Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Office of the
Nursing & Midwifery
Services Director

Standard Operating Procedure for Nursing and Midwifery Quality Care-Metrics Data Collection In

Public Health Nursing Services

Nursing & Midwifery
Quality
Care-Metrics

Tús Áite do Shábháilteacht Othar
Patient Safety First

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NURSING & MIDWIFERY
QUALITY
CARE-METRICS

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Public Health Nursing Services

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1.0 Introduction:

Nursing and Midwifery Quality Care-Metrics are a measure of the quality of nursing and midwifery clinical care processes aligned to evidenced based standards and agreed through national consensus in healthcare settings in Ireland. Quality Care-Metrics will enable midwifery and nursing staff to frequently review real time data in order to improve clinical practice appropriately (Harrison 2011).

2.0 Procedure Statement:

This procedure provides a standardised interpretation when collecting nursing and midwifery Quality Care-Metrics data. Consistent data collection is promoted through adherence to this procedure within all Public Health Nursing services currently implementing Quality Care-Metrics.

3.0 Purpose:

The purpose of this procedure is to guide Quality Care-Metrics data collectors to interpret consistently thereby providing reliability and validity in the data collection process.

4.0 Scope:

This procedure applies to all identified nursing and midwifery Quality Care-Metric data collectors within the Public Health Nursing Services, who are currently implementing this care measurement initiative. The Quality Care-Metrics have been generated using consensus methodology, in line with evidenced based practice, current legislation and national standards. They are adapted from national policies, procedures, protocols and guidelines (PPPG's). Evidence of sources for Quality Care-Metrics is available in the reference list.

5.0 Glossary of Terms & Definitions:

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).

Nursing Metrics:

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

Policy:

A policy is a written statement that clearly indicates the position and values of the organisation on a given subject (HIQA 2006).

Procedure:

A procedure is a written set of instructions that describe the approved and recommended steps for a particular act or sequence of events (HIQA 2006).

Quality Care-Metrics:

Quality Care-Metrics are a measure of the quality of nursing and midwifery clinical care processes, in healthcare settings in Ireland, aligned to evidenced based standards and agreed through national consensus.

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 the Test Your Care system.

Active Public Health Nursing Service Caseload:

An active case is a patient/client admitted to the caseload that requires ongoing nursing interventions (e.g. daily/weekly/monthly/3 monthly), has a current care plan/record on file and has a review date recorded.

6.0 Roles & Responsibilities:

A range of stakeholders are involved in the implementation of Quality Care-Metrics. It is important that the data collectors and all stakeholders refer to the Guiding Framework for the Implementation of Nursing and Midwifery Quality Care-Metrics in Ireland (HSE 2015) for specific information on individual roles and responsibilities. Appendix i should be signed by all Quality Care-Metric data collectors to provide assurance to Directors of Public Health Nursing that they have read and understood this procedure.

7.0 Procedure for Data Collection:

Data collectors are selected within each Network by their Director of Public Health Nursing. Authorisation is given to enter data on the Test Your Care System using an individualised username and password. Monthly Quality Care-Metrics are collected using a sample size of 10 patient records from a RPHNs/RGNs active caseload (e.g. clients seen daily/weekly/monthly/3 monthly or very recently discharged from active caseload) within the overall Network. Data collectors agree to follow the advice in the standard operating procedure in order to ensure consistency and standardisation of measurement.

Data collectors should be mindful of the clinical area they are attending, following protocols for that service, to include: obtaining permission as required to enter the clinical area, dress code as per policy and adherence to infection prevention and control procedures in the clinical area. At all times, individuals should be treated with respect and dignity and afforded the necessary confidentiality and anonymity. The following Quality Care-Metrics have been generated for the Public Health Nursing Service:

PUBLIC HEALTH NURSING SERVICE DOCUMENTATION

Nursing Assessment
Nursing and Midwifery Care Plan
Nursing and Midwifery NMBI Guidance
Discharge Planning and Caseload Management

*** Data Collection for Documentation Quality Care-Metric to exclude Child and Family Health Caseload**

The following information will provide the data collector with detail on the specific Metric to be measured (**M**=Metric), the evidence base and standards supporting the metric (**S**=Standard) and additional advice (**A**=Advice).

