NATIONAL GUIDELINE FOR MIDWIFERY QUALITY CARE-METRICS DATA MEASUREMENT IN

MIDWIFERY SERVICES 2018

OFFICE OF THE
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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National Guideline for Midwifery Quality Care-Metrics Data Measurement in Midwifery Services 2018

Is this document a:

Policy		Procedure		Protocol		Guideline	X

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

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1.0 INITIATION OF QUALITY CARE-METRICS AT SERVICE LEVEL

1.1 Glossary of Terms and Definitions

Clinical Governance:

"The system through which healthcare teams are accountable for the quality, safety and satisfaction of patients in the care they have delivered. For healthcare staff, this means specifying the clinical standards you are going to deliver and showing everyone the measurements you have made to demonstrate that you have done what you set out to do" (HSE 2014).

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).

Evidence Based Practice:

Evidence based practice is the integration of best research evidence with clinical expertise and patient values in order to improve healthcare outcomes (Steevens 2013).

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).

Policy:

A policy is a written statement that clearly indicates the position and values of the organisation on a given subject (HSE 2016).

Procedure:

A procedure is a written set of instructions that describe the approved and recommended steps for a particular act or sequence of events (HSE 2016).

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).

1.2 Abbreviations

ASSIA	Applied Social Sciences Index and Abstracts
ADoM/ADoN	Assistant Director of Midwifery/Assistant Director of Nursing
AVPU	Alert-Voice-Pain-Unresponsive
BMI	Body Mass Index
BPM	Beats per Minute
CTG	Cardiotocography
CDSR	Cochrane Database of Systematic Reviews
CENTRAL	Cochrane Central Register of Controlled Trials
CINAHL	Cumulative Index to Nursing and Allied Health Literature
CMM/CNM	Clinical Midwife Manager/Clinical Nurse Manager
DARE	Database of Abstract of Reviews of Effects
DOB	Date of Birth
EMBASE	Excerpta Medica Database
GP	General Practitioner
HEFT	Heart of England Foundation Trust
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-Assessment-Recommendation
IT	Information Technology
MCN	Medical Council Number
MDA	Misuse of Drugs Act
MN-CMS	Maternal & Newborn Clinical Management System
NCEC	National Clinical Effectiveness Committee
NHS	National Health Service (United Kingdom)
NMBI	Nursing and Midwifery Board of Ireland
NMPDU	Nursing and Midwifery Planning and Development Unit
ONMSD	Office of the Nursing and Midwifery Services Director
PEWS	Paediatic Early Warning Score
PIN	Personal Identification Number
PPPG	Policies, Procedures, Protocols and Guidelines
PRN	Pro re nata (as required)
QCM	Quality Care-Metrics
TYC	Test Your Care
TYC HSE	Test Your Care Health Service Executive
SpO2	Peripheral Capillary Oxygen Saturation

1.3 Introduction

1.3.1 Patient safety is one of the most critical issues facing healthcare today. The delivery of care that is safe, patient-centred, compassionate, effective and efficient is the responsibility of all health care professionals. As midwives and nurses are at the centre of the care delivery continuum delivering clinical care around the clock, their contribution to influence high quality, safe care is immense. Research suggests that errors and patient harm are caused by system and process failures (Institute of Medicine 1999).

1.3.2 Midwives and nurses are a well-educated, highly skilled and experienced and a valuable resource to the health service, their contribution makes a significant impact to optimise patient care delivery and outcomes. Quality Care-Metrics provide nurses and midwives with a framework and a measurement tool to engage in continuous quality improvement at the point of care delivery in order to positively influence the care experience for women, children and families.

1.3.3 This National Guideline outlines the essential criteria that need to be in place by the health service provider in order to participate in Quality Care-Metrics and to ensure fidelity of data quality. The ONMSD is responsible for leading the national implementation of nursing and midwifery Quality Care-Metrics in Ireland. A suite of documents to support this initiative is available at the following link: **www.hse.ie/eng/about/who/onmsd/safecare/qcm**

1.3.4 Clinical care processes delivered by midwives and nurses are based on scientific evidence, standards and/ or professional consensus. Measuring the degree to which midwives and nurses adhere to care processes plays an important role in assuring, sustaining and improving the safety and quality of care delivered to mother's/babies /family.

1.3.5 Nursing and Midwifery Quality Care-Metrics present ways of measuring the quality of midwifery and nursing care utilising care process quality indicators, which provide a framework for how the fundamentals of midwifery/nursing care can be measured (Foulkes 2011).

1.3.6 Measurements of clinical care and outcomes have, in the past, proved to be complex and were not always nurse or midwife specific. Many healthcare providers and organisations lack basic information on the quality of nursing and midwifery care. Anecdotal evidence was often used as an indicator of concerns in relation to care delivery. Feedback in a systematic way to the individual nurse or organisation was not always available.

1.3.7 Nursing and Midwifery Quality Care-Metrics aim to illuminate the contribution of midwifery and nursing, to safe and effective care and provide the evidence and assurance to managers, governance structures and regulators that care quality is a priority for the professions of nursing and midwifery.

1.3.8 Nursing and Midwifery Quality Care-Metrics are fundamentally a continuous quality improvement journey, highlighting areas of practice that require improvement and measuring for tangible evidence that improvement efforts are impacting in the delivery of care.

1.4 Background

1.4.1 The concept arose from work undertaken in the United Kingdom by the Heart of England NHS Foundation Trust (HEFT). The Chief Nurse at HEFT developed a web based tool entitled Test Your Care (TYC) to monitor patient safety and promote care quality following an increase in complaints, falls, pressure ulcers and medication management errors.

1.4.2 In 2011, through Nursing and Midwifery Planning and Development Units (NMPDU), Nursing and Midwifery Quality Care-Metrics were developed and implemented in over 100 clinical areas across the North West, North East & Dublin North and endorsed by the Office of the Nursing & Midwifery Services Director (ONMSD) Health Service Executive (HSE).

1.4.3 In the Republic of Ireland, a small number of acute hospitals had also commenced measuring nursing and midwifery care processes. These sites either employed external agencies to develop a system to meet their single site requirements or used the Microsoft excel application.

1.4.4 In 2014, the ONMSD entered into a service level agreement with HEFT to provide access to the TYC System nationally to HSE organisations across the Republic of Ireland. The online web based measurement system TYC HSE is now widely available to all Directors of Nursing/Midwifery who wish to embed Quality Care-Metrics within their local quality governance frameworks.

1.5 What are Quality Care-Metrics?

1.5.1 Nursing and Midwifery Quality Care-Metrics are a measure of the quality of nursing and midwifery clinical care processes aligned to evidence based standards and agreed through national consensus in healthcare settings in Ireland. The process of national consensus is achieved through workstream working groups (HSE 2018).

1.5.2 The Donabedian (1966) conceptual framework (Figure 1) is one of the most commonly used measurement framework to estimate care quality and broadly falls into the categories of structure, process and outcome. Healthcare quality as defined by Donabedian, has been universally accepted and is widely used in the empirical literature in the development of quality standards (Haj et al. 2013).

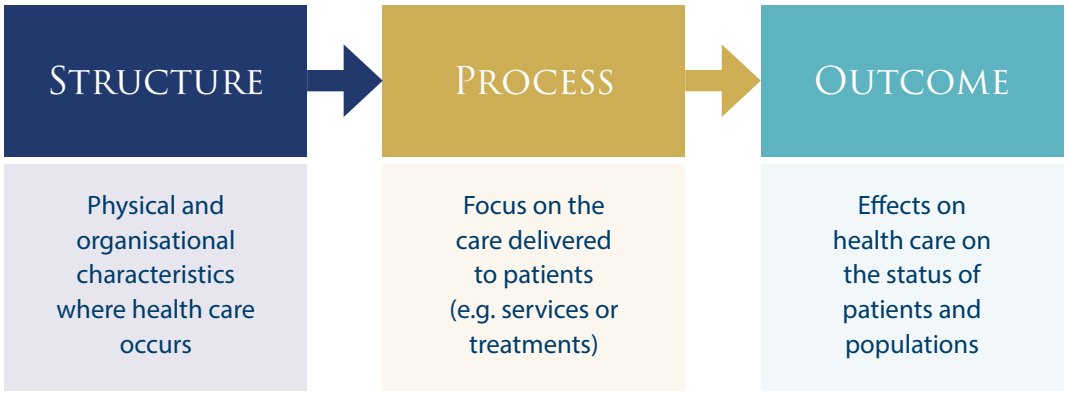


Figure 1: Donabedian's Conceptual Model for Evaluating Quality of Care (1966)

1.5.3 Structural indicators describe all the factors that affect the context in which care is delivered to include the physical facility, equipment, human resources as well as organisational characteristics such as staff training and qualifications.

1.5.4 Process indicators relate to the transactions between patients and care providers. It examines how care is provided in terms of its appropriateness, acceptability, completeness and competency. It includes dimensions such as communication, patient knowledge and the quality of the care intervention, the technical delivery of care and the interpersonal aspect of the clinician – patient relationship. Nursing and Midwifery Quality Care-Metrics examine indicators which measure the process components of care.

1.5.5 Outcome indicators refer to the end points of care such as improvement in function, recovery or survival and seek to capture whether the goals of care were achieved. They include measures such as immunisation rate, failure to rescue rate, falls incidence, hospital acquired pressure ulcers.

Work-streams

Nursing and Midwifery Quality Care-Metrics standardised across seven workstreams

Figure 2: Quality Care-Metrics Work Streams

1.5.6 Nursing and Midwifery Quality Care-Metrics currently consist of a core suite of quality indicators across seven workstreams; Midwifery, Acute Care, Older Persons, Mental Health, Intellectual Disability, Public Health Nursing services and Children's services (Figure 2).

