been given

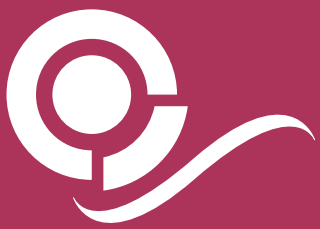
Abdominal examination (after 24 weeks gestation) on Current or Last Assessment	Midwifery specific care processes associated with abdominal examination	NICE (2008) Antenatal care for uncomplicated pregnancies, Clinical guideline [CG62]	Inspection findings Palpation-Fundal height in cms where appropriate Palpation-Lie Palpation-Presentation where appropriate Palpation-Position where appropriate Palpation-Engagement where appropriate Palpation-Fetal activity (if present) Auscultation-Fetal heart rates-Use of Pinard or hand-held Doppler with a record of fetal heart rate in BPM.
Intrapartum Fetal Wellbeing	Midwifery specific care processes associated with intrapartum assessment of fetal wellbeing (excluding cardiotocography)	RCPI (2012) Intrapartum Fetal Heart Rate Monitoring, CG 6. NICE (2014) Intrapartum care: Care of healthy women and their babies during childbirth, Clinical Guideline 190.	There is evidence of fetal heart monitoring with Pinard/Doppler on initial assessment When using intermittent auscultation, the fetal heart is recorded at least every 15 minutes in the first stage of labour and at least every 5 minutes in the 2nd stage of labour. There is documented evidence of date and time of infant's birth in the labour record. Colour and volume of liquor are documented
Intrapartum Fetal wellbeing cardiotocography	Midwifery specific care processes associated with intrapartum assessment of fetal wellbeing by cardiotocography	RCPI (2012) Intrapartum Fetal Heart Rate Monitoring, CG 6. NICE (2014) Intrapartum care: Care of healthy women and their babies during childbirth, Clinical Guideline 190.	Documented evidence of indication for CTG The date/time is validated at the start of CTG The woman's name and hospital number are recorded on the CTG by the midwife The maternal pulse is recorded on the CTG strip on commencement of the CTG tracing There is documented evidence of systematic CTG interpretation occurring hourly (baseline, variability, accelerations, decelerations, uterine activity and plan of care) There is documented evidence that CTGs of concern have been reviewed by the Senior midwife and/or obstetrician

Intrapartum Maternal wellbeing	Midwifery specific care processes associated with intrapartum assessment of maternal wellbeing including assessment of progress of labour	RCPI (2012) Intrapartum Fetal Heart Rate Monitoring, CG 6. NICE (2014) Intrapartum care: Care of healthy women and their babies during childbirth, Clinical Guideline 190.	There is documented evidence of recording of maternal vital signs during labour according to the woman's condition. A narrative is recorded at least hourly, to provide record of the woman's condition Consent to perform vaginal examination is recorded Indication for vaginal examination is recorded There is documented evidence of abdominal examination prior to vaginal examination. There is evidence of systematic documentation of the findings of all vaginal examinations Documented evidence that a discussion has occurred with the woman about her care to include birth preferences Documented evidence of contraction assessment at least every 30 minutes. There is documented evidence of date and time of onset of each stage of labour. The name and designation of the person professionally requested to review the woman is documented as appropriate Indication and consent for amniotomy is recorded Indication and consent for administration of oxytocin is recorded Oxytocin infusion has been reduced or stopped when uterine tachystystole is present. Where a CTG is of concern, there is evidence that the oxytocin infusion was reduced or discontinued and a medical review was undertaken. There is documented evidence of findings of assessment for perineal trauma Where perineal repair is necessary is performed by midwife, there is documented evidence of repair There is documented evidence of estimated blood loss at birth The date, time and method of birth are recorded
Risk assessment for Venous Thromboembolism (VTE) in Pregnancy & the Puerperium	Midwifery specific care processes associated with risk assessment for VTE in pregnancy and puerperium	Institute of Obstetricians and Gynaecologists, Health Service Executive & Irish Haematology Society (2013) Venous thromboprophylaxis in pregnancy. Clinical practice guideline: Dublin.	Evidence of VTE assessment on admission Evidence of VTE assessment postnatally