*** Where the indicator refers to Patient, this includes the patient, and/or the carer and/or significant other.**

7.1 Public Health Nursing Service Documentation Quality Care-Metric

7.1.1 Nursing Assessment

Nursing Assessment		
	M = *Metric* **S** = *Standard* **A** = *Data Collectors Advice* **Y** = *Yes* **N** = *No* **N/A** = *Not Applicable*	
1	M	**The Individuals' name and date of birth are on each page/screen and the initial assessment date and time are recorded**
	S	ABA (2002) Recording Clinical Practice Guidance for Nurses and Midwives, 7.5, p10, 7.7, p11, 7.8, p11, 7.16, p13. HSE (2011) Standards and Recommended Practices for Healthcare Records Management, V3, 2.4.26, p54.
	A	Check each assessment documentation to ensure that the individuals name and DoB or HCRN are on each page/screen and admission date and time are recorded. Mark **Yes** if all components are completed. Mark **No** if date/time is not entered using 24 hour clock or if any component is missing.
2	M	**Presenting reason for and source of referral/admission to caseload is recorded and appropriate for the PHN Service**
	S	ABA (2002) Recording Clinical Practice Guidance for Nurses and Midwives, 7.1, p9. Health Service Executive (2009a) Guideline for Assessment of Adults (including Older Adults) Referred to the Public Health Nursing Service, LHO North West Dublin, Dublin: HSE.
	A	Mark **Yes** if admission details provide an appropriate reason for referral/admission to caseload, the source of referral and this is clearly recorded on relevant documentation. Mark **No** if referral or admission to caseload is inappropriate or if the information is not clearly recorded. Mark **No** if source of referral is not clearly recorded.
3	M	**The Nursing assessment is evident and is sensitive to the patient's condition, includes an assessment of physical, psychological, social and environmental well-being**
	S	An Bord Altranais (2002) Recording Clinical Practice Guidance to Nurses and Midwives. An Bord Altranais (ABA), Dublin. Health Service Executive (2009a) Guideline for Assessment of Adults (including Older Adults) Referred to the Public Health Nursing Service, LHO North West Dublin, Dublin: HSE.
	A	Mark **Yes** if a nursing assessment is evident, is individualised to the patient's condition and includes an assessment of physical, psychological, social and environmental well-being. Mark **No** if this information is not clearly recorded.
4	M	**Past Nursing, Obstetric, Medical, Surgical, Mental Health and Social History are recorded as appropriate**
	S	ABA (2002) Recording Clinical Practice Guidance for Nurses and Midwives, 7.1, p9.
	A	Mark **Yes** if past nursing, midwifery, medical, surgical and mental health details are clearly documented. Mark **No** if relevant history is not clearly recorded on relevant documentation or if this is left blank in nursing documentation.

