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Nursing & Midwifery Planning & Development
Office of the Nursing Services Director
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Balheary Road
Swords
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2014
Foreword

I am pleased to present the findings of this Evaluation Report of the development and implementation of Nursing and Midwifery metrics in healthcare services in the Dublin North HSE region.

The central driver for initiating the development and implementation of Nursing and Midwifery metrics is to generate real time data to monitor Nursing and Midwifery care and promote a culture of quality and patient safety. This evaluation provides evidence on how the system of metrics and the associated software system provide an appropriate methodology of monitoring compliance with legislative and professional standards and quality indicators. It also assists in creating an open, transparent and learning culture where accountability is an integral component of service delivery within participating services. The evaluation highlights the potential for metrics to assist in the development of strategic leadership capabilities within nursing management along with the establishment of a common language for professionals to articulate the standard of care at every level in the organisation.

I wish to thank the Directors of Nursing and Midwifery who worked in collaboration with the Nursing and Midwifery Planning and Development unit in developing and implementing this initiative. Their leadership and dedication to this process provides Nursing and Midwifery managers with a recognised connection and firsthand knowledge of the quality of care at the front line. The participating Directors of Nursing and Midwifery in this Foreword also share their experience of implementing metrics within their respective organisations.

I wish to acknowledge the staff from all participating services that supported the implementation of metrics and contributed to the focus groups. I am particularly indebted to the Project Officers - Ms Caroline Kavanagh and Ms Dolores Dempsey Ryan for their professionalism and commitment to this project, their contribution has in no same way contributed to its success.

Eithne Cussack
Director of Nursing & Midwifery Planning & Development
HSE Dublin North
Directors of Nursing & Midwifery Forewords

Ms. Margaret Philbin  
Director of Midwifery and Nursing, The Rotunda Hospital

The value of the work of Midwives and Nurses is very difficult to define yet these professionals provide the most consistent frontline care in the Health Service. The continuous drive for the provision of quality assurance care means that we need to be able to prove that the care given meets National and professional standards, while simultaneously assuring the public that they are in receipt of a quality service. The introduction of Midwifery and Nursing metrics has greatly assisted in providing the data that Directors of Midwifery and Nursing and hospitals require to validate the quality of the work that is undertaken each day in healthcare organisations as this tool measures work against an agreed standard. The information I have received since the introduction of Midwifery and Nursing metrics in the Rotunda Hospital ensures that I can now quantify the extent of compliance of care delivered within our service with these standards and practice guidelines. The ward managers and I can also quickly identify what further work needs to be done to support staff in meeting the desired standard. It also means that data is available for Midwives and Nurses at unit and hospital level. From a corporate perspective the measurement of Midwifery and Nursing metrics provides me with valuable information to bring to the Board of Governors that demonstrate the quality of care provided to women that receive our services. Overall the introduction of metrics has been a very positive experience for the hospital and staff and most importantly has contributed to better care for women.

Mr. Sean Tone  
Area Director of Nursing, Dublin North City Mental Health Service

As Area Director of Nursing I am committed to continuous improvement in the quality, effectiveness, safety and variety of evidence based approaches of nursing care offered and delivered. Historically in our service, nurses were involved in regular clinical audits that were often too detailed, cumbersome and required manual inputting and analysing of data that were not always user friendly and manageable. The challenge for us in nursing was to produce reliable consistent data that reflected the quality of nursing care, in a structured, formal and reliable way. Nursing and midwifery metrics for us has ticked all the boxes. The central driver for nursing and midwifery metrics is to promote a culture of safety and ensure quality of care is standardised and measured. The metrics in mental health, as in all disciplines have been generated in line with evidence based practice, current legislation, national and international standards and in line with local Policy Procedures, Protocols and Guidelines.

Equally important in this climate of cutbacks, budget restraints and high profile reports identifying poor quality nursing care is that we have system that not only gives us early indications of poor or unsafe practice but that we acknowledge record and celebrate areas of excellence and high standards of care. The implementation of nursing and midwifery metrics in Dublin North City Mental Health Services (DNCMHS) has given a sense of ownership and pride in achieving high scores and likewise a sense of urgency to take action when scores are low. Implementing metrics has supported embedding evidence based practice into front line nursing services, thus ensuring standards are met and clinical governance infrastructures are in place. It is our intention to implement nursing and midwifery metrics service wide in 2014.
Ms. Cathy Hennebry  
Director of Nursing, St. Pauls Special School and Hospital

In the absence of an agreed standard to benchmark documented person centred plans and medication administration and storage, metrics data proved to be an effective means to establish a baseline and thereafter to monitor progress in terms of quality improvement in these areas. Visual display of the measurement findings on a monthly basis helped drive continuous quality improvement. The metrics has helped services to prepare to meet statutory (Health Act 2007) and regulatory requirements (HIQA) whilst at the same time highlighting deficits in need of focused attention. One such example is the whole area of child and family advocacy.

Measurement of data and the associated findings brought with it the need for a systematic approach in communicating the findings to staff at all levels within the organisation. The electronic Traffic Light system, with associated percentage, was beneficial in identifying performance levels at a glance and aided presentation and feedback to both staff and members of the board of management. To date the metrics has informed our Person Centred Planning Working Group, the Rights Committee, and the development of relevant policies and procedures.

Overall the experience of nursing and midwifery metrics has proved a positive experience as it brought focus to performance, standard measurement, quality and staff development.

Ms. Suzanne Dempsey  
Director of Nursing, Children’s University Hospital, Temple Street

As a Director of Nursing with overall accountability for the quality and standard of nursing care delivered to our children and their parents in Temple Street Children’s University Hospital, I have found the nursing and midwifery metrics to be an invaluable tool to support decision making, service planning and to influence the corporate agenda. I present the data quarterly at the Board of Management meetings assuring them that quality of the nursing care provided is of the highest possible standard.