Figure 3 demonstrates the updated Quality Care-Metrics which are available nationally for measurement and monitoring across the regions utilising the Quality Care-Metrics Test Your Care HSE (TYC HSE) system.

Nursing and Midwifery Quality Care-Metrics (2018)

Acute Care Services	Children's Services	Intellectual Disability Services	Older Persons Services	Mental Health Services	Public Health Nursing Services	Midwifery Services	Theatre
Patient Monitoring and Surveillance	Medicines Management	Nursing Documentation	Skin Integrity	Assessment	Pressure Ulcer Prevention and Management	Midwifery Plan of Care	Communication
Health Care Associated Infection Prevention and Control	Nursing Care Planning	Medication Management	Assessment and Management of Pressure Ulcers	Care Plan	Wound Care Management	Booking	Tissue Viability
Pain Assessment and Management	Healthcare Associated Infection Prevention	Environment	Optimizing Nutrition and Hydration	Management of Risk	Health Care Associated Infection Prevention & Control	Abdominal Examination (after 24 weeks gestation) on Current or Last Assessment	Pain Management
Nutrition and Hydration	Nutrition	Safeguarding	Pain Assessment and Management	Management of Violence and Aggression	Continence Assessment and Management	Intrapartum Fetal Wellbeing	Immediate Post-Operative Care
Continence Assessment and Management	Pain Assessment and Management	Person Centred Communication	Medicines Prescribing	Physical Health and Wellbeing	Client/Family/Carer Experience	Intrapartum Fetal Wellbeing Cardiotocography (CTG)	
Care Plan Development and Evaluation	Vital Signs Monitoring / PEWS	Physical health Assessments	Medicines Administration	Recovery Based Care	Health Promotion	Intrapartum Maternal Wellbeing	
Care Plan NMBI Guidance	Child and Adolescent Mental Health	Mental health Assessment	Infection Prevention and Control	Nursing Communication	Care Plan Development and Evaluation	Risk Assessment for Venous Thromboembolism (VTE) in Pregnancy & the Puerperium	
Medication Safety	Discharge Planning	Risk Assessment and Management	Activities of Daily Living	Medication Management	Medication Safety	Immediate Post Birth Care	
Medication Storage and Custody		Nursing Care Plan	Falls Risk	Service User Experience	Maternal Health	Communication (Clinical Midwifery Handover)	
Falls and Injury Management		Person Centred Planning	Falls Prevention		Infant Nutrition	Pain Management (other than labour)	
Delirium Prevention and Management		Positive Behaviour Support	Continence Assessment, Promotion and Management		Child Development Assessment	Infant Feeding	
Wound Care Management		End of Life/Palliative care	Frailty Nursing Assessment		Child and Family Health Needs Assessment	Postnatal Care (daily midwifery care processes)	
Pressure Ulcer Prevention and Management			End of Life and Palliative Care		Child Welfare and Protection	Post Birth Discharge Planning for Home	
			Psychological Nursing Assessment		Safeguarding Vulnerable Adult	Medication Administration	
			Responsive Behaviour Support			Medication, Storage and Custody (excluding MDAs)	
			Safeguarding Vulnerable Adults			MDA Scheduled Controlled Drugs	
			Social Assessment			Intravenous Fluid Therapy	
			Activities (Holistic)/Social Engagement			Clinical Record Keeping	
			Person Centred Care Planning			IMEWS Documentation Standards	
			MDA Medicines			IMEWS Parameters	
			Medicine Storage and Custody				
			Person Experience				

1.6 Rationale for Measuring Nursing and Midwifery Care

1.6.1 The quality of healthcare is a national and international concern. Increasing reports of patient harm and poor quality care has created the requirement for healthcare professionals to question what is known about the quality of care being delivered in the clinical environment. In most organisations there is a wealth of data but no systematic means to collate, analyse and interpret data that will track the quality of care delivery.

1.6.2 Midwifery and Nursing Quality Care-Metrics provide a standardised system to measure the fundamentals of where care, can be monitored and improved against evidenced based standards and professional consensus. In a climate of greater fiscal controls on health budgets, focused attention is needed to maintain high-quality care delivery. There is an increased onus on healthcare providers to provide tangible evidence that they are assessing, monitoring and measuring the quality of care delivery.

1.6.3 Nursing and Midwifery Quality Care-Metrics provide a framework to identify gaps in care delivery, enabling action planning for quality improvement and provide the mechanism by which care providers can be accountable for the quality of their care delivery.

1.7 Clinical Governance

1.7.1 HSE (2014) defines clinical governance as: *"the system through which healthcare teams are accountable for the quality, safety and satisfaction of patients in the care they have delivered. For healthcare staff, this means specifying the clinical standards you are going to deliver and showing everyone the measurements you have made to demonstrate that you have done what you set out to do".*

1.7.2 Nursing and Midwifery Quality Care-Metrics supports Directors of Nursing/Midwifery to provide an accountability system that enables assessing, monitoring, reporting and feedback to teams about performance and identifies areas for improvement (HSE 2014; Donaldson et al. 2005); using "real time" information regarding the quality of care patients/ clients are receiving.

1.8 Benefits

1.8.1 Nursing and Midwifery Quality Care-Metrics provide a measuring system for individual nurses and midwives and their managers that:

- Monitors and assesses performance against evidenced based standards
- Quantifies trends and characteristics
- Highlights exceptional care and areas of risk which require immediate attention
- Provides a standardised system to track and benchmark the quality of care
- Offers direction on educational needs for healthcare staff
- Promotes staff engagement and accountability for the quality of care delivered to women

1.8.2 In addition to providing real time information to midwives and nurses about how patients are benefiting from midwifery quality care delivery, metric data enables managers to monitor individual ward performance and organisational progress in delivering safer, quality focused patient care.

1.9 Purpose

1.9.1 The purpose of this guideline is to ensure a consistent approach to the implementation of Quality Care-Metrics by the Midwifery services.

1.9.2 This guideline 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.

1.10 Scope

1.10.1 This guideline applies to all registered midwives and nurses within Midwifery services, who are engaged with Quality Care-Metrics in midwifery and nursing practice.

1.10.2 This guideline does not apply to other disciplines outside of midwifery and nursing.

1.10.3 Application of the guideline in individual HSE and HSE funded facilities is subject to local agreement, the development and application of a local supporting PPPG and the establishment of local governance structures.

1.10.4 The application of this guideline is aligned to the Quality Care-Metrics Midwifery Services Research Report (HSE 2018).

1.10.5 All midwives and nurses within Midwifery services, who are engaged with Quality Care-Metrics in midwifery and nursing practice, should complete Appendix I, Signature Sheet to indicate that they have read, understood and agree to the guideline. The completed signature sheet should be retained at service level.

1.11 Objective

1.11.1 The objective of this guideline is to enable midwives and nurses to engage with and implement Nursing and Midwifery Quality Care-Metrics using a consistent and standardised approach.

1.12 Outcomes

1.12.1 The guideline provides a framework for midwives and nurses to engage in care measurements for continuous quality improvement.

1.12.2 Application of this guideline will enable consistency in the reliability and validity of the data collection to support a standardised approach in Midwifery services nationally.

1.12.3 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.

2.0METRICS, INDICATORS & ADVICE FOR MIDWIFERY SERVICES

The following Midwifery Quality Care-Metrics are available for Midwifery Services as outlined in Figure 4.

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 4: 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 <u>are</u> held by a midwife on their person. Mark **No** if a midwife is <u>not</u> 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 <u>unlocked</u> 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 <u>not</u> 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 <u>has</u> two signatures for members of day staff and night staff on changeover shifts in last 72 hours. Mark **No** if duty roster does <u>not</u> 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 <u>not</u> have two signatures for each MDA Scheduled Controlled drug administered within the last 72 hours. Mark **N/A** if unit does <u>not</u> store MDA Scheduled Controlled drugs currently or <u>no</u> MDA <u>Scheduled</u> 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 <u>is</u> locked and the keys are held by the designated midwife. Mark **No** if MDA <u>Scheduled</u> Controlled Drugs cupboard is <u>not</u> locked. Mark **No** if designated midwife does <u>not</u> 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

3.0IMPLEMENTATION FRAMEWORK

3.1 Purpose

The purpose of this implementation framework is to provide support and guidance to midwifery and nursing and organisations within the HSE, who wish to implement the Nursing and Midwifery Quality Care-Metrics initiative. A standardised approach to implementation of Quality Care-Metrics across HSE and voluntary organisations will ensure consistency in the measurement of the standard of care across all services.