5	M	**The Nursing Assessment includes the views and observations of the patient**
	S	An Bord Altranais (2002) Recording Clinical Practice Guidance to Nurses and Midwives. An Bord Altranais (ABA), Dublin.
	A	Mark **Yes** if the nursing assessment includes the patient's views and where appropriate includes the views of the carer/family members/significant other. Mark **No** if the nursing assessment does not include the views of the patient/family members/significant other as appropriate.
6	M	**Clinically Indicated Assessments have been completed and fully documented, dated, timed and signed**
	S	ABA (2005) The Requirements and Standards for Nurse Registration Education Programmes, 3rd Edn, Domain 2, Criteria 2.1, p14, Domain 3, Criteria 3.2, p14. Anthony, D. et al. (1998). An evaluation of current risk assessment scales for decubitus ulcer in general inpatients and wheelchair users. Clinical Rehabilitation. 12(2), p.136-142. Carey, E. et al. (2008). Prediction of Mortality in Community-Living Frail Elderly People with Long-Term Care Needs. Journal of the American Geriatrics Society. 56 (1), p68-75. Gupta, A. (2008) Measurement Scales Used in Elderly Care. Radcliffe, UK. Health Service Executive (2012) Manual Handling and People Handling Policy, Dublin: HSE. HIQA (2012) National Standards for Safer Better Healthcare, Standard 2.2, p44, 5.8.1, p100. Mahoney, J. et al. (2000). Problems of Older Adults Living Alone After Hospitalization. Journal of Geriatric Internal Medicine. 15, p611-619. McGee, H. et al. (2008). Vulnerable Older People in the Community: Relationship Between the Vulnerable Elders Survey and Health Service Use. Journal of American Geriatrics Society. 56 (0), p8-15. NMBI (2016) Nurse Registration Programmes Standards and Requirements. 4th Edn, Domain 2, p52 Perell, K. et al. (2001). Fall Risk Assessment Measures: An Analytic Review. Journal of Gerontology. 56A (12), pM761-M766.
	A	Mark **Yes** if assessments have been undertaken as per Local/National policy, dated, timed in 24hr clock and signed. Examples include but not limited to; Mental Test Assessment, Activity of Daily Living, Nutritional Assessment, Patient's Manual Handling Requirement, Falls Risk Assessment, Common Summary Assessment Report, Geriatric Depression Scale. Mark **Yes** if where a risk has been identified the care plan includes immediate actions taken to alleviate risk as per National/Local policy. Mark **No** if all relevant assessments have not been undertaken and are not documented. Mark **No** if assessments have not been dated timed or signed. Mark **No** if the care plan does not include immediate actions taken to alleviate identified risk.
7	M	**Medications and Allergy Status are clearly documented in the appropriate section of the nursing assessment. Where there are none known, this is also clearly documented**
	S	ABA (2007) Guidance to Nurses and Midwives on Medication Management, 1.5, p12. HSE (2010) Code of Practice for Healthcare Records Management-Abbreviations, p7.
	A	Mark **Yes** if medications are documented in the appropriate section in the nursing documentation and if any known allergies are clearly documented. Mark **Yes** if "No Medications" or "No Known allergies" are documented in appropriate section. Mark **No** if medications are not documented in the appropriate section on the nursing documentation. Mark **No** if there is no medication or allergy status recorded.

8	M	**Where a RPHN/RGN is administering prescribed medication the prescription is available in the nursing documentation, is legible, is signed by the registered prescriber, is updated within a specified timeframe in line with local policy and a care plan is initiated**
	S	ABA (2007) Guidance to Nurses and Midwives on Medication Management, 1.5, p12.
	A	Mark **Yes** if the prescription is available in the nursing documentation, is legible, is signed by the registered prescriber, is updated within a specified timeframe in line with local policy and a care plan is initiated. Mark **No** if any of these elements are missing. Mark **N/A** if PHN/RGN is not administering medication.
9	M	**There is documented evidence that the infection status has been discussed with the patient, recorded within the patient's documentation and updated as appropriate**
	S	HIQA (2009) A Guide to the National Standards for the Prevention and Control of Healthcare Associated Infections, Standard 7, p28-30. SARI (2005) The Control and Prevention of Infections in Hospitals and in the Community, SARI infection and Control Subcommittee, Guidelines for the control of MRSA in Ireland, HSE Health Protection and Surveillance Centre, p.6. HSE (2010) Guideline for the Control of Methicillin Resistant Staphylococcus Aureus (MRSA) in the PHN Service Louth PCCC, p.6.
	A	Mark **Yes** if there is documented evidence that the infection status has been discussed with the patient/ carer/significant other. Mark **No** if there is no evidence of a discussion of infection status recorded.

7.1.2 Nursing and Midwifery Care Plan

Nursing and Midwifery Care Plan		
	M = *Metric* **S** = *Standard* **A** = *Data Collectors Advice* **Y** = *Yes* **N** = *No* **N/A** = *Not Applicable*	
1	M	**A Nursing Care Plan is evident, reflects the individuals current condition and shows evidence that it was developed in partnership with the patient. Each care plan and intervention is dated, timed and signed**
	S	ABA (2002) Recording Clinical Practice Guidance to Nurses and Midwives, Standard 7.2, p.9, p.2. ABA (2005) The Requirements and Standards for Nurse Registration Education Programmes, 3rd Edn, Domain 2, Criteria 2.2, p14. European Convention on Human Rights (1998) European Court of Human Rights, Strasburg. Health Service Executive (2009) Management of referrals into the Public Health Nursing Service, Dublin: HSE. HIQA (2012) National Standards for Safer Better Healthcare, Standard 2.2, p44. NMBI (2014) Standards of Conduct for Registered Nurses and Midwives. NMBI, Dublin. NMBI (2016) Nurse Registration Programmes Standards and Requirements. 4th Edn, Domain 2, p52 Porter P. Perry A. (2010) Canadian Fundamentals of Nursing. Elsevier Canada, Toronto. Reed J. Cook G. Childs S. McCormack B. (2005) A literature review to explore integrated care for older people. International Journal Integrated Care 5, 1-10.
	A	Mark **Yes** if an individualised nursing care plan is in place and is reflective of the individual's current condition and shows evidence that it was developed in partnership with the patient and/or carer and/or significant other. These should be dated, timed (in 24hr clock) and signed (legible and inclusive of job title) by the assessing staff member. Mark **No** if no individualised care plan is devised or was not devised in partnership with the patient and/or carer and /or significant other, or is not up to date or reflective of the individual's current condition. Mark **No** if all elements are not present.