The data is interrogated for common themes and trends. The results are discussed by the Nursing Executive team as part of our performance and quality dashboard weekly and also at our Clinical Nurse Managers’ meetings to ensure there is ownership and sustainability of the initiative across the organisation. It has highlighted areas where we needed to provide coaching and enhanced support to a clinical nurse manager who was finding their leadership role challenging.

Ultimately, it motivates us as senior nurse managers to strive to improve our targets for improved patient outcomes and experiences.
Ms. Mary Flanagan  
Director of Nursing, Older Person’s Services  

Nursing and midwifery metrics which originally started as a pilot has now been extended to all areas within the older person’s services. Initially, there was feeling of fear and trepidation as can be expected with any new project. However, nursing and midwifery metrics has now become incorporated into practice which is a true indicator of how the quality improvement cycle works. It is a ‘snapshot’ of how the unit/service is functioning on a monthly basis for example in medication management, falls, nursing documentation and tissue viability. It provides a benchmark to work towards and identifies areas of good practice and areas for improvement. Due to the implementation of the metrics the organisation has adapted documentation to ensure that certain criteria are included in order to reach higher results. In addition, the traffic light system is very user friendly and clearly shows how results vary from one month to the next. The clinical nurse managers currently complete the metrics and naturally want to see their units doing well. Furthermore, they are ideally placed to make the necessary changes and communicate with the team on their progress. Senior management discuss the results at managers meeting and offer ongoing support.  
The introduction of the metrics was supported by our Practice Development Coordinators. With their support and that of the NMPDU nursing and midwifery metrics has been a success.

Ms. Sheila Mc Guinness  
Director of Nursing, Beaumont Hospital  

Metrics is one piece of the quality jigsaw. It fits in with other current initiatives such releasing time to care- Productive ward project and the wider corporate quality improvement agenda. From the time we started capturing data in the hospital, there is evidence of month on month improvement on metrics scores. The key to its success lays with the Clinical Nurse Managers and the ward teams. They have engaged positively with the metrics project and have used the data provided to drive and sustain significant improvements. The project leads and the wider nursing team have supported and enabled this process. The provision of the ‘TestYourCare’ system which provides access to real time data and reports and IT devices to support auditing, supported by the NMPDU have been crucial to successful implementation. The metrics journey is only starting. There is still a significant body of work which will include sustaining the improvements already achieved, generating and developing metrics for specialised areas of care and expanding the suite of measurements.
Sr. Marian Harte  
Director of Nursing, Daughters of Charity, Navan Road  

We are acutely aware there is a great demand for evidence from nurses to show the standard of care and intervention we provide for users of our services. Using metrics in an Intellectual Disability service is a good way of being able to identify the standard of nursing contribution to the client and also to see if the processes for clients have been improved. Nursing and midwifery metrics has been a positive experience for us here in St Vincent’s Centre Navan Road. Yes it was a slow start but as staff became more confident they saw the benefits of the metrics, which are in line with the HIQA national standards and HSE policies which strive for high quality safe and effective care. Metrics has also been a good process for identifying areas needing improvement and also highlighting areas where we perform well so it covers both. Metrics has also focused the unit/ward Managers on displaying evidence of how the unit/ward performed that month. There is great scope within metrics as they are a very useful tool going forward and can be used for benchmarking within various parts of the Service, thus ensuring that elements of good practice and improvements can be shared for in the overall service.

Ms. Mairead Lyons  
Director of Nursing, Connolly Hospital, Blanchardstown  

Connolly Hospital, Blanchardstown is pleased to have been involved in the development, generation and implementation of a nursing and midwifery metrics system in HSE Dublin North services. Nursing and midwifery metrics provide us with a system for generation of evidence of the quality and safety of care being delivered within our service. Patients and the public expect a high standard of quality and safe nursing care. It has generated valuable information and learning has been achieved from introducing metrics. This system has informed and strengthened clinical governance within Connolly Hospital.

I wish to acknowledge the ward managers who are critical to introducing, leading and sustaining this quality initiative at unit level. I would also like to pay tribute to all our nursing staff that participated and contributed to the development and generation of nursing and midwifery metrics and this evaluation. I would like to thank the Nursing and Midwifery Planning and Development Dublin North for their leadership, expertise and knowledge in the implementation of a nursing and midwifery metrics system in our healthcare services.
Mr. Declan Lavery  
Director of Nursing, St. Vincent’s Hospital, Fairview

We in the mental health services, St Louise’s Ward, St Vincent’s hospital, Fairview and St Aloysius Ward, Mater M University Hospital started metrics in November 2012, initially focusing on seven areas of care. Following consultation with staff and managers some minor changes had to be made. It is still going strong 15 months later. Feedback from staff indicates that metrics is the way forward. Staff have embraced and engaged with metrics framework. It provides a clear framework for the day-to-day work nurses are doing; it provides indicators for care and measures quality. In our service it has established good processes and contributed to improved outcomes for service users. The results indicate that a high standard of care is being provided. The data is very valuable for managers to highlight how well the unit/ward/organisation is performing. Metrics data are evidence for governance bodies as they are based on Quality Standards, Mental Health policy and legislation.

Ms. Kathy O’ Sullivan  
Director of Nursing, National Orthopaedic Hospital, Cappagh

Having been introduced to ‘Metrics’ by Mandie Sunderland, Chief Nurse at the Heart of England Trust I could immediately see the potential for nursing and midwifery metrics in Cappagh National Orthopaedic Hospital. We was one of the first initial hospitals involved in the Metrics initiative with the NMPD in HSE Dublin North. From the beginning there has been involvement and a very positive response from nursing staff. The consistency of monthly results confirms the accuracy of the audit tool, as well as displaying care that is well delivered and areas for improvement. Action plans are put in place by the Ward Managers in association with the Director of Nursing to address these. The combined percentage and traffic light system for displaying the instant audit results on a dashboard is universally recognised by all levels of staff. It is now possible to present a ratified audit of nursing care to the Board of Directors, Executive Committee and Patient Care Committee in the Hospital. The benefits that we hope to achieve as a result of introducing the nursing and midwifery metrics is; improved patient care, ownership of issues within nursing, accountability at individual and ward/unit level, resilience to external scrutiny, improved governance & management of risk.