3.2 Foundations of the Framework

This framework was developed to support the implementation of Nursing and Midwifery Quality Care-Metrics to ensure a systematic, cohesive and sustainable approach. The framework is based on a clear vision statement, a set of core principles and a step-by-step guide (see Figure 5: Framework for Implementation) for Implementation of Quality Care-Metrics

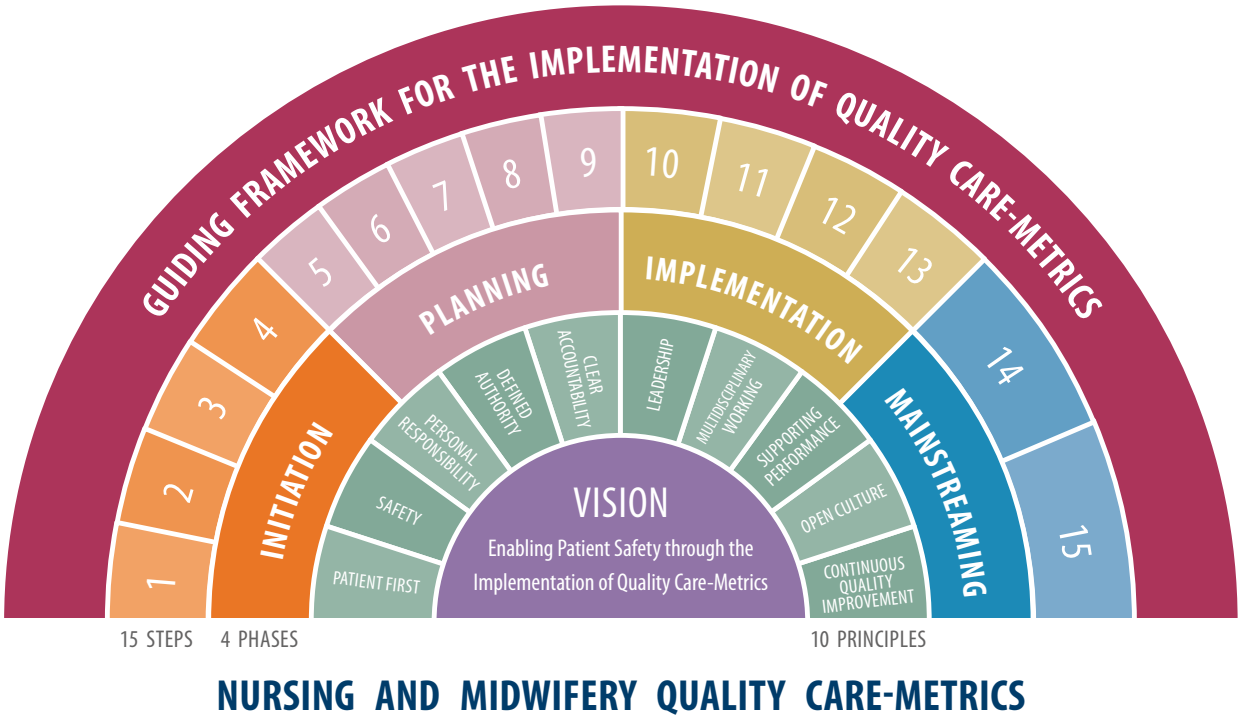


Figure 5: Framework for Implementation of Quality Care-Metrics

3.2.1 Vision Statement: The vision statement outlines the purpose and ambition in the introduction of Quality Care-Metrics to HSE and Voluntary healthcare organisations in Ireland.

3.2.2 Core Principles: The ten core principles in Figure 6 replicate the clinical governance principles developed by the HSE (2012) and provide the foundations for patient safety and quality improvement. A descriptor for each of the 10 Guiding Principles is provided (Figure 7), which outlines in more detail, information relating to the each of the principles and their relationship with clinical governance in order to improve patient outcomes.

Figure 6: Guiding Principles for Clinical Governance (HSE 2012)

GUIDING PRINCIPLES DESCRIPTOR *(Source: HSE (2012a) Quality and Patient Safety, Clinical Governance Information Leaflet)*	
PATIENT FIRST	Based on a partnership of care between patients, families, carers and healthcare providers in achieving safe, easily accessible, timely and high quality service across the continuum of care.
SAFETY	Identification and control of risks to achieve effective, efficient and positive outcomes for patients and staff.
PERSONAL RESPONSIBILITY	Where individuals, whether members of healthcare teams, patients or members of the public, take responsibility for their own and others healthcare needs.
DEFINED AUTHORITY	The scope given to staff at each level of the organisation to carry out their responsibilities. The individual's authority to act, the resources available and the boundaries of the role are confirmed by their direct line manager.
CLEAR ACCOUNTABILITY	A system whereby individuals, functions or committees agree accountability to a single individual.
LEADERSHIP	Motivating people towards a common goal and driving sustainable change to ensure safe high quality delivery of clinical and social care.
INTER-DISCIPLINARY WORKING	Work processes that respect and support the unique contribution of each individual member of a team in the provision of clinical and social care. Interdisciplinary working focuses on the interdependence between individuals and groups in delivering services. This requires proactive collaboration between all members.
SUPPORTING PERFORMANCE	In a continuous process, managing performance in a supportive way, taking account of clinical professionalism and autonomy in the organisational setting. Supporting a director/manager in managing the service thereby contributing to the capability and the capacity of the individual and organisation. Measurement of the patients and staff experience being central in performance measurement (as set out in the National Charter 2010).
OPEN CULTURE	A culture of trust, openness, respect and caring where achievements are recognised. Open discussion of adverse events are embedded in everyday practice and communicated openly to patients. Staff willingly report adverse events and errors, so there can be a focus on learning, research, improvement, and appropriate action taken where there have been failings in the delivery of care.
CONTINUOUS QUALITY IMPROVEMENT	A learning environment and a system that seeks to improve the provision of services with an emphasis on maintaining quality in the future and not just controlling processes. Once specific expectations and the means to measure them have been established, implementation aims at preventing future failures and involves setting goals, education and the measurement of results so that improvement is on-going.

Figure 7: Guiding Principles Descriptor

3.2.3 Implementation Phases

The introduction of Nursing & Midwifery Quality Care-Metrics is based on the four stages of the project management lifecycle which are:

- Initiation
- Planning
- Implementation
- Mainstreaming

The steps to support implementation are outlined in Figure 8.

Figure 8: 15 Steps to Support Implementation of Quality Care-Metrics

Initiation	STEP 01	NMPDU invite expressions of interest from services	Services contact their regional NMPD
	STEP 02	NMPDU provide information sessions	Services are invited to send key managers and staff
	STEP 03	Services prepare, complete and submit State of Readiness Checklist to NMPDU	Services need to have systems and processes in place to implement Quality Care-Metrics
	STEP 04	Director of Midwifery/Nursing enables an appropriate Governance structure to oversee the implementation and maintenance of the Quality Care-Metrics Initiative	This involves identification of: service lead and data collectors, agreement on set of monthly metrics and establishment of membership of governance group with terms of reference
Planning	STEP 05	Director of Midwifery/Nursing informs NMPDU of Service Lead	Local implementation plan is developed
	STEP 06	Director of Midwifery/Nursing agrees the number of sites, data sharing and order of priority	Service lead informs NMPDU Quality Care-Metrics Project Officer of site names & prefix for TYC HSE
	STEP 07	Sites go live on TYC HSE	NMPDU Quality Care-Metrics Project Officer arranges site set up on TYC HSE
	STEP 08	Director of Midwifery/Nursing agrees and identifies data collectors to undertake Quality Care-Metrics monthly	Service Lead requests usernames and passwords from NMPDU Quality Care-Metrics Project Officer for all authorised staff to access TYC HSE
	STEP 09	Data collectors, managers and staff undertake Quality Care-Metrics education session	NMPDU Quality Care-Metrics Project Officer provides initial education session to relevant staff followed by Train the Trainer approach thereafter
Implementation	STEP 10	Data collectors undertake collection of Quality Care-Metrics in agreed sites monthly as per implementation plan	Immediate Risk/Safety Forms and brief feedback are provided to Clinical Midwife/Nurse Manager (CMM/CNM) onsite. Data is entered onto TYC HSE
	STEP 11	CMM/CNM or designate views results and prints same for team	CMM/CNM enables team discussion on achieving quality standards
	STEP 12	CMM/CNM or designate draws up action plans for any amber or red indicators	Service Lead and CMM/CNM liaise re action plans each month
	STEP 13	Results, action plans and interventions presented at relevant governance and management meetings	Service lead provides reports and findings at appropriate governance meetings
Mainstreaming	STEP 14	Communicate and disseminate results and findings	Choose dissemination routes
	STEP 15	Monitor, review and evaluate local implementation plan at set intervals	Update local implementation plan, Introduce further sites Provide training for new members of staff

3.3 Governance

3.3.1 The ONMSD provides the overarching national governance that enables the development of a robust system and infrastructure for the introduction of Quality Care-Metrics in clinical organisations.

3.3.2 The initiative is managed and co-ordinated by a national lead and is supported by project officers from each NMPDU.

3.3.3 In addition, the ONMSD provides the leadership to enable the development of a suite of Quality Care-Metrics that are sensitive to nursing and midwifery care processes. The development of new nurse/midwife-sensitive quality care-metrics were organised through seven work-streams (see Figure 9).