2	M	**There is documented evidence of the rationale behind nursing care decisions within the care plan**
	S	An Bord Altranais (2002) Recording Clinical Practice Guidance to Nurses and Midwives. An Bord Altranais (ABA), Dublin. Mykkanen M. Saranto K. Miettinen M. (2012) Nursing audit as a method for developing nursing care and ensuring patient safety. Nursing Informatics. June 23: 2012: 301.ecollection, accessed 11/06/15. Urquhart C. Currell R. Grant M. Hardiger N. (2009) Nursing record systems: effects on nursing practise and healthcare outcomes, Cochrane Data Systematic Review, Issue 1. The Cochrane Collaboration, John Wiley & Son Ltd.
	A	Mark **Yes** if there is a clear rationale documented for nursing care decisions in the care plan. Mark **No** if there is no rationale documented for nursing decisions.
3	M	**There is evidence in the care plan that, where appropriate discharge education and preparation has begun**
	S	An Bord Altranais (2002) Recording Clinical Practice Guidance to Nurses and Midwives. An Bord Altranais (ABA), Dublin, p.12.
	A	Mark **Yes** if there is evidence in the care plan that discharge education and preparation has begun. Mark **No** if there is no evidence in the care plan that discharge preparation and education has begun. Mark **N/A** if discharge planning is not appropriate.
4	M	**Evaluation of nursing care plan is evident and has been updated within specified timeframe, documenting patient's clinical outcomes following nursing interventions (including delegated care)**
	S	ABA (2002) Recording Clinical Practice Guidance to Nurses and Midwives Standard 7.2, p9, p.2. ABA (2005) The Requirements and Standards for Nurse Registration Education Programmes, 3rd Edn. Domain 2, Criteria 2.2, p14. HIQA (2012) National Standards for Safer Better Healthcare, Standard 2.2, p44. Mykkanen M. Saranto K. Miettinen M. (2012) Nursing audit as a method for developing nursing care and ensuring patient safety. Nursing Informatics. June 23: 2012: 301. ecollection, accessed 11/06/15. NMBI (2016) Nurse Registration Programmes Standards and Requirements. 4th Edn, Domain 2, p52
	A	Mark **Yes** if evaluation of nursing care plan is undertaken in accordance with review date including patient outcomes following nursing interventions (including delegated care). Mark **Yes** if care plan is evaluated within specified timeframe in line with local policy. This should reflect nursing care delivered as per nursing care plan; any deviations from care plan; review of care plan and communications with patient or carer/significant other. Mark **No** if evaluation of nursing care plan is not evident, does not clearly show clinical outcomes, or is not in line with review date. Mark **N/A** if evaluation review date has not been reached.
5	M	**There is appropriate documentation to reflect the involvement of other professionals and any contact is documented, dated, timed and signed**
	S	Health Service Executive (2013c) Public Health Nursing Service Community and Continuing Care Service in Longford and Westmeath, HSE.
	A	Mark **Yes** if there is appropriate documentation to reflect the involvement of other health professionals where patient conditions/assessed needs identify it is appropriate. Mark **Yes** if all contact with other health professionals is dated, timed in 24hr clock and signed. Mark **No** if documentation to reflect the involvement of other health professionals is not available. Mark **No** if the patient has not been referred to the appropriate health professionals. Mark **No** if documentation of contact with other health professionals is not dated timed or signed. Mark **N/A** if it is not appropriate for any other health professional to be involved in the patient's care.