Cappagh is an independently accredited hospital and the nursing and midwifery metrics audit results will be a demonstrative measure of nursing care for our next re-accreditation process.
Nurses need to believe in their own practice, they also need to know that they are delivering care competently in a way that matters most to those they care for. The implementation of nursing and midwifery metrics in North Dublin Mental Health Service has provided a road map to measure what nurses do in terms of both patient experience and outcome. It has raised mental health nurses visibility and shows nursing contribution in a more tangible way. It is definitely a step in the right direction and measures the work we do in a more positive way. It has helped us identify good practice that others can learn from and highlight areas for improvement. It has also has an influence on our compliance with the Mental Health Commission and has helped us meet the statutory requirements under the Mental Health Act 2001. It has helped us deliver high quality care and measure its impact on patient’s experience against real patient feedback. It focuses on clinical skills and patient safety is paramount. Nurses in the pilot sites have taken a leadership role in ensuring the fundamentals of care are person-centred and supports learning in practice. With the ongoing support of the practice development department and the NMPDU nursing and midwifery metrics have the potential to support and improve nursing in all areas of care delivered in the North Dublin Mental Health Service and can make a positive difference to our patients.

Like recovery nursing and midwifery metrics provides a vision of where you want to be and helps you find ways of getting there.
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List of Abbreviations

ABA   An Bord Altranais
BSC   Balance Score Card.
CEO   Chief Executive Officer.
DoH   Department of Health
HCAI  Healthcare Associated Infection
HEFT  Heart of England Foundation Trust
HIQA  Health Information and Quality Authority
HSE   Health Service Executive
MDT   Multi-Disciplinary Team
MHC   Mental Health Commission
NDNQI National Data base of Nursing Quality Indicators
NEWS  National Early Warning Score
NHS   National Health Service
NMBI  Nursing & Midwifery Board of Ireland
NMPD  Nursing & Midwifery Planning and Development
ONMSD Office of the Nursing and Midwifery Services Directorate
RCSI  Royal College of Surgeons in Ireland
SOP   Standardised Operating Procedures
UK    United Kingdom
**Glossary of Key Terms**

**Clinical governance** is described as the system through which healthcare teams are accountable for the quality, safety and satisfaction of patients in the care they have delivered (HSE 2011).

**Indicators** are measurement tools, screens, or flags that are used as guides to monitor, evaluate, and improve the quality of patient care, clinical support services, and organisational function that affect patient outcomes (Mainz 2003).

**Metrics** are agreed standards of measurement for nursing and midwifery care where care can be monitored against agreed standards or benchmarks (Foulkes 2011).

**Nursing-sensitive indicators** identify structures of care and care processes, both of which in turn influence care outcomes. Nursing-sensitive indicators are distinct and specific to nursing, and differ from medical indicators of care quality (Montalvo 2007).

**Quality of care** can be defined as ‘the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge (Donabedian 1987).
Chapter 1: Introduction & Context

1.1 Introduction and Context

In an era of global economic austerity, Ireland like many European countries is reconstructing its healthcare system in order to improve efficiencies, implement cost cutting initiatives and to meet political and budgetary targets. Economic constraint has placed a significant strain on the Irish healthcare system at every level. Employees are expected to do more with the same or less resources (Ohman 2000) and the consequences of this is shown in the England’s Francis Report (2013), which discusses how nurses were criticised for failing to prevent poor care after nurse staffing was reduced to meet financial targets. According to Aiken et al (2014) nursing is a so-called soft target because savings can be made quickly by reduction of nurse staffing whereas savings through improved efficiency are more difficult to achieve. The challenge for healthcare professionals is to ensure that patient safety and the quality of care delivered is not compromised as a result of cutbacks in resources to the healthcare system. Carney (2010) states that the current cost containment together with reduced recruitment places increased pressure on healthcare providers which will result in adverse effects on patient care. Aiken et al’s (2014) study indicates that increasing a nurse’s workload by one patient increased the likelihood of inpatient hospital deaths. The nursing profession like other professions in healthcare is vulnerable as a result of cost reducing efforts; both in the area of staffing levels and skill mix.

In the United Kingdom (UK), the Mid-Stafford Trust (Francis) enquiry National Health Service (NHS) (2009) describes how an NHS Trust galvanized into radical action to meet financial targets and compromised good quality care. Similarly an independent report by Berwick (2013) into patient safety in the NHS highlights that quantitative targets and financial goals should not override protection of patients from harm. Berwick (2013) suggests that where scarcity of resources threatens to compromise patient safety, healthcare staff should raise concerns to their colleagues and superiors and be welcomed in so doing.

A number of Irish healthcare investigations have identified risks to patient safety and evidence of poor quality care provision including; the HSE report on the Midland Regional Hospital, Portlaoise Perinatal Deaths (2014), the published HIQA report identifying failures in the provision of the most basic elements of care provided by the HSE and University Hospital Galway to Savita Halappanavar (2013a), the Tallaght Hospital Investigation conducted by HIQA (2012a) into the quality, safety and governance of care provided to patients attending the emergency department, the HIQA (2009a) investigation into the arrangements for providing services at the Mid-Western Regional Hospital Ennis and the Lourdes Hospital Inquiry (2006). These reports all highlight how poor care and poor organisational performance impacts on patient safety.

In Ireland a wide range of initiatives are underway at national level to progress the patient safety agenda. The Health Information and Quality Authority (HIQA) were established to drive continuous improvement in Ireland’s health and social care services and The Mental Health Commission (MHC) were established to strengthen and reform regulatory frameworks for providers and professionals and to foster the establishment and maintenance of high standards in the delivery of healthcare services within the Health Service Executive (HSE). The National Clinical Care Programmes (2010) and the Quality and Patient Safety Directorate (2012) were established by the HSE to drive and monitor patient services and care delivered.