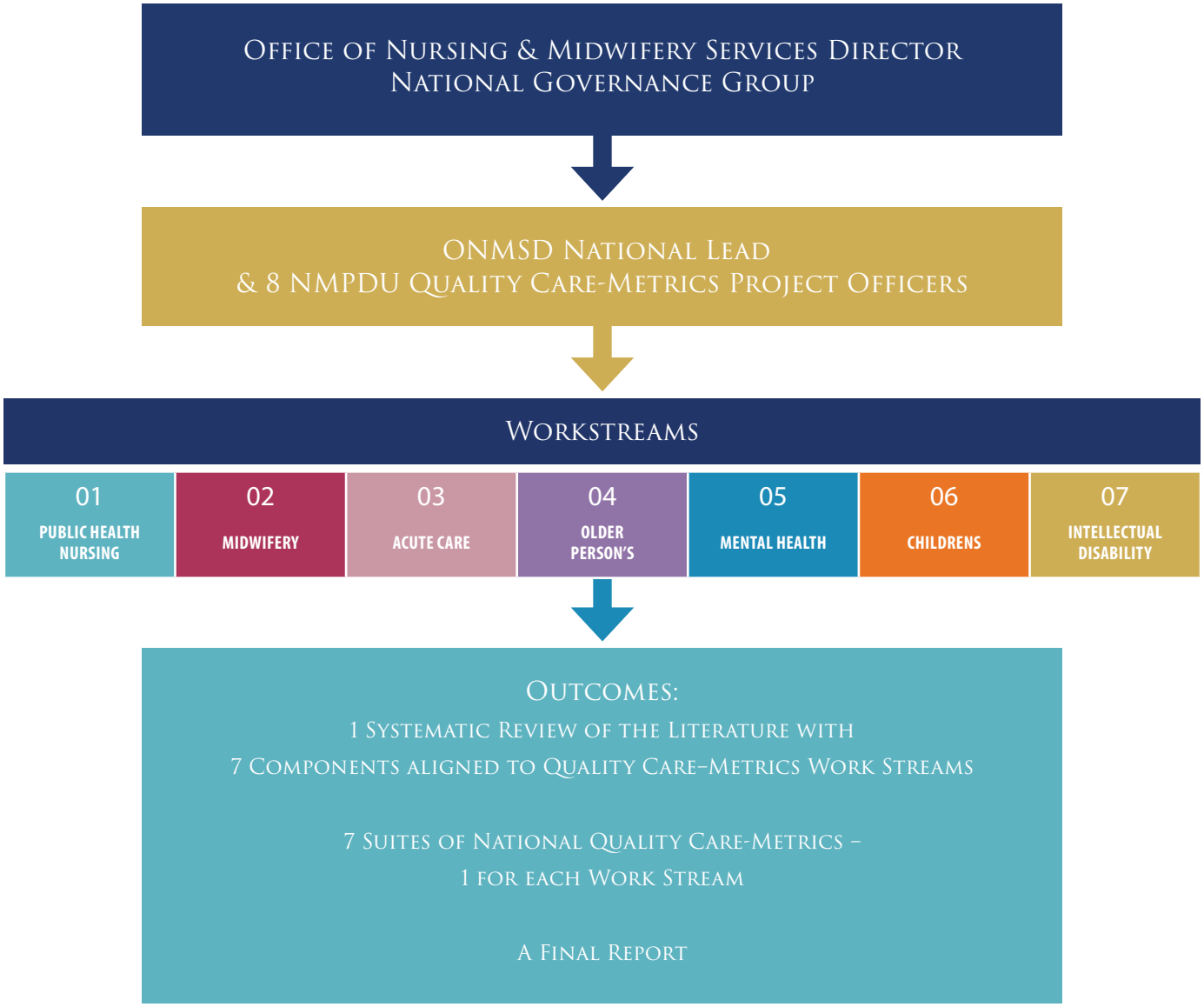


Figure 9: Nursing and Midwifery Quality Care-Metrics Governance Flow Chart

3.3.4 The ONMSD is not responsible for the data and evidence generated from the data collection system on **http://www.testyourcarehse.com.** Directors of Midwifery and Nursing are the accountable officers for all data generated on the TYC HSE system.

3.3.5 NMPDU Directors play a key role in supporting and advising on the implementation and management of Quality Care-Metrics in clinical organisations.

3.3.6 Each NMPDU Director has identified a project officer to support nominated service leads, to establish and embed Quality Care-Metrics in practice.

3.3.7 Governance for the implementation of Quality Care-Metrics in clinical organisations is the responsibility of Directors of Midwifery and Nursing .

3.3.8 Directors of Nursing & Midwifery are accountable for the quality of nursing and midwifery care delivery and to ensure appropriate governance and leadership structures are in place to assess, monitor and review care standards to include:

- Development of a plan for the monitoring, audit and evaluation of Quality Care-Metrics including timelines and identification of the lead person(s) responsible for these processes.
- Identification of the specific outcomes which the implementation of Quality Care-Metrics aims to achieve and processes to measure these outcomes.
- Development of a communication plan for dissemination of the Quality Care-Metrics results/findings to the relevant stakeholders (as appropriate) at ward/unit or management level.
- Implementation of processes to support continuous improvement in the development, implementation, monitoring, auditing and evaluation of Nursing and Midwifery Quality Care-Metrics data measurement in Midwifery services such as PPPG development groups, project sponsors or appropriate governance groups, quality and safety groups/committees etc.

3.4 State of Readiness and Capacity Checklist

3.4.1 If a nursing or midwifery service has interest in implementing Quality Care-Metrics, this service can self-assess their organisation in relation to key factors on how ready they are to begin the implementation process using the State of Readiness and Capacity Checklist as outlined in Figure 10.

Rate your organisation from the perspectives of capacity and readiness to implement the Quality Care-Metrics	**READINESS** *How would you rate your organisation's readiness?*			**CAPACITY** *How would you rate your organisation's capacity?*		
Areas for Consideration	High	Medium	Low	High	Medium	Low
The Management team are fully supportive of the implementation of Nursing and Midwifery Quality Care-Metrics						
There is a level of shared understanding among nursing and midwifery staff with regards to Quality Care-Metrics.						
A Quality Care-Metrics Implementation and Governance Plan is in place or in development e.g. phased roll-out, selection of specific metrics to be collected						
There is a level of resources available to support the Quality Care-Metrics implementation. Consider:						
• A Quality Care-Metrics Project Lead/Champion with allocated time & responsibility						
• Identified Quality Care-Metrics Data Collectors						
• ICT resources and support e.g. Laptops, printers, tablets etc						
• Internet and Wi-fi availability: online or offline collection will both be possible						
There is a defined reporting process to feedback and disseminate findings from the Quality Care-Metrics e.g. ward communication boards, monthly staff meetings						
There is an action plan review process and governance system to escalate and action on any risks or poor performance identified in Quality Care-Metrics measurement.						
There is a Whole Systems Approach on how findings can be disseminated and utilised in conjunction with key nursing and midwifery data to improve care delivery						

Figure 10: State of Readiness and Capacity Checklist

3.4.2 Providing this information assists the Quality Care-Metrics Project Leads in developing a regional and national plan for implementation. It also assists the service in identifying what is required in order to increase their organisation's readiness to successfully implement the Nursing and Midwifery Quality Care-Metrics.

4.0 IMPLEMENTATION AT SERVICE LEVEL

4.1 Implementation Plan

4.1.1 The implementation framework as set out in Figure 5 should be used at local level to support the implementation of Quality Care-Metrics in order to support a systematic, cohesive and sustainable approach to the implementation process.

4.1.2 As part of the development of an implementation plan, due consideration should be given to the identification of required actions, facilitators and the determined timelines for implementation in addition to any possible barriers which may impede the implementation process.

4.1.3 To determine the readiness of the organisation to commence the implementation process, the State of Readiness and Capacity Checklist (Figure 10) must be completed and submitted to the Quality Care-Metrics Project Officer prior to commencement of the implementation process.

4.2 Education/Training Plans for Implementation

4.2.1 Education/training plans should be developed by the nominated service lead at service level to meet local requirements. This can be completed in collaboration with the relevant NMPDU Nursing and Midwifery Quality Care-Metrics Project Officer who may provide information/education sessions to individual healthcare organisations with a view to the services undertaking a Train the Trainer approach for on-going education.

4.2.2 The Nursing and Midwifery Quality Care-Metrics hub on HSELanD is also available to support education/training plans as it is an online resource that provides relevant information and learning resources on Quality Care-Metrics for midwives and nurses.

4.3 Identification of Lead Person(s) Responsible for Implementation

4.3.1 As part of the governance structure at service level to support the implementation of Nursing and Midwifery Quality Care-Metrics, the Director of Midwifery and Nursing is required to nominate a Service Lead who will co-ordinate the implementation process through the development of local implementation plan.

4.4 Specific Roles and Responsibilities

4.4.1 Nursing & Midwifery Planning and Development Unit Director

- Advise and support the development and implementation of Nursing and Midwifery Quality Care-Metrics in healthcare organisations within their region.
- Provide resources to implement Nursing and Midwifery Quality Care-Metrics.
- Establish, monitor and evaluate progress aligned to NMPDU regional implementation plans.
- Make recommendations as required to the National Lead.

4.4.2 NMPDU Quality Care-Metrics Project Officer

- Each NMPDU has identified a Project Officer within their region to enable implementation at local and regional level and to support the development of new Nursing and Midwifery Quality Care-Metrics in the established workstreams.
- Work collaboratively under the direction of the National Lead in order to ensure consistency of approach and that the goals and targets agreed on behalf of the ONMSD are achieved.
- Contribute to local implementation plans developed and agreed with their respective NMPDU Director.
- Lead on the development of new metrics through the established workstreams.
- Work collaboratively with Nursing and Midwifery Quality Care-Metrics Service Leads in individual healthcare organisations to support implementation of agreed Nursing and Midwifery Quality Care-Metrics.
- Provide information/education sessions to individual healthcare organisations with a view to the services undertaking a Train the Trainer approach for on-going education.
- Arrange the issue of usernames and passwords to new users on the TYC HSE system.
- Liaise with Nominated Service Lead in relation to new site setup on the TYC HSE system and any technical issues experienced by users which may require escalation to the TYC HSE IT support person.

- Monitor and track the uptake and usage of Nursing and Midwifery Quality Care-Metrics within clinical services.
- Participate in Nursing and Midwifery Quality Care-Metrics National Group meetings.
- Support the National Lead in the promotion, marketing and evaluation of Nursing and Midwifery Quality Care-Metrics, to include conference presentations and journal publications.

4.4.3 Director of Nursing and Midwifery

- Liaise with Regional NMPDU Director and/or Regional NMPDU Nursing and Midwifery Quality Care-Metrics Project Officer in order to introduce Nursing and Midwifery Quality Care-Metrics within their organisation.
- Approve the implementation of Nursing and Midwifery Quality Care-Metrics within their organisation.
- Nominate a Quality Care-Metrics Service Lead and delegate responsibility for implementation in agreed locations.
- Agree the governance structure for the management of Nursing and Midwifery Quality Care-Metrics data internally to include data collection methods, monitoring of results, action planning and follow-up.
- Create a vision for how Midwifery and Nursing Quality Care-Metrics data contribute to the hospital and/or services quality governance framework.