6	M	**There is documented evidence of verbal consent from patient and/or next of kin for sharing of information with other health professionals where appropriate**
	S	An Bord Altranais (2002) Recording Clinical Practice Guidance to Nurses and Midwives. An Bord Altranais (ABA), Dublin. Health Service Executive (2013b) Procedure on all Manual Documentation for recording and maintaining clinical records in Sligo Leitrim/West Cavan Public Health Nursing Service, HSE. HSE (2013) National Consent Policy, Standard 3 p. 23, Standard 7.4 p.38.
	A	Mark **Yes** if there is documented evidence of verbal consent from the patient and/or next of kin for sharing of information with other health professionals where the need is identified. Mark **No** if patient information has been shared with other health professionals and there is no evidence of gaining verbal consent from patient and/or next of kin for sharing of patient information. Mark **N/A** if no information has been shared with other health professionals.
7	M	**Continuation notes reflect the patient's current condition and improvements or deterioration in the patient's condition are clearly documented**
	S	An Bord Altranais (2002) Recording Clinical Practice Guidance to Nurses and Midwives. An Bord Altranais (ABA), Dublin, p.2. Bergen-Jackson K. Sanders S. Herr K. Fine P. Titler M. et al. (2009) Determining community provider practices in hospices: the challenges of documentation. Journal Hospice Palliative Nursing 11, 334-31. Collins S. Cato K. Albers D. Scott K. et al. (2013) Relationship between nursing documentation and patients" mortality. American Journal of Critical Care 22, 306-313. Tornvall E. Wilhelmsson S. (2008) Nursing documentation for communicating and evaluating care. Journal of Clinical Nursing 17, 2116-2124.
	A	Check entries for last 72 hours (or last three entries of current admission to caseload) Mark **Yes** if the continuation notes reflect the patient's current condition and improvements or deterioration in the patient's condition are clearly documented. Mark **No** if the continuation notes do not reflect the patient's current condition and improvements or deterioration in the patient's current condition are not documented.

7.1.3 Nursing and Midwifery Board of Ireland (NMBI) Guidance

NMBI Guidance		
	M = *Metric* **S** = *Standard* **A** = *Data Collectors Advice* **Y** = *Yes* **N** = *No* **N/A** = *Not Applicable*	
1	M	**All entries are written in permanent black ink, concise, current, comprehensible to nurses and patients alike, legible, dated, timed, signed and the time the event took place is documented**
	S	ABA (2002) Recording Clinical Practice Guidance to Nurses and Midwives, 7.3, 7.4, 7.5 p10, 7.8, p11. HSE (2011) Standards and Recommended Practices for Healthcare Records Management, V3, 2.4.16, p53, 2.4.25, p54. NMBI (2014) Standards of Conduct for Registered Nurses and Midwives. NMBI, Dublin. Jefferies D. Johnson M. Griffiths R. (2010) Ameta-study of the essentials of quality nursing documentation. International Journal Nursing Practice, 16, 112-124. Moore C. Wisnivesky J. Williams S. McGinn T. (2003) Medical errors related to discontinuity of care from an inpatient to an outpatient setting. Journal General Internal Medicine, 8, 646-651. Porter P. Perry A. (2010) Canadian Fundamentals of Nursing. Elsevier Canada, Toronto. Reed J. Cook G. Childs S. McCormack B. (2005) A literature review to explore integrated care for older people. International Journal Integrated Care 5, 1-10. Urquhart C. Currell R. Grant M. Hardiger N. (2009) Nursing record systems: effects on nursing practise and healthcare outcomes, Cochrane Data Systematic Review, Issue 1. The Cochrane Collaboration, John Wiley & Son Ltd. Wang N. Hailey D. Yu P. (2011) Quality of nursing documentation and approaches to its evaluation: a mixed-methods systematic review. Journal Advanced Nursing 9, 1858-1875. World Health Organisation (2011) http://who/lbdoc.who.int/publications/2011/9789241501958:_eng.pdf.
	A	Check entries for last 72 hours (or last three entries of current admission to caseload). Mark **Yes** if entries are written in permanent black ink, concise, current, comprehensible to nurses and patients alike, legible, day/month/year is recorded for each 24 hours and time is listed in 24 hour clock and the time the event took place is documented. Mark **Yes** if Date is acceptable at beginning of each day. Mark **Yes** if all entries have signature of nurse (including job title of the person recording) and that a signature bank is available for each signature corresponding to full name. Mark **No** if date is not re entered after 12midnight for next day. Mark **No** if any time does not follow 24 hr clock. Mark **No** if all elements are not adhered to.
2	M	**All entries are in chronological order with no blank spaces or pages between entries. Late entries are dated, timed and signed and the words 'Late Entry' written beside them**
	S	ABA (2002) Recording Clinical Practice Guidance to Nurses and Midwives, 7.6, 7.7, p11. National Hospitals Office (2007) National Hospitals Office Code of Practice for Healthcare Records Management – Recommended Practices for Clinical Staff. National Hospitals Office, Health Service Executive.
	A	Check entries for last 72 hours (or last three entries of current admission to caseload). Mark **Yes** if all entries in the nursing documentation are in chronological order. Mark **Yes** if late entries are dated timed and signed with the words 'Late Entry' documented. Mark **No** if late entries are not documented, not in order or if there are blank pages or blank spaces between entries.