Immediate post birth care	Midwifery specific care processes associated with immediate post birth care of mother and infant	DOH (2014) The Irish Maternity Early Warning System (IMEWS) National Clinical Guideline No. 4. HSE (2012) National Infant Feeding Policy for Maternity and Neonatal Services NICE (2014) Intrapartum care: Care of healthy women and their babies during childbirth, Clinical Guideline 190. BFHI Ireland Audit Tool for Step 4 (2015) [Grey literature] [use following in SOP WHO (2002) Global Strategy on infant and young child feeding. Step 4 of the 10 steps to successful breastfeeding which recommends feeding within the first hour of life.]	Maternal vital signs are recorded on the IMEWS Chart, prior to transfer to the postnatal ward Maternal urinary output is documented Skin to skin contact is recorded Breast feeding initiation time is recorded for a woman who chooses to breastfeed Neonatal condition at birth (live, neonatal death, fetal death) is documented Findings of initial systematic examination of the newborn is documented
Communication (Clinical Handover) in Midwifery Services	idwifery care processes related to Clinical handover, specifically identification of maternal risk factors and conformation of baby identity	DOH (2014) Communication (Clinical Handover) in Maternity Services National Clinical Guideline No. 5. Hatten-Masterson SJ, Griffiths ML. SHARED maternity care: enhancing clinical communication in a private maternity hospital setting. Med J Aust. 2009 Jun 1;190(11 Suppl):S150-1.	Mother- Identification of risk factors in handover is recorded Baby- Confirmation of identify band checking is recorded Baby- Gender of newborn recorded Baby- Security tag is recorded as present and active
Pain management (other than labour)	Midwifery care processes related to woman's response to actions taken to reduce pain	DOH (2014) The Irish Maternity Early Warning System (IMEWS) National Clinical Guideline No. 4.	Woman's response to actions taken to reduce pain are recorded

Infant feeding	Midwifery care processes related to method and effectiveness of infant feeding	HSE (2012) National Infant Feeding Policy for Maternity and Neonatal Services NICE (2014) Intrapartum care: Care of healthy women and their babies during childbirth, Clinical Guideline 190. BFHI Ireland Audit Tool for Step 4 (2015) [Grey literature] [use following in SOP WHO (2002) Global Strategy on infant and young child feeding. Step 4 of the 10 steps to successful breastfeeding which recommends feeding within the first hour of life.]	Method of infant feeding is recorded Assessment of effectiveness of baby feeding is recorded The actions taken if feeding is ineffective are recorded
Postnatal care (daily midwifery care processes)	Midwifery care processes related to daily maternal and neonatal assessment, postnatal education and evaluation of how well woman is coping postnatally	DOH (2016) National Maternity Strategy: creating a better future together 2016-2026. DOH: Dublin. HSE (2017) The Specialist Perinatal Mental Health: Model of Care for Ireland. HSE: Dublin. MNCMS info: Psychosocial: woman Coping Postnatal, woman's interaction with healthcare team, woman Feelings/ Concerns, Psychosocial Interventions, EPND Score, woman Coping Postnatal-Coping well, Baby blues, Excessive Anxiety, Postnatal Depression, Other (as per MNCMS)	There is documented evidence of ongoing postnatal education being offered to the woman There is evidence of daily assessment of the mother (as per national health care record/local policy) There is evidence of how well the woman is coping postnatally There is evidence of daily assessment of the neonate (as per national health care record/local policy)
Post birth discharge planning for home	Midwifery care processes related to post birth discharge planning for home	HSE (2014) Integrated Care Guidance: A Practical Guide to Discharge and Transfer from Hospital, v2, p17. Faculty of Paediatrics and HSE (year not given) Pulse Oximetry Testing for Newborn CHD: Clinical Care Pathway.	Discharge date and time are recorded The name of midwife completing discharge is recorded The destination of the woman is recorded on discharge [include home, independently, alternative address in SOPs] Referral for professional skilled services (e.g. lactation consultant, physio, social work, speciality clinic), if required, is documented Evidence of neonatal pulse oximetry screening having been performed is documented if appropriate Evidence of discharge advice/discussion on health and wellbeing of self and baby having been offered to the woman

Medication administration	Midwifery care processes related to identification of allergy status and administration of a valid prescription	ABA (2007) Guidance to Nurses and Midwives on Medication Management. HSE (2012) National Policy for Nurse and Midwife Medicinal Product Prescribing in Primary, Community and Continuing Care	The Allergy Status is clearly identifiable on the front page of prescription chart. Administration of medication in presence of a prescription that complies with prescription writing requirements set out in hospital /HSE policy
Medication, Storage and Custody *(excluding MDAs)*	Midwifery care processes related to medication, storage and custody	ABA (2007) Guidance to Nurses and Midwives on Medication Management.	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.
MDA Drugs	Midwifery care processes related to MDA medication storage and administration	ABA (2007) Guidance to Nurses and Midwives on Medication Management.	MDA drugs are checked & signed at each changeover of shifts by midwifery 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
Intravenous fluid therapy	Midwifery care processes of completing fluid balance charts accurately	ABA (2007) Guidance to Nurses and Midwives on Medication Management.	Fluid balance charts are completed accurately and totalled
Clinical Record Keeping	Midwifery care processes related to good recording keeping	NMBI (2015) Recording Clinical Practice: Professional guidance HSE (2010) Code of Practice for Healthcare Records Management	All entries are dated and timed (24 hour clock) All written records are legible, in permanent ink and signed and name printed All entries are in chronological order All abbreviations/grading systems are from a national or local approved list/ system Alterations/corrections are as per HSE Standards and Recommended Practices for Healthcare Records Management Care provided by midwifery students is countersigned by a registered midwife



NURSING & MIDWIFERY

QUALITY CARE-METRICS

DECEMBER 2018

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