4.4.4 Nominated Service Lead

- Coordinate and manage the implementation of Nursing and Midwifery Quality Care-Metrics within the organisation.
- Agree Nursing and Midwifery Quality Care-Metrics for implementation with the Director of Nursing/Midwifery.
- Facilitate training sessions for midwifery/nursing Quality Care-Metrics data collectors on the TYC HSE system and establish a train the trainer approach for future education.
- Participate in the Nursing and Midwifery Quality Care-Metrics local governance committee.
- In conjunction with the Director of Nursing/Midwifery, identify data collectors with senior nurse/midwifery management experience.
- Establish a monthly process for data collection.
- Liaise with CMM/CNM on action plans where performance improvement is required at ward/unit level.
- In conjunction with CMM/CNM and midwife/Nurse Practice Development Coordinator, contribute to practice issues highlighted as part of this process and take remedial action as appropriate.

- Attend required meetings with Director of Midwifery/Nursing to report on Nursing and Midwifery Quality Care-Metrics data results.
- Liaise with NMPDU Nursing and Midwifery Quality Care-Metrics Project Officer on Quality Care-Metrics data collected and reports as required.
- Escalate risk incidents identified during Nursing and Midwifery Quality Care-Metrics data collection as appropriate.

4.4.5 Clinical Midwife/Nurse Manager

- Liaise and support the Nursing and Midwifery Quality Care-Metrics data collectors to undertake data collection in their area of responsibility.
- Receive and act on feedback from Nursing and Midwifery Quality Care-Metrics data collectors.
- Review online reports on the TYC HSE System.
- Devise responsive action plans consistent with Nursing and Midwifery Quality Care-Metrics results as required in consultation with line manager.
- Provide feedback to ward/unit healthcare staff on Nursing and Midwifery Quality Care-Metric results, acknowledging the achievement of standards and leading on improvement action plans as required.
- Display and share Nursing and Midwifery Quality Care-Metrics reports on unit/ward notice board.
- Present evidence of Nursing and Midwifery Quality Care-Metric results to appropriate nursing/midwifery governance structures.

4.4.6 Quality Care-Metrics Data Collector

The Nursing and Midwifery Quality Care-Metrics Data collector should not be directly employed within the collection area. He/she should:

- Have a working knowledge of the guideline as appropriate to each metric, to ensure accuracy, standardisation and consistency in the interpretation of the metric.
- Attend the required training session(s) on Nursing and Midwifery Quality Care-Metrics.
- Have a working knowledge of the TYC HSE system prior to conducting data collection
- Liaise with CMM's/CNM's to arrange suitable time for data collection.
- Undertake data collection on a monthly basis and enter into the TYC HSE system using allocated username and password.
- Provide feedback as appropriate to CMM's/CNM's.
- Provide information to CMM's/CNM's and take appropriate action where areas of risk are identified.

5.0 PROCESS FOR QUALITY CARE-METRICS DATA COLLECTION

5.1 PROCESS

5.1.1 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.

5.1.2 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.

5.1.3 The data collector is required to confirm that they have a working knowledge of the guideline as appropriate to each metric, to ensure accuracy, standardisation and consistency in the interpretation of the metric – as outlined in **Section 2 Part A**.

5.1.4 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.

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

Figure 11 outlines the process for undertaking Nursing and Midwifery Quality Care-Metrics

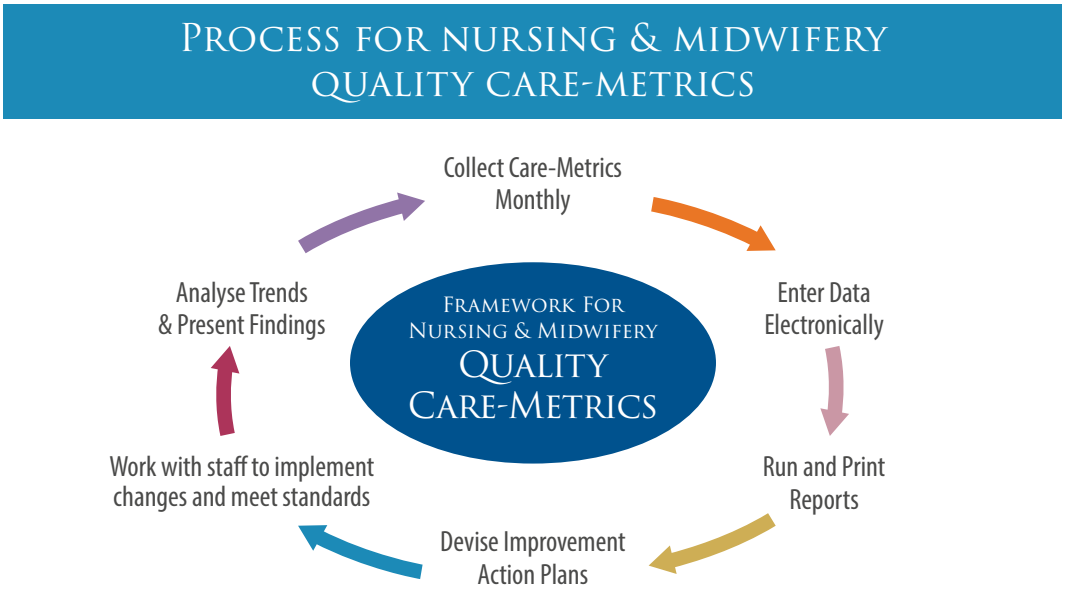


Figure 11: Undertaking Quality Care-Metrics at Service Level

5.2 Sample Size

5.2.1 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.

5.2.2 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.

5.3 Timing of Monthly Data Collections

5.3.1 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.

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

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

5.4 Accessing Test Your Care HSE System

5.4.1 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 12: TYC HSE System

5.4.2 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 12.

5.4.3 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

5.4.4 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.

5.5 Data Entry

5.5.1 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.

5.5.2 A drop down menu (Figure 13) 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 13: Data Entry: TYC HSE System

5.5.3 Data entry occurs through the selection of the predetermined answers 'Yes/No/Not Applicable' (Figure 14 and 15)

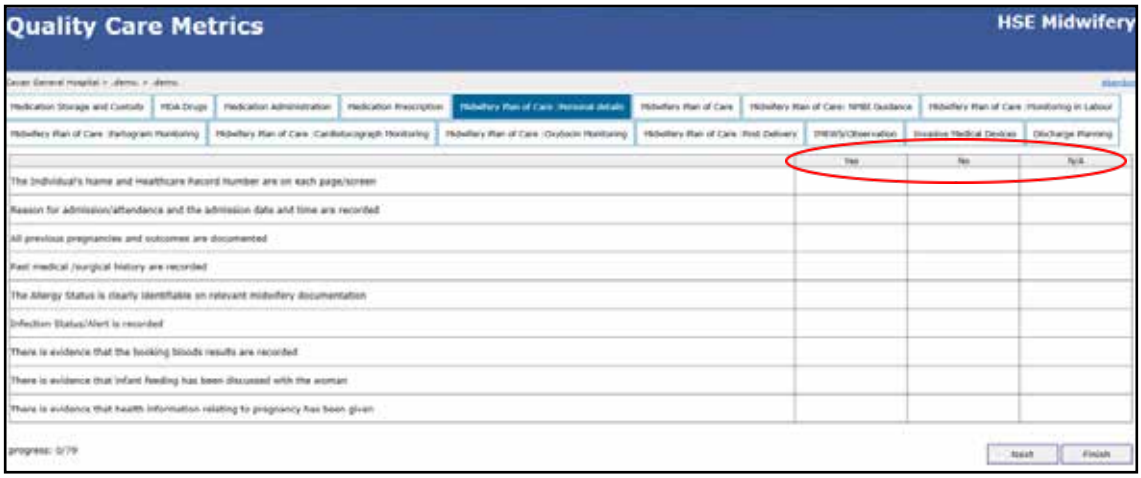


Figure 14: Data Entry: TYC HSE System (1)

- 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

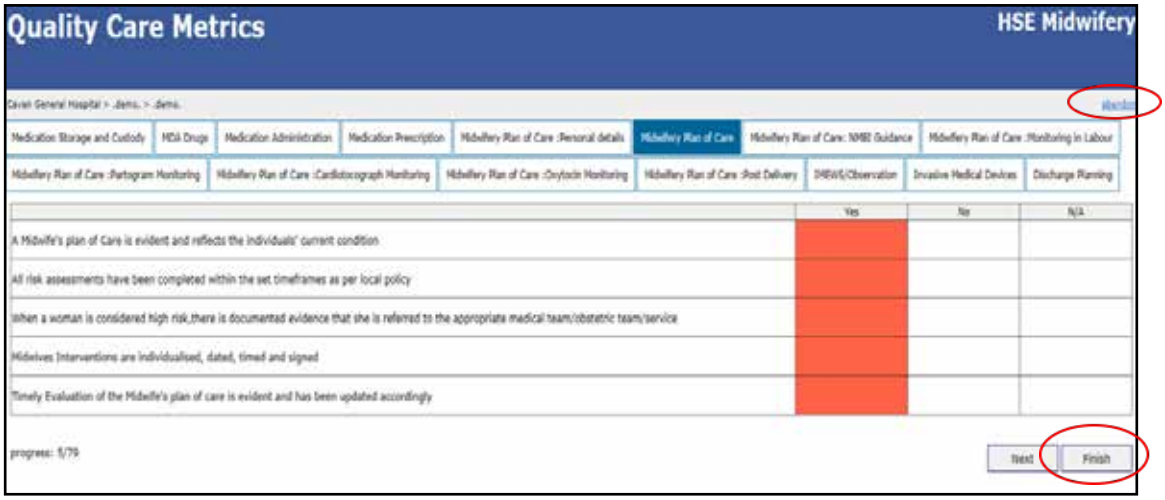


Figure 15: Data Entry: TYC HSE System (2)

6.0QUALITY CARE-METRICS DATA ANALYSIS

6.1 Scoring System

6.1.1 Scores are illustrated easily using a Traffic Lights Scoring System which highlights areas of improvement, areas of risk and areas of excellence (Figure 16). 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 16: Traffic Light Scoring System

6.1.2 The highlighted score will be colour coded as illustrated in Figure 16. The arrows will be coloured according to the score achieved and so could be any of the 3 colours green, amber or red Figure 17 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 17: Scoring System

6.2 Reporting

6.2.1 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.