The need for greater reliability and less variation in the quality and standards of healthcare has been readily accepted and documented (Lakeman 2008; Care Quality Commission 2010; Derry 2010; HIQA 2012b), Regulatory bodies such as the Nursing and Midwifery Board of Ireland (NMBI), the MHC and HIQA highlight...
the requirement for healthcare organisations to monitor care provision against agreed national standards of care. The Healthcare Standards (MHC 2007; HIQA 2012b) clearly outline what is expected of a health service provider and what standard of care an individual, their family, carers, or the public can expect to receive within the Irish health care setting. In Ireland evidenced based systems that utilize quality and safety care indicators as measures of effectiveness have been introduced in recent years (HIQA 2012b). The National Service Plan (2014) advocates the development and use of a comprehensive set of quality and safety indicators to measure the quality and safety of Ireland’s healthcare service.

The Nursing and Midwifery profession made a decision to develop and implement a system of metrics. The central drivers for which is to have real time data to monitor nursing and midwifery care; to promote a culture of patient safety and to ensure quality of care is not compromised as a result of economic and resource restrictions. Measuring quality of care is central to providing a healthcare system that is open, transparent and accountable and one which is focused on organisational improvement and learning. Nurses and midwives need to advance the way they use measurement for optimum effect. Health care professionals/nurses and midwives are challenged to produce reliable consistent real time data which provides information on both the quality of care provided at frontline level and on how agreed variables can be measured for impact on care.

The Nursing and Midwifery Planning and Development (NMPD) in HSE Dublin North implemented a quality initiative ‘Nursing and Midwifery Metrics’ in twelve healthcare services within its region. The aim of the initiative was to measure the quality of fundamental nursing care against national standards, as set out by Irish regulatory bodies in both healthcare and the nursing and midwifery professions. Core standardised metrics were generated by nursing and midwifery clinical experts from participating services (Figure 1). Twelve healthcare services participated in this initiative in the Dublin North HSE area (Figure 2). Metrics on patient experience were also generated and measured in a number of healthcare organisations; this included seeking patient’s views on the services received and their experience of care delivered. The Metric care indicators hereafter called ‘Metrics’ are defined as ‘agreed standards of measurement for nursing and midwifery care where care can be monitored against agreed standards or benchmarks’ (Foulkes 2011).

**Figure 1: List of Metric Care Indicators Developed and Implemented in Healthcare Services in Dublin North (September 2012 – August 2013)**

1. Medication Storage & Custody
2. Medication Administration
3. Patient Observations (NEWS)
4. Falls
5. Pressure Ulcer
6. Nursing Documentation
7. Provision of Information
8. Personal Plan
9. Patient Experience
Figure 2: List of Organisations that Participated in Nursing and Midwifery Metrics

The healthcare services involved in this initiative included:

- 3 Acute Hospitals,
- 3 Mental Health Services,
- 1 Maternity Hospital,
- 1 Children’s Hospital,
- 2 Intellectual Disability Services and
- 2 Care of the Older Person’s Services.

At the outset, the NMPD Nursing and Midwifery metrics initiative involved liaison with the Heart of England Foundation Trust (HEFT) to view their metric system and contract the software system that HEFT had developed to support their pioneering work called TestYourCare.

1.2 TestYourCare IT System

The Information Technology (IT) system used to support the NMPD nursing and midwifery metrics TestYourCare was sourced from the Heart of England Foundation Trust (HEFT) in the UK and the software package was used to analyse and report on nursing and midwifery metrics throughout the pilot project. The software used is a web based system designed to collect data and create immediate reports. The software provides reports individualised to each ward or location, indicating targets achieved using a traffic light and a percentage system. The traffic light system enables healthcare staff identify when the quality of care being delivered has fallen below the required standard of care through a visual colour coded traffic light effect. Real time data is available following a metrics audit and feedback is immediately available to the Clinical Nurse/Midwife Manager through printing out of results. Real time data shows how a ward/unit is performing and identifies possible areas for improvement. Metric results are presented using a coloured dashboard with arrows showing status and trend information for performance measures. Red indicates area for improvement, amber indicates moderate performance and green indicates meeting performance standards (Higgins et al 2008). Data results are reported to the Director of Nursing and Midwifery and Assistant Director of Nursing and Midwifery for information on how wards are performing at nursing/midwifery governance meetings. Visually discerning and rich graphical dashboards can dramatically accelerate the speed and quality of the decision making cycle (Nelson 2010). The purpose of dashboards is to reduce time reviewing content, increase time for informed and appropriate action and to provide real time data measures of nursing quality (Royal College of Nursing 2011). Figure 3 shows an example of metrics and the corresponding dashboard used to communicate metrics results at both ward/unit level and management level using the traffic light system.

Figure 3: TestYourCare IT system

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1.3 Project Aims
The aim of the evaluation of the development and implementation of a Nursing and Midwifery metrics system in HSE Dublin North healthcare services is:

• To evaluate if the nursing and midwifery metrics system provides an appropriate reporting mechanism for the quality and standard of care being delivered at ward/unit level at a point in time using the metric care indicators listed in Figure 1 and
• To evaluate if the IT TestYourCare system is fit for this purpose.

1.4 Project Objectives
The objectives of the evaluation of the development and implementation of a Nursing and Midwifery metrics system in HSE Dublin North healthcare services is:

• To evaluate the process used to identify and generate core areas of fundamental nursing and midwifery care for measurement i.e. metric care indicators
• To produce a quantitative and qualitative evaluation report outlining the contribution of nursing and midwifery metrics to the standard and quality of care being delivered at frontline service.
• To evaluate if the IT TestYourCare system is fit for purpose
• To make recommendations as appropriate for the implementation of metrics at local and national level

1.5 Publication Format
This evaluation of the development and implementation of a Nursing and Midwifery metrics system in HSE Dublin North Healthcare services report is published in the following format:

Chapter 1: Introduction and Context
Chapter 2: Summary of Key Findings
Chapter 3: Recommendations and Conclusion
Chapter 4: Literature review
Chapter 5: Methodology
Chapter 6: The Change Process
Chapter 7: Findings from Focus Groups
References
Chapter 2: Summary of Key Findings