3	M	**All abbreviations/grading systems are from a national or local approved list/system**
	S	ABA (2002) Recording Clinical Practice Guidance to Nurses and Midwives, 7.9, 7.10, p11. American Medical Informatics Association (AMIA) and AHIMA Terminology and Classification Policy Task Force (2006) Healthcare terminologies and classifications: an action agenda for the United States. Perspectives in Health Information Management, November 13, 2006, www.ahima.org. HSE (2011) Standards and Recommended Practices for Healthcare Records Management, V3, 2.4.17, p53, 2.4.28, p54. HSE (2013e) Best Practice Standards for Documentation of Nursing Practice in Community Nursing including use of Abbreviations, Public Health Nursing Services, Laois/Offaly & Longford/Westmeath. Thoroddsen A. Ehrenberg A. Sermeus W. Saranto K. (2012) A survey of nursing documentation, terminologies and standards in European countries. Nursing Informatics, June 23: 2012: 406.ecollection, accessed 06/06/15.
	A	Check entries for last 72 hours (or last three entries of current admission to caseload). Mark **Yes** if abbreviations from the National abbreviations list are used. Mark **No** if abbreviations used are not on this list. Mark **N/A** if no abbreviations have been used.
4	M	**All Alterations/corrections are as per NMBI Guidance (Bracketed with a single line through them so the original entry is still legible. The alteration must be dated and signed with the initials of the person altering the record)**
	S	ABA (2002) Recording Clinical Practice Guidance to Nurses and Midwives, 7.7, 7.11, p12.
	A	Check entries for last 72 hours (or last three entries of current admission to caseload). Mark **Yes** if entries are bracketed with a single line through them so the original entry is still legible. The alteration must be dated and signed with initials of person altering the record. Mark **No** if erasure fluid is used. Mark **No** if alterations do not follow this format. Mark **N/A** if no alterations have been made.
5	M	**Student entries are countersigned by the supervising nurse or midwife**
	S	ABA (2002) Recording Clinical Practice Guidance to Nurses and Midwives, 7.18, p13. HSE (2011) Standards and Recommended Practices for Healthcare Records Management, 3.4.11, p75.
	A	Check entries for last 72 hours (or last three entries of current admission to caseload). The standard of record keeping of those under supervision in the clinical area e.g. student nurses/midwives/PHN's or nurses/midwives undertaking supervised clinical practice prior to registration, should be monitored by the nurse/midwife/PHN charged with responsibility for the supervision of her/his delegate. Mark **Yes** if all student entries are countersigned. Mark **No** if any student signature has not been countersigned. Mark **N/A** if there are no student nurses in the service or no entries by a student nurse.