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

6.2.3 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.

6.2.4 To access reporting click the **Report** tab in the top right hand corner (Figure 18)

Figure 18: Accessing Reports from TYC HSE

6.2.5 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

6.2.6 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

6.2.7 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 19 and 20).

- 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'

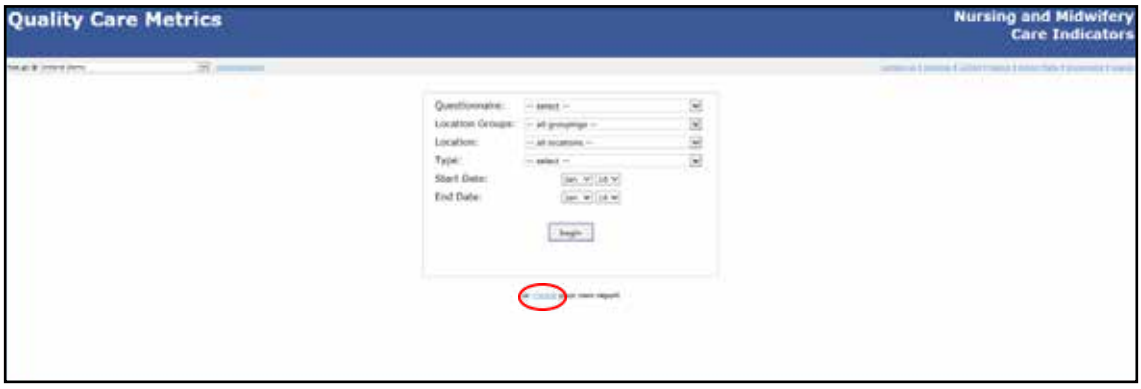


Figure 19: Create your own Report

Figure 20: 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 21).

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

6.2.8 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 19 and 22).

- 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'

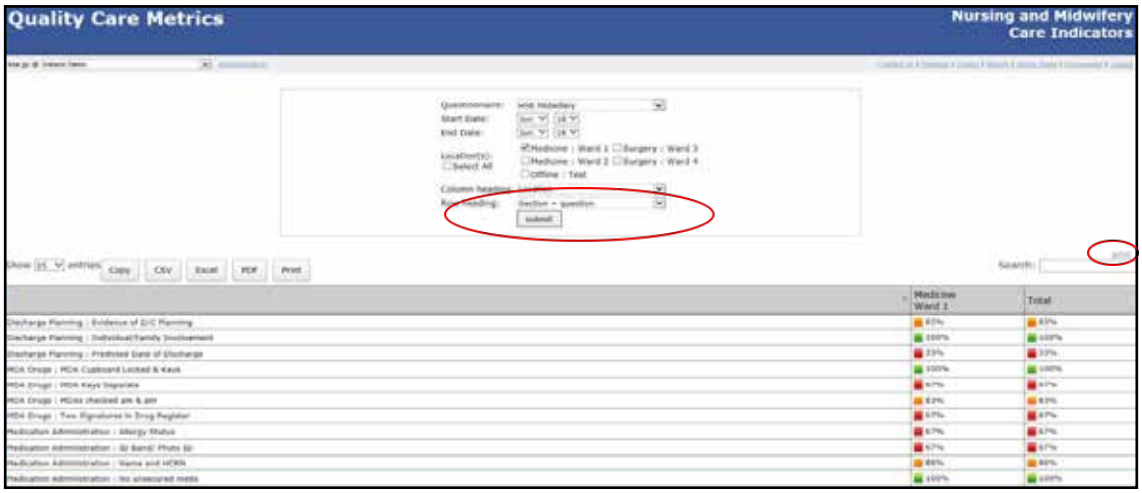


Figure 22: Create your own Report: Results; Column Heading: Location and Row Heading: Section and Question

- 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).

6.2.9 Create your own Report (3): if a more detailed report is required the 'Create your own report' option may be used (Figure 19 and 23).

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

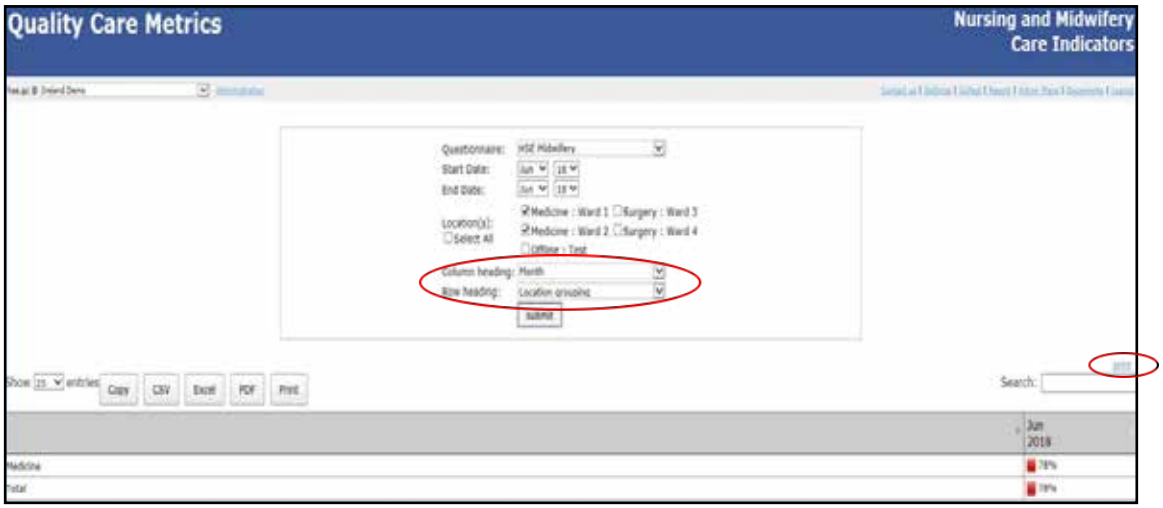


Figure 23: Create your own Report: Results; Column Heading: Month and Row Heading: Location Grouping

- This selection, **'Column Heading: Month and Row Heading: Location Grouping'** supports the ADoM/ADoN to compare groupings/divisions per month if set up (Figure 23).

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 24).

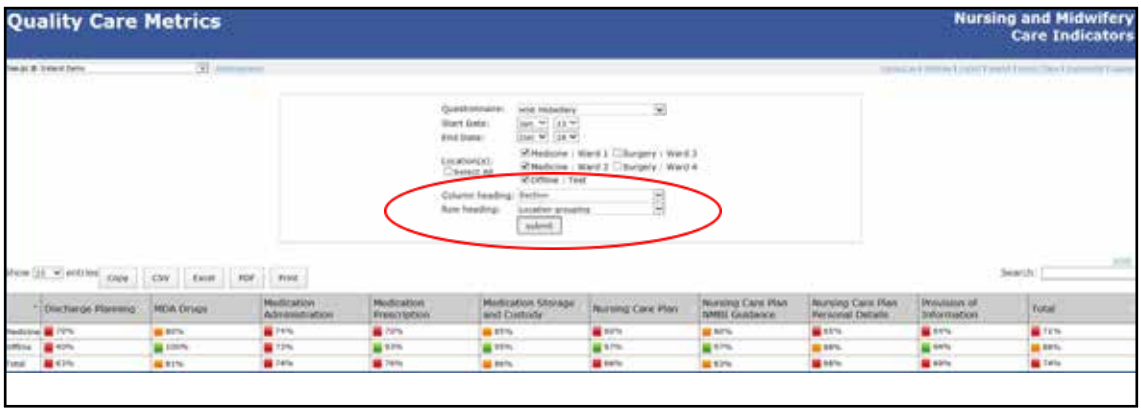


Figure 24: Create your own Report: Results; Column Heading: Section and Row Heading: Location Grouping

7.0 QUALITY CARE-METRICS ACTION PLANNING

7.1 ACCESSING ACTION PLANNING ON TYC HSE

7.1.1 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 25.

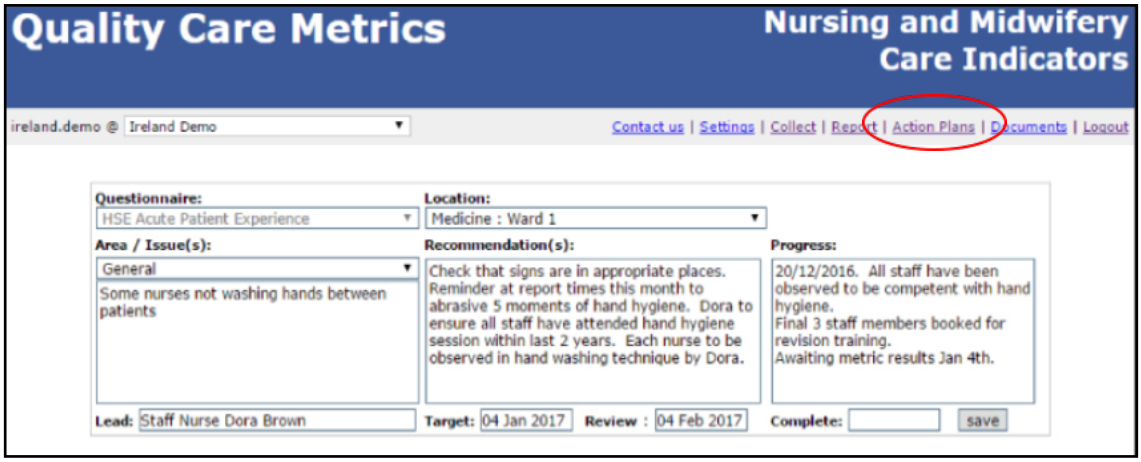


Figure 25: Accessing Action Planning on Test Your Care HSE

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

7.2 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

7.2.1 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

7.2.2 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

7.2.3 Step 3; Writing the Action Plan

- Having identified what areas (metric/indicator) to tackle - be SMART as guided by Figure 26
- 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 26: SMART Goals

7.2.4 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

7.2.5 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

7.2.6 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?