2.1: Key Findings of the Evaluation of the Development and Implementation of a Nursing and Midwifery Metrics System in HSE Dublin North Healthcare services

The following is a summary of the keys findings which emerged from the focus groups undertaken with key stakeholders involved in developing and implementing nursing and midwifery metrics in a variety of healthcare services within HSE Dublin North Region. The findings are organised and categorized under the following six themes:

1. Governance & Leadership
2. Communication
3. Quality & Standards
4. Engagement
5. Outcomes
6. Usage of the metrics system

2.1.1: Theme 1: Governance & Leadership

Effective leadership and robust governance systems emerged as critical in delivering high quality care, ensuring patient safety and facilitating positive staff development. Leadership along with the requirement for quantitative measurements is necessary in order for Directors of Nursing and Midwifery to demonstrate and articulate the standard of quality care at ward/hospital level at corporate board meetings. This theme emanated from the Director of Nursing/Senior Nursing focus group and the following are the key findings from this group under this theme:

- A number of the participants in the focus groups highlighted the importance of communicating ward metric results to the ‘Board of Management’ within their respective organisations. Some of the focus group participants identified how they utilised metrics to provide evidence of the quality of frontline care to hospital corporate management.
- Participants outlined how metrics provided ‘a language to talk about nursing care at corporate level and assisted in the development of the strategic leadership capabilities of Directors of Nursing’.
- Metrics was also seen as a vehicle to allow Directors of Nursing and Midwifery to refocus on nursing as their primary concern, in addition to their other managerial responsibilities.
- One participant described how previously ‘we reacted to incidents as they occurred’ but ‘metrics helped to improve the system so that incidents didn’t occur’.
- Another participant described how access to metrics alerted her to at an early stage when ‘care is dipping’ which enabled a more proactive response.
- A participant identified that the issues highlighted as needing attention as a result of nursing and midwifery metrics were often related to and highlighted systematic issues which needed corporate review and decisions.
Another outlined how they had used the nursing and midwifery metrics system to inform discussions about a range of strategic issues such as quality and patient safety, finance, human resources, risk management and national services plans.

Some of the participants outlined how nursing and midwifery metrics had been used to inform the corporate team both formally and informally about care, performance and to ‘see at a glance where improvements have been made’.

Another participant outlined ‘that quality of patient care’ was seen to be within the remit of the Director of Nursing and Midwifery only and not corporate managers.

It was highlighted that the introduction of nursing and midwifery metrics was still at an early stage in some organisations and that there was ‘not enough to report on to influence the executive team’. However, participants indicated that the ‘executive team’ were ‘happy’ with metrics being introduced and were ‘looking forward to [receiving] quarterly reports’.

Overwhelmingly, participants welcomed nursing and midwifery metrics and felt that metrics had made a significant contribution to gaining greater insight into quality of care and a catalyst to encourage staff engagement. In some organisations nursing and midwifery metrics were already contributing to improving the quality of care. Access to metric data and the use of a ‘standardised’ and ‘consistent’ approach provided transparent information to identify issues of concern and to prompt changes to existing practice.

Examples of this included greater service user involvement in mental health services. ‘Service users are now using language such as ‘care plans’ and ‘recovery’, metrics is promoting greater and more meaningful family involvement’.

Some of the participants outlined that one of the challenges of using nursing and midwifery metrics at executive level was that they ‘… can be seen as very narrow in an MDT environment’. Participants suggested that consideration should be given to changing the name to ‘Quality Assurance Metrics’ as a means of gaining the attention of the corporate team. They felt that that metrics were not a ‘nursing’ measure but more a ‘patient care’ measure. It was argued that this change in language would be more influential at corporate level and that it was important to ‘find the right language to talk about patients at the corporate table’.

In contrast a number of participants had not had the opportunity to make use of nursing and midwifery metrics at executive level. The reason given was that some organisations are at an earlier stage of implementation and require more time to integrate metrics and to be confident that they provide valid and reliable data.

Some focus groups indicated that the standardisation of metrics, sharing information and learning from other organisations was a positive feature of the metrics initiative.

Nursing and midwifery metrics were identified as contributing to professional development by ensuring professional standards and policies were implemented. Furthermore nursing and midwifery metrics were found to facilitate discussions about quality of care at all levels. The metric results acted as a motivator for staff by encouraging them participate in meetings to discuss and examine nursing and midwifery metrics data.

Analysing, interpreting and managing the metrics results enabled services to review their management structures to enable the establishment of more appropriate and accountable models of divisional management and leadership within Nursing and Midwifery.
2.1.2: Theme 2: Communication

Communication was a constant theme in all focus groups and in this context includes use of information, feedback, transparency and accessibility of results. The theme relates to communication within all levels of the organisation; from staff nurse/midwife to Director of Nursing and Midwifery and CEO and communication externally with other healthcare services, professional and regulatory bodies, HSE corporate and DoH.

- Common to all of the groups was the recognition of the importance of communication as an integral part of the nursing and midwifery metrics process. This involved a systemic approach: communicating the nursing and midwifery metrics approach and the results throughout the entire organisation from clinical staff at ward level to senior organisational managers, Directors of Nursing and Midwifery and CEO and General Manager.

- Some of the respondents highlighted the strengths of nursing and midwifery metrics as ‘a fast continuous flow of quick, easily understood information into the DoN and this brings the DoN down to ward level immediately and brings patient care into the board room’.

- Transparency and accessibility of the ‘metric report’ to staff was seen as fundamental to make a meaningful difference. ‘Information goes on the board for all staff to see’. The majority of participants described how they had ‘debated at the beginning if they should publicise results’ but after presenting the results at a team meeting ‘everyone got behind metrics and it brought the team together’. It also created a context that they described as one that ‘challenged us as nurses to lay ourselves bare’.

- Openness ‘allows everyone in the organisation to see if we are up or down’ in our metric scores. Some participants outlined how the Assistant Director of Nursing had actively shared nursing and midwifery metrics with other clinical areas to help raise awareness and show case the work that had been undertaken.