7.1.4 Discharge Planning and Caseload Management

Discharge Planning and Caseload Management		
	M = *Metric* **S** = *Standard* **A** = *Data Collectors Advice* **Y** = *Yes* **N** = *No* **N/A** = *Not Applicable*	
1	M	**Provision of Public Health Nursing Service discharge plan (and estimated discharge date if appropriate) has been documented and communicated to the patient**
	S	Coleman E. Boult C. (2003) Improving the quality of transitional care for persons with complex needs. J Am Geriatr Soc 51, 556-557. Health Service Executive (2013c) Public Health Nursing Service Community and Continuing Care Service in Longford and Westmeath, HSE. Health Service Executive (2009b) Guideline for Nurse/Midwife Facilitated Discharge Planning, Dublin: ONMSD. Instefjord M. Aasekjaer K. Espehaug B. Graverholt B. (2014) Assessment of quality in psychiatrist nursing documentation – a clinical audit. BMC Nursing, 13, 32.
	A	Mark **Yes** if there is documented evidence of discharge planning (and estimated discharge date if appropriate) and evidence that discharge planning has been discussed with the patient/carer/significant other. Mark **No** if there is no documented evidence of discharge planning or communication of discharge planning with the patient/carer/significant other. Mark **N/A** if Discharge Planning is not appropriate at this time.
2	M	**There is evidence of a comprehensive nursing assessment for patient discharge**
	S	Badger et al (1989) District Nurses' patients-issues of caseload management, Journal of Advanced Nursing, 14(7), 518-527. Clark D, Seymour J, Douglas H et al (2002) Clinical nurse specialists in palliative care. Part 2. Explaining diversity in the organisation and costs of Macmillan nursing services, Palliat Med 16(1), 375–85.
	A	Mark **Yes** if there is evidence of a comprehensive nursing assessment for patient discharge. Mark **No** if there is no evidence of a nursing assessment for patient discharge. Mark **N/A** if discharge is not appropriate for this patient at this time.

3	M	**There is documented evidence of communications with patient and/or Primary Care Team members involved in patient care regarding discharge from RPHN caseload**
	S	Coleman E. Boult C. (2003) Improving the quality of transitional care for persons with complex needs. J Am Geriatr Soc 51, 556-557. Health Service Executive (2013d) Management of Discharge of Clients from an Active PHN Caseload, Public Health Nursing Service Community and Continuing Care Service in Longford and Westmeath, HSE. Holland D. Harris M. (2007) Discharge planning, transitional care, coordination of care, and continuity of care: clarifying concepts and terms from the hospital perspective. Home Health Care Service Quality 26, 3-19. Naylor M. Aiken L. Kurtzman E. Olds D. Hirschman K. (2011) The importance of transitional care in achieving health reform. Health Affairs 30, 745-754. Naylor M. Keating S. (2008) Transitional care. J Soc Work Educ 44, Supplement 65-73. NMBI (2014) Standards of Conduct for Registered Nurses and Midwives. NMBI, Dublin.
	A	Mark **Yes** if there is documented evidence of communications with patient and/or carer and/or significant other and/or Primary Care Team members involved in patient care regarding discharge from PHN caseload. Mark **No** if there is no documented evidence of communications with patient and/or carer and/or significant other and/or Primary Care Team members involved in patient care regarding discharge from PHN caseload. Mark **N/A** if discharge planning is not appropriate for the patient at this time.
4	M	**There is documented evidence that the patient is involved in their discharge plan and has received and understood appropriate written and verbal health care education and advice throughout the episode of care in preparation for self care upon discharge**
	S	Coleman E. Boult C. (2003) Improving the quality of transitional care for persons with complex needs. J Am Geriatr Soc 51, 556-557. Health Service Executive (2009b) Guideline for Nurse/Midwife Facilitated Discharge Planning, Dublin: ONMSD. Health Information and Quality Authority. National standard for patient discharge summary information (2013), http:www.hiqa.ie/publications/national-standard-patient-discharge-summary-information: accessed June 2015. Health Service Executive (2013d) Management of Discharge of Clients from an Active PHN Caseload, Public Health Nursing Service Community and Continuing Care Service in Longford and Westmeath, HSE. Instefjord M. Aasekjaer K. Espehaug B. Graverholt B. (2014) Assessment of quality in psychiatrist nursing documentation – a clinical audit. BMC Nursing, 13, 32.
	A	Mark **Yes** if there is documented evidence that the patient/carer/significant other is involved in their discharge plan and has received and understood appropriate written and verbal health care education and advice throughout the episode of care in preparation for self care upon discharge (As appropriate: healthy eating, falls prevention, influenza vaccination, smoking cessation, keeping active, home safety and security and medication management where appropriate). Mark **No** if there is no documented evidence of communication in relation to discharge with the patient. Mark **No** if the patient has not received appropriate health care education and advice throughout the episode of care in preparation for self care upon discharge. Mark **No** if there is no documented evidence that self-care upon discharge has been assessed. Mark **N/A** if discharge education and advice is not appropriate for this patient at this time.