7.2.7 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

8.0QUALITY CARE-METRICS HUB

8.1 The Nursing and Midwifery Quality Care-Metrics hub on HSELanD is located within the ONMSD Nursing and Midwifery Hub at **http://qcmhub.hseland.ie/using-tyc/**

8.2 The aim of the hub is to create an online resource that provides relevant information and learning resources on Nursing and Midwifery Quality Care-Metrics for nurses and midwives.

8.3 The hub guides 'Test Your Care' users and potential users through

- 'QCM Explained'
- 'Implementing QCM'
- Using 'Test Your Care'
- 'Improving Practice' section focused on action planning
- 'News' to keep users and those with an interest in QCM up to date in QCM project developments
- 'Help and Resources' to support implementation processes

Testimony from expert users from around the country is also featured to encourage those starting their journey

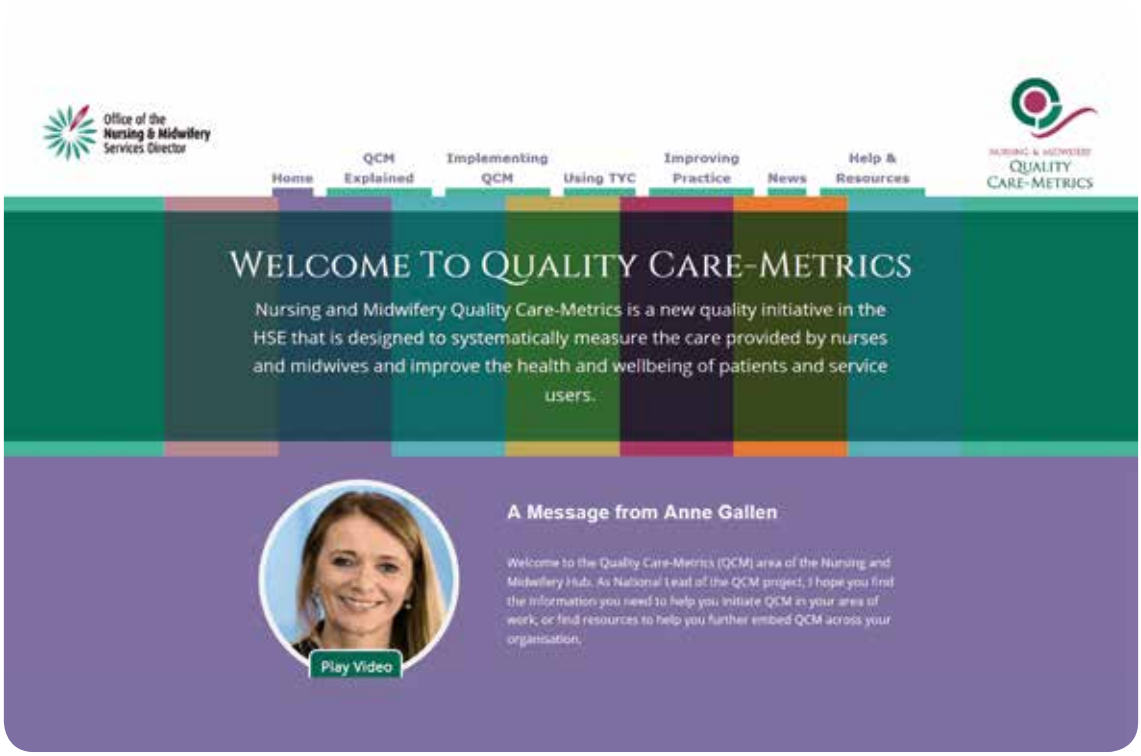


Figure 27: Quality Care-Metrics Hub

8.4 To access the Quality Care-Metrics hub on HSELanD:

- Log in to **www.HSELanD.ie**
- Go to - All hubs
- Go to - Nursing and Midwifery
- Go to - Quality Improvement
- Go to - Quality Care-Metrics

PART B:
Guideline Development Cycle

1.0 INITIATION

1.1 Purpose

Please refer to Part A, 1.9

1.2 Scope

Please refer to Part A, 1.10

1.3 Objective

Please refer to Part A, 1.11

1.4 Outcomes

Please refer to Part A, 1.12

1.5 Guideline Development Group

1.5.1 This guideline has been developed by the National Quality Care-Metrics Project Lead and team (NMPDU, Nursing and Midwifery Quality Care-Metrics Project Officers) under the guidance of the ONMSD. Refer to Appendix III for Membership of the Guideline Development Group.

1.5.2 Guideline Conflict of Interest Declaration Forms have been completed by each member of the Guideline Development Group as per Appendix IV and are retained with the master copy of this guideline.

1.5.3 Additional contributors and reviewers of this guideline are identified within Appendix V

1.6 Guideline Governance Group

1.6.1 The ONMSD Governance Group has provided governance for the project and guideline development. Refer to Appendix VI for Membership of the Guideline Governance Group.

1.7 Supporting Evidence

1.7.1 Legislation and regulation publications, which are relevant to the Midwifery Services Quality Care- Metrics development were reviewed and are incorporated in the development of this guideline and are listed below. In addition, existing policy and standards were reviewed and incorporated into the development of the guideline.

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

1.7.2 PPPGs being replaced by this PPPG:

- *Guiding Framework for the implementation of Nursing and Midwifery Quality Care-Metrics in the Health Service Executive Ireland. (HSE 2015)*
- *Standard Operating Procedure for Nursing and Midwifery Quality Care-Metrics Data Collection in Midwifery Services. (HSE 2015a)*

1.7.3 Related PPPGs:

- *National Guideline for Nursing and Midwifery Quality Care-Metrics Data Measurement in Acute Health Services. HSE, (2018a)*
- *National Guideline for Nursing and Midwifery Quality Care-Metrics Data Measurement in Mental Health Services. HSE, (2018b)*
- *National Guideline for Nursing and Midwifery Quality Care-Metrics Data Measurement in Intellectual Disability Services. HSE, (2018c)*
- *National Guideline for Nursing and Midwifery Quality Care-Metrics Data Measurement in Public Health Nursing Services. HSE, (2018d)*
- *National Guideline for Nursing and Midwifery Quality Care-Metrics Data Measurement in Older Person Services. HSE, (2018e)*
- *National Guideline for Nursing and Midwifery Quality Care-Metrics Data Measurement in Children's Services. HSE, (2018f)*

1.8 Glossary of Terms and Definitions

Please refer to Part A, 1.1

1.9 Abbreviations

Please refer to Part A, 1.2

2.0 DEVELOPMENT OF GUIDELINE

2.1 Development

2.1.1 The development of this guideline is to support implementation of the Midwifery Services Quality Care-Metrics (2018)

2.1.2 This guideline has been developed following a robust research project which aimed to (a) critically review the scope of existing Nursing and Midwifery Quality Care Process Metrics and relative indicators and (b) identify additional metrics and indicators relevant to the Midwifery Services. This was undertaken through the completion of a systematic review and consensus methodology.

2.1.3 The development and content of this document has been informed in part by the Quality Care-Metrics Midwifery Research Report (HSE 2018). This report outlines the research process undertaken as a collaborative between the ONMSD National Quality Care-Metrics Project Team and the National University of Ireland, Galway. It includes the final suite of *Midwifery Process Metrics and Indicators* developed from the research.

2.1.4 The *Midwifery Services Process Metrics and Indicators* are adapted from national and international evidence based practice including PPPGs and reflect what mental health nurses nationally felt was important to measure.

2.1.5 Evidence of the sources for Quality Care-Metrics generated from this robust research is available in the Quality Care-Metrics Midwifery Services Research Report (HSE 2018) and as listed in 1.7 above.

2.2 Research Design

The study design had four phases as follows:

Phase 1: A systematic literature review to identify metrics that have been used in the respective fields and the indicators for same.

Phase 2: A two-round online Delphi survey of midwives to develop consensus on metrics to be measured.

Phase 3: A two-round online Delphi survey of midwives to develop consensus on indicators for prioritised metrics.

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

2.3 Literature Search Strategy

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

2.3.2 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.

2.3.3 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.

2.4 Method of Evidence Appraisal

2.4.1 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.