- Information about nursing and midwifery metrics and results using the traffic light system were most often displayed on a notice-board in the ward or unit office. More detailed information was provided in separate folders and specific information recorded using other methods, such as the ‘communication book’. Verbal feedback was provided to staff, generally by the clinical nurse /midwife manager during report, to small groups and on a one-to-one basis.

- Some of the participants described how the focus of the metrics meetings was to ‘talk about areas for improvement’ and how the ‘face-to-face feedback had been beneficial’. Participants found that ‘general feedback was not getting through’ but feedback provided on a one-to-one basis or with small groups of 2-3 nurses was a more effective approach. The approach adopted was usually informal and was described by one group as ‘when doing metrics we stop and chat with staff’ about metric scores. This was seen to provide an opportunity to work with staff in developing and communicating action plans. Other participant’s contrasted this approach with the previous audit system where results were ‘never fed back on time’.

- The nursing and midwifery metrics results were communicated to organisational committees with clinical oversight and to strategic level management committees. Some participants described how they made information available to the drugs and therapeutics committee, quality and safety, tissue viability, and the falls prevention committee. The majority of participants indicated that this level of communication was important due to the multi-disciplinary nature of the committees and that it also provided an opportunity for ‘everyone to hear what is going on’.
2.1.3: Theme 3: Quality & Standards

This theme relates to the potential of nursing and midwifery metrics to provide assurance of the quality and standards of care within organisations. A clear connection was made between nursing and midwifery metrics and their role in assisting services to meet statutory and regulatory requirements for quality and standards. Metrics were viewed as a useful approach for demonstrating compliance with national standards and quality indicators such as HIQA, HSE KPIs, Mental Health Commission, Early Warning Scores and NMBI’s standards and guidelines.

- Nursing and midwifery metrics were identified as being ‘hugely empowering and enabling regarding bringing quality onto the agenda’.
- The majority of the focus group participants stated that one of the key contributions that metrics had made is the ability to identify if they are ‘doing well or not’, ‘where we [they] are at, at this moment in time’ and to highlight ‘good and poor practice’.
- One of the participants highlighted that ‘when HIQA came for an announced inspection they commented on the ward that had their ‘know how you are doing boards’ in place, with metric results clearly displayed. They noted that nurses on the wards had a real awareness of implementing standards and had quality improvement plans in place and felt the displaying of these results was really positive’.
- Furthermore nursing and midwifery metrics were described as a ‘great quality tool’ that can be ‘linked to other measures’.
- The standardised approach to generating the metrics enabled healthcare services to compare findings with other hospitals, ‘we now know that what we are measuring is now being measured in all other hospitals in North Dublin Region’.
- The majority of participants highlighted the benefit of organisations coming together as regional groups in generating the care indicators. They identified the ‘sharing of information, using common language and exploring other services work practices’ as a success factor for the initiative.
- Some participants highlighted that nursing and midwifery metrics are measuring national, evidenced based standards of care across a number of healthcare services and this ‘reduces variations in practice and ensures that we are all measuring the same thing’.
- Nursing and midwifery metrics were identified as a ‘good tool to measure practice’ and could ‘help the team in achieving compliance with [HIQA] standards’. Some of the respondents indicated that staff were eager to use the metrics to demonstrate to HIQA ‘where they are doing well, like action plans’ they also indicated that HIQA ‘have asked for metric results’.
- Other participants had provided the metric results as evidence of quality of care to the Mental Health Commission. They have also linked nursing and midwifery metrics to the HSE KPI’s used to measure organisational performance.
• When comparing KPI’s with nursing and midwifery metrics, most of the respondents favoured metrics as they ‘could influence the metric result and were in control of changes to improve practice’.

2.1.4: Theme 4: Engagement

The engagement theme reflects an overall positive experience of focus group participants involved in metrics, one of the largest sub sections related to accountability, ownership and control. Nursing and midwifery staff involvement in generating metrics was considered fundamental to its sustainability and success.

• The large majority of participants highlighted staff involvement in nursing and midwifery metrics as fundamental to its sustainability and success.

• The contribution of clinical experts to the generation and development of the specific metric care indicators was critical to the success of the initiative; their contribution provided staff with ‘ownership’ of the project and supported ‘buy in and commitment’ from key stakeholders and leaders within organisations.

• Engagement with metrics spanned all key stakeholders from Director’s of Nursing and Midwifery providing strategic leadership to senior nurse/midwife managers, clinical nurse/midwife managers, clinical nurse/midwife specialist and staff nurses/midwives.

• ‘Reflection of practice’ was highlighted by the majority of participants as a positive element of nursing and midwifery metrics and this process facilitated ‘protective time’ for senior nurse/midwife managers and clinical nurse/midwife managers. The protected time enabled senior staff and nurse/midwife managers to ‘sit down together and develop action plans when we scored red’ thus increasing the standards of care and focusing on improving practice.

• Participants highlighted how frontline staff are now involved in checking each other’s work to find out ‘why metric results are down’ and this encouraged staff to ‘develop a strength and desire to improve practice within the team’. Nursing and midwifery metrics facilitated a culture where greater awareness for improvement of practice was achieved.

• The majority of the participants identified ‘where we are going wrong and where we can improve’ as a crucial element in nursing and midwifery metrics and this facilitated and challenged staff to look at their own practices and identify areas that required improvement.

• Service user involvement in nursing metrics was identified by those working within mental health services as a critical factor to its success in practice. ‘Listening to the views of the service users through the patient experience metric enables the voice of the service user to be heard at all levels’.

• Nursing and midwifery metrics was seen as a catalyst that enabled nurses and midwives to discuss issues such as documentation and this facilitated a change in behaviour and ‘improved aspects of documentation such as care planning and evaluating practice’.

• The term ‘Buy-in’ was used by a large number of the participants and related to the importance of gaining support from ward staff and from other key stakeholders such as the nursing and midwifery practice development department.
• The participants believed that it was important that a non-punitive approach to analysis and interpretation of metrics results was adopted at service level. It is important from the participant’s responses that nursing and midwifery metrics were not seen as ‘a tool to beat staff with’ but ‘a tool to educate and find areas for improvement’. This was considered fundamental to creating an environment of trust, transparency and ‘buy-in’.