5	M	**The decision to discharge the patient is based on the achievement of nursing objectives**
	S	Badger et al (1989) District Nurses' patients-issues of caseload management, Journal of Advanced Nursing, 14(7), 518-527. Health Service Executive (2013c) Public Health Nursing Service Community and Continuing Care Service in Longford and Westmeath, HSE. Newbury, J. & Hatherell C.A. (2004) Audit on discharging patients from community specialist palliative care nursing services, International Journal of Palliative Nursing, 10(1), 24-31.
	A	Mark **Yes** if the patient has been discharged once all nursing objectives have been achieved (including patients referred to appropriate services based on needs). Mark **No** if the patient was discharged prior to nursing objectives being met. Mark **No** if nursing objectives were achieved but patient remains on the caseload. Mark **No** if the notes do not indicate that the patient was discharged. Mark **N/A** if discharge is not appropriate for the patient at this time. Mark **N/A** if termination of service was out of the control of the PHN Service.
6	M	**Where the patient has been discharged or transferred to another service there is documentation to identify what information has been provided on discharge or transfer to receiving service**
	S	Health Service Executive (2009b) Guideline for Nurse/Midwife Facilitated Discharge Planning, Dublin: ONMSD. Health Service Executive (2013d) Management of Discharge of Clients from an Active PHN Caseload, Public Health Nursing Service Community and Continuing Care Service in Longford and Westmeath, HSE.
	A	Mark **Yes** if appropriate documentation identifies what information has been provided to the receiving service or the patient/care/significant other on discharge from the PHN Service. Mark **No** if there is no evidence of what information was transferred to the receiving service or patient/care/significant other on discharge. Mark **N/A** if the patient has not been discharged or transferred to another service.

8.0 Revision & Audit:

This procedure will be reviewed every 2 years.

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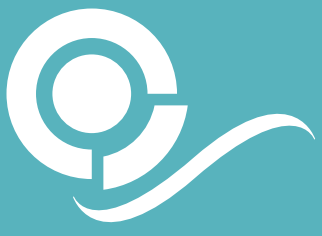
Appendices



NURSING & MIDWIFERY
QUALITY
CARE-METRICS

Appendix One
Signature Sheet

Name of Procedure: .....

I have read, understand & agree to adhere to the attached PPPG

Print Name	Signature	Area of Work	Date

Appendix Two
Contact Details for the National Lead and Project Officers: Nursing and Midwifery Quality Care-Metrics

	Name	Email Address	Land Line	Mobile
National Lead:	**Anne Gallen** *Director of the Nursing & Midwifery Planning and Development, HSE North West*	anne.gallen@hse.ie	071 982 2106	087 222 1682

NMPD Project Officers for Nursing and Midwifery Quality Care-Metrics

Project Officers	Name	Email Address	Land Line	Mobile
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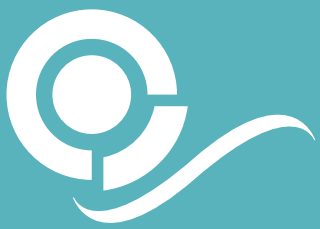
HSE South East	*Leonie Finnegan*	leonie.finnegan@hse.ie	056 778 5620	087 682 9423
HSE North East	*Margaret Nadin*	margaret.nadin@hse.ie	041 987 5281	087 956 8274
HSE Midlands	*Mary Nolan*	mary.nolan13@hse.ie	057 935 7865	086 791 8101
HSE West/MidWest	*Gillian Conway*	gillian.conway@hse.ie	065 686 3225	087 202 3377
HSE North West	*Paula Kavanagh*	paula.kavanagh@hse.ie	071 982 2106	087 909 0478
HSE Dublin South, Kildare & Wicklow	*Ciara White*	ciara.white1@hse.ie	01 620 1737	087 645 8059
HSE Dublin North	*Martina Giltenane*	martina.giltenane@hse.ie	01 890 8703	087 640 0454



NURSING & MIDWIFERY QUALITY CARE-METRICS

APRIL 2016

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

Health Service Executive
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