2.4.2 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

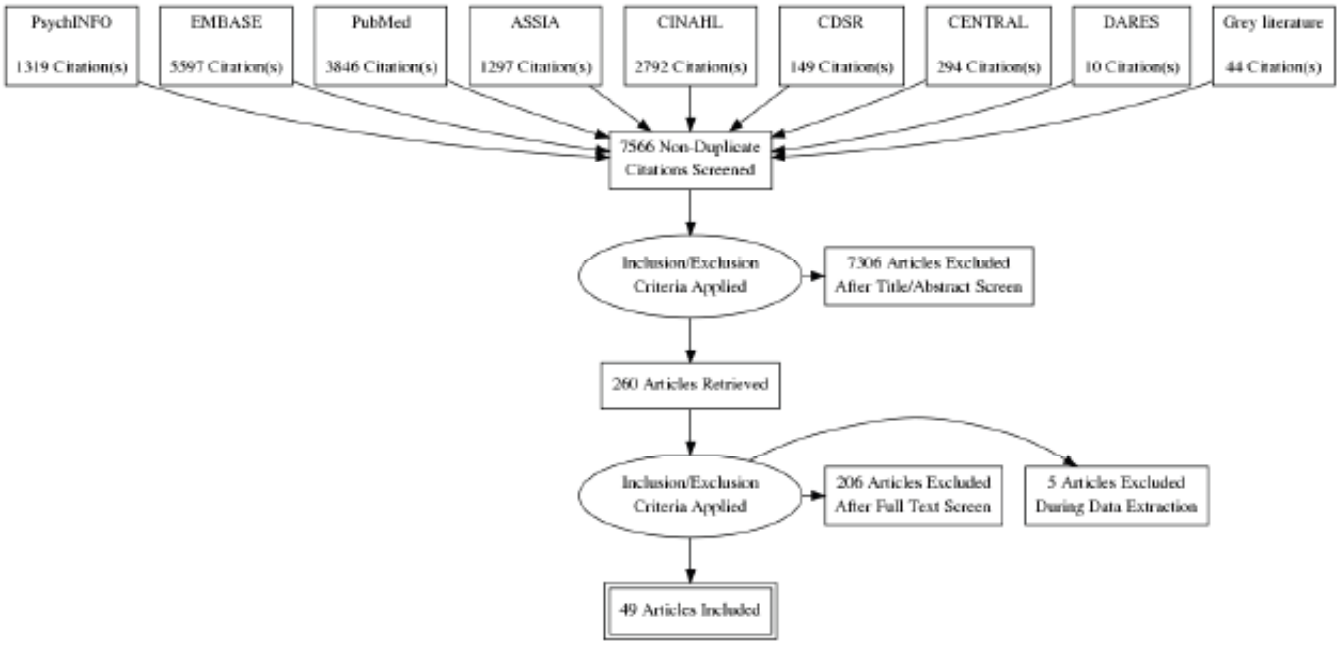
then tagged depending on their relevance to each of the seven workstreams i.e., acute, children, intellectual disability, mental health, midwifery, older person, or public health nursing services.

2.5 Summary of Evaluation from the Literature

2.5.1 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. 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 (HSE 2015a). 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.

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

Figure 28 shows a flow diagram of the study selection process.



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

Figure 28: Study Selection Process Flow Diagram for Midwifery Work Stream

2.6 Consensus Process

2.6.1 Delphi Process: Two two-round Delphi surveys (Phase 2 & 3) were conducted consisting of four rounds of data collection and analysis in each to condense the opinions of participants into group consensus on what (a) metrics and (b) their indicators should be used. Responses to each round were collated, analysed, and redistributed to participants for further comment in successive rounds (HSE 2018).

2.6.2 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 (Figure 29), 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.

THE METRICS/INDICATOR CONTRIBUTES CLEARLY TO THE MEASURE OF MIDWIFERY CARE PROCESSES	
01	**PROCESS FOCUSED** The metrics/indicators contributes clearly to the measurement of midwifery care processes.
02	**IMPORTANT** The data generated by the metric/indicator will likely make an important contribution to improving nursing 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.

Modified from: eRegistries indicator evaluation tool (Flenady et al. 2016)

Figure 29: Nursing and Midwifery Quality Care-Metrics Judgement Framework Tool

2.6.3 Consensus Findings: 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. 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.

2.7 Resources Necessary to Implement the Guideline Recommendations

2.7.1 The resources required for the implementation of the guideline recommendations e.g. Quality Care-Metrics at service level, are outlined within 3.2.3 Implementation Phases; 15 Steps to Support Implementation and 3.4, State of Readiness and Capacity Checklist.

2.7.2 Consideration of each Implementation Phase and Completion of the State of Readiness and Capacity Checklist will provide services with the opportunity to identify what resources may be required locally.

2.7.3 Directors of Nursing and Midwifery should be cognisant of local structures and/or requirements when completing the State of Readiness and Capacity Checklist.

2.8 Outline of Guideline Steps/ Recommendations

Refer to Part A

3.0 GOVERNANCE AND APPROVAL

3.1 Formal Governance Arrangements

3.1.1 The National Nursing and Midwifery Quality Care-Metrics Approval Governance Group (Appendix VI) provided formal governance for the project, the Director of the ONMSD is the designated chairperson for this group.

3.1.2 The National Nursing and Midwifery Quality Care-Metrics Approval Governance Group worked to an agreed scope and terms of reference. Roles and responsibilities of this advisory group membership along with the process of meeting were clearly outlined and agreed.

3.1.3 The National Nursing and Midwifery Quality Care-Metrics Project Lead reported to the National Nursing and Midwifery Quality Care-Metrics Approval Governance Group and the ONMSD. The national project plan and work of the National Nursing and Midwifery Quality Care-Metrics Project Officer Group was presented by the National Project Lead at all governance meetings.

3.2 Guideline Development Standards

3.2.1 The guideline was developed within the HSE National Framework for Developing PPPGs (2016) and has adhered to the NCEC standards as set out within.

3.3 Copyright/Permission Sought

3.3.1 Not required.

3.4 Guideline Checklist

3.4.1 The approved checklist has been completed as per Section 4 of the HSE National Framework for developing PPPGs (2016) and is retained with the master copy of this guideline.

4.0 COMMUNICATION AND DISSEMINATION

4.1 Staff will be made aware of this guideline through HSE Directorate communication mechanisms, nursing forums and the ONMSD communication process. This guideline will be available on **http://www.hse.ie/eng/about/Who/ONMSD/**

5.0 IMPLEMENTATION

5.1 Implementation Plan: Refer to Part A, 4.1
5.2 Education/Training plans required for Implementation: Refer to Part A, 4.2
5.3 Identification of Lead Person(s) responsible for Implementation: Refer to Part A, 4.3
5.4 Specific Roles and Responsibilities: Refer to Part A, 4.4

6.0 MONITORING, AUDIT AND EVALUATION

6.1 The ONMSD provides the overarching governance and leadership to support structures for monitoring, audit and evaluation of PPPGs related to Quality Care-Metrics through the ONMSD Governance Group.

6.2 The National Quality Care-Metrics Project team is responsible for the development and dissemination of this guideline to support services in the implementation process for Nursing and Midwifery Quality Care-Metrics Data Measurement within the Midwifery Services.

7.0 REVISION/UPDATE

7.1 This guideline will be due for revision three years from approval. The procedure for this revision will be in alignment with the HSE National Framework for developing PPPGs (2016).

7.2 In the event of new evidence emerging which relates directly to this guideline, a working group will be convened to revise and amend the guideline if warranted.

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9.0 APPENDICES

Appendix I
Signature Sheet

Appendix II
Immediate Safety/Risk Identification Form for Nursing and Midwifery Metrics

Appendix III
Membership of the Guideline Development Group

Appendix IV
Conflict of Interest Declaration Form Template

Appendix V
Additional Guideline Contributors and Reviewers

Appendix VI
Membership of the Guideline Approval Governance

Appendix I
Signature Sheet

I have read, understand and agree to adhere to this Guideline:

Print Name	Signature	Area of Work	Date

Appendix II
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.

During the conduction of metrics in the ward today, the following safety/risk concerns are identified.

To be Completed by the data collector undertaking Metric	
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 III
Membership of the Guideline Development Group (National Quality Care-Metrics Project Team)

Chairperson: **Dr. Anne Gallen** National Lead for Nursing & Midwifery Quality Care-Metrics
Angela Killeen NMPDU Quality Care-Metrics Project Officer, NMPD HSE North West
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Leonie Finnegan NMPDU Quality Care-Metrics Project Officer, NMPDU HSE South East
Margaret Nadin NMPDU Quality Care-Metrics Project Officer, NMPDU HSE Dublin North East
Mary Nolan NMPDU Quality Care-Metrics Project Officer, NMPDU HSE Midlands

Appendix IV
Conflict of Interest Declaration

A Conflict of Interest Declaration Form has been completed by each member of the Guideline Development Group (National Quality Care-Metrics Project Team) and is retained with the master copy of the guideline.

Appendix V
Additional Contributors/Reviewers PPPG

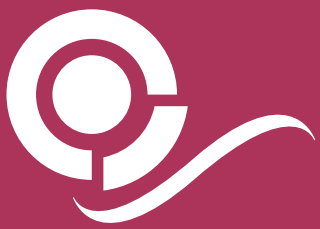
Mary Frances O'Reilly	DIRECTOR NMPDU, HSE WEST/MIDWEST

Appendix VI

Membership of the Approval Governance Group (ONMSD Governance Group)

Chairperson: **Ms Mary Wynne** Director of the Office of the Nursing and Midwifery Services Director	SIGNATURE: Mary Wynne DATE: 5TH DECEMBER 2018

Dr Anne Gallen (NMPDU) ONMSD National Lead QCM
Professor Laserina O'Connor (UCD) QCM Academic Group Rep
Ms Gillian Conway (NMPDU) QCM NMPD Project Officers Rep
Hospital Group Chief Nurse Reps / IADNAM DON/M Reps:
Ms Julie Nohilly Acute Care
Ms Mary Brosnan Midwifery
Ms Suzanne Dempsey Children's Nursing
Ms Georgina Bassett Older Persons Care
Ms Catherine Adams Area Director of Mental Health Nursing Rep
Ms Mary B Finn-Gilbride Director of Public Health Nursing
Ms Theresa O'Loughlin Director of Nursing Intellectual Disability
Dr Jennifer Martin HSE Quality Improvement Division Rep
Mr Pat Kelly HSE ICT Rep
Ms Martina Harkin-Kelly INMO Rep
Ms Aisling Culhane PNA Rep
Ms Aideen Carberry SIPTU Rep
Ms Anne Harris Patient Voice
Ms Anita Gallagher Secretary to the Group



NURSING & MIDWIFERY

QUALITY CARE-METRICS

DECEMBER 2018

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

Health Service Executive
Dr. Steevens' Hospital
Dublin 8
Ireland

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