• Staff communication and education were identified as approaches to enhance the potential for nursing and midwifery metrics within services. The majority of participants stated that one-to-one meetings with staff were very beneficial in building support within the team.

• Some of the participants described how nursing and midwifery metrics led to enhancing student learning in the clinical area.

• The issue of access to metrics reports was seen as a motivating factor by a majority of the participants stating that ‘access to the results was considered an important aspect of nursing staff engagement with nursing and midwifery metrics’.

• Creating a culture of openness, transparency and ownership was identified by some of the participants as important factors in overcoming resistance towards metrics. By linking the metrics back to what they called ‘making our service the best we can’, staff were said to appreciate the link made to HIQA/MHC standards and they felt good about ‘what they were doing well’. The ‘showing’ and ‘seeing’ what was being ‘done well’ was echoed by other participants.

• Participants throughout the focus group interviews indicated that involvement in nursing and midwifery metrics was linked to accountability for care at all levels of the organisation including the need for results to be discussed by the nursing/midwifery executive and the hospital CEO.

2.1.5: Theme 5: Outcomes

Nursing and midwifery metrics were seen to assist in the development of strategic leadership capabilities within nursing. A nursing and midwifery metrics system contributes towards transparency, professional responsibility and accountability for practice in healthcare services. It is a stimulus for the review of clinical practice, including care planning, a review of risk assessments and providing the service user and families with information regarding care and treatment. Key elements reviewed included clinical recording and documentation. It also identified areas for staff development and improvement, including performance and continuous professional development needs.

• Respondents used nursing and midwifery metrics to inform discussions about a range of strategic issues such as quality and patient safety, finance, human resources, risk management and national services plans.

• Metrics initiated changes in the process of care which transferred into changes in behaviour and approach to care. Examples provided included changes in how consent was obtained, the role of advocacy and the identification and honouring of the ‘rights of service users’.

• A common thread throughout the outcome theme was the contribution that nursing and midwifery metric makes to identify areas for quality improvement and continuous professional development.
• The most evident outcome of the introduction of nursing and midwifery metrics appeared to be related to nursing and midwifery documentation and records. The metrics results highlighted a number of areas where care was not recorded or where the record was inconsistent with the requirements of the metric standard. Metrics were seen as a stimulus for reviewing and updating documentation. An example of the type of comments recorded included nursing and midwifery metrics ‘highlighted areas in documentation we need to improve’ and that it provided ‘opportunity to look at documentation and care planning and improve how we documented care.’

• Metrics were also seen as a mechanism for providing feedback to staff on ‘good performance and poor performance’ that impacted on practice.

• Areas for improvement identified by the participants included streamlining documentation to make it more relevant to service users. Some participants reported how metrics had contributed to more positive changes to service user, family and key worker involvement in care.

• Nursing and midwifery metrics has also contributed to cross disciplinary working and other disciplines within the healthcare setting are now looking at our nursing and midwifery metric tools.

• Some participants highlighted ‘nurses have now taken control and accountability on measuring and being transparent about our practice in the provision of quality care’.

• The mental health focus group participants identified ‘greater service user involvement’ as an important outcome of introducing nursing metrics…… ‘service users are much more involved in their care…… service users are now using the same language as the healthcare professionals…recovery, care planning…’. Participants further highlighted ‘metrics facilitated the integration of the service user’s voice in the management and delivery of services in a more meaningful way’.

• Changes in documentation transferred into changes in behaviour and approach to care. Examples from participants included changes in how consent was obtained, the role of advocacy and the identification and honouring of the ‘rights of service users’.

• Medication management was identified as an area where practice was changed in an effort to ‘reduce errors’. Some participants described how nursing and midwifery metrics ‘had helped to identify issues related to patients not being discontinued from medications’. Participants described how they had been ‘struggling with doctors prescriptions’, metrics provided ‘evidence to support better practice and to ‘get doctors to take the issue seriously’. This resulted in a change in practice and medications were discontinued as appropriate.

• Mental health service participants described how nursing metrics has had a significant impact on practice and has even ‘influenced the model of care’ used…… ‘metrics has resulted in a move away from a medical model towards a biopsychosocial model of care involving a greater emphasis on a recovery orientated approach to care with more involvement of service users and families’.

• Nursing and midwifery metrics highlighted issues around the recording and documentation of care and ‘promoted greater awareness of recording care’.

• Nursing and midwifery metrics were seen as playing a pivotal role in stimulating discussion and reflection on core issues around service user involvement in care, capturing information on family involvement and advocacy. Changes to practice include the introduction of care contracts with service users to ensure they are ‘now in charge of their journey’; raising service user’s knowledge about advocacy and more participation of client focus groups as a way of ensuring the service users is
involved in the development of service. This was seen to have contributed to a ‘change in culture that made service users more involved, visible and listened to’.

- Participants also reported that the complaints procedure has now changed and that ‘complaints are now dealt with better’.
- Nursing and midwifery metrics were seen as a tool to ‘identify clinical knowledge gaps/skills and training needs within an organisation’. In addition the majority of participants also used metrics as a tool to help inform and ‘enhance student learning’.
- Reporting of metrics was seen to have raised greater awareness of nursing and midwifery practice issues and was a catalyst for discussion and reflection amongst nurses and midwives. The outcomes theme is summed up by the following statements - ‘metrics is driving improvements in documentation’ and that ‘when results are down, we now ask why, and what are we doing?’

2.1.6: Theme 6: Usage of the Metrics IT System

Focus group participants expressed a positive experience of using the TestYourCare system, and would compare the system more favorably than the previous paper based audit system. Key areas identified related to the speed of access to results and the timeliness of information providing greater efficiency in time management. The timely feedback of results supported the integration of audited information into the activity of the ward/unit giving the data meaning and relevance and currency in clinical practice.

- Overall, the majority of participants expressed a positive experience of using the nursing and midwifery metrics system and would compare it more favourably than previous audit systems in place within their organisation. Positive aspects that were identified of the TestYourCare System were related to speed of access to results and timeliness of information. ‘a smooth process that speeds up information in a timely manner … much quicker; print off results and calculations are done… questions are simplistic and user friendly’, ‘… concise, easy to do’ and ‘time saving.’
- Participants liked the fact that metrics provided information on a monthly rather than six monthly basis. When describing the ‘old system’, some of the groups used terms such as ‘ineffective’, ‘laborious’ and ‘tedious’, taking ‘too much time’ and lacking the ‘… appropriate tools to calculate results’.
- When comparing metrics with the previous systems in use within their organisation some of the participants ‘compared to the previous audit approach information is now available immediately and in real time’. They argued that previously information was ‘never fed back on time’ and that this resulted in the data losing its meaning and relevance. This limited the opportunities for change whereas nursing and midwifery metrics allowed them to ‘properly’ close the ‘loop in practice’.
- Due to the ease and localised nature of data collection some of the participant’s felt that it wasn’t seen as ‘double jobbing’ as the metrics were integrated into what was happening on the ward.
- However, some participants indicated that there was a ‘time commitment’ and initially using the metrics was ‘time consuming’ but they indicated that they ‘became faster at doing it’ over time.
• The majority of the participants identified nursing and midwifery metrics as a more ‘structured measurement tool’ to measure practice. Positive features highlighted in the nursing and midwifery metrics system were the ability to display monthly charts and graphs, results were all together and the use of percentages in the results.

• The visibility of dashboards was highlighted as key to its success by the majority of the participants; this allowed them to ‘view critical information on how the ward was performing on a monthly basis’.

• The majority of the participants indicated that ‘we are starting to have conversations monthly on quality and patient safety and this has happened now at ward level’.
Chapter 3: Recommendations & Conclusion

The following chapter includes the recommendations that have been identified as a result of undertaking the evaluation of the development and implementation of a nursing & midwifery metrics system in HSE Dublin North Healthcare services.

3.1 Recommendations

It is recommended that:

1. Application of this nursing and midwifery metrics system should be endorsed at national level to provide Nursing and midwifery services with a set of standardised measurements to measure care of nursing and midwifery services in as near real time as possible for healthcare managers, regulators and HSE.

2. Standardised Metric Care Indicators should be generated to provide a common language and accurate information for healthcare services on compliance to standards in a nationally consistent format.

3. The HSE through the ONMSD should promote the implementation of nursing and midwifery metrics nationally to provide Directors of Nursing and Midwifery with a quality assurance methodology for measuring care.

4. The HSE through the ONMSD should promote nursing and midwifery metrics as a methodology to meet statutory and regulatory requirements for quality and standards in nursing and midwifery care services within healthcare organisations.

5. A system of metrics should incorporate quantitative and qualitative methods including the patient/service user’s voice and experience.

6. All metrics systems must include the service user’s voice in order to measure the quality of care that is being delivered and to identify signals that indicate when the delivery of care is being compromised.

7. All Nursing and midwifery services use a system of metrics to support the monitoring of the standards of care being delivered, clinical/patient safety improvement issues and regular reporting of nursing performance.

8. The implementation of nursing and midwifery metrics will enhance accountability for care at all levels of the organisation and bring the patient experience into the boardroom.

9. The implementation of nursing and midwifery metric will contribute to a culture where patient care, continual improvement and learning is prioritised within services.

10. Healthcare leaders and healthcare management need to create a culture within healthcare organisations where openness, transparency and accountability occur at all levels of care provision.

11. Staff will be supported in taking responsibility and accountability for results, the development of action plans as appropriate and provide feedback on outcomes and compliance with standards.
12. The involvement and consultation with staff and clinical specialists in the generation and development of care indicators is critical to ownership and the sustainability of metrics at local level.

13. A system of metrics helps to identify knowledge deficits and continuous professional development needs and these should actioned.

14. The performance of healthcare services against agreed metrics criteria should be the responsibility of and sponsored by every member of the corporate team.

15. Consideration should be given to changing the title of nursing and midwifery metrics to ‘Quality assurance metrics’ as a means of engaging the attention of all members of the corporate team.

16. The HSE through the Quality & Patient Safety Directorate should promote and sponsor the expansion of ‘Quality Assurance Metrics’ to all professional groups and healthcare organisations.

17. The HSE and Management teams should initiate and facilitate an inter/multi-disciplinary metrics system for every healthcare environment; certain limitations were identified in a system of metrics with a unidisciplinary focus.

18. A technical environment must be available whereby clinicians have access to TestYourCare or similar system, technical support, IT hardware and software in order to support staff to measure performance, collect data and support quality improvement.

19. The provision of a software system that provides speed of access to results, timeliness of information, a system that supports visual access and percentile data which creates openness and transparency of results is made available to Directors of Nursing and Midwifery as an essential requirement of a metrics system.

20. Handheld electronic devices should be provided to support ease of access to information, more efficient method of collating data, organisation of results and immediate feedback.

21. Consideration should be given to providing universal Wi-Fi for our healthcare services.

22. A quality control policy is developed to identify reliability and validity of the care indicators; to guarantee different metrics auditors achieve the same results and to ensure good inter-auditor reliability.
3.2 Conclusion

Quality of care and patient safety cannot be measured and improvements made without having reliable data and a system to support analysis of this information. Data generated from Nursing and Midwifery metrics should be available for use at both front line and boards of management level. Such information should include: the views and experiences of patients and their families; measures of care and compliance with national standards, measures of the reliability of safety processes; information on practices that encourage monitoring of safety on a daily basis; the capacity to anticipate risk issues; and on the capacity to respond and learn from such safety information. The findings of the Evaluation of the Development and Implementation of a Nursing & Midwifery metrics System in HSE Dublin North Healthcare services suggest that nursing and midwifery metrics have the potential to measure fundamental nursing care processes. Metrics can identify when care is falling below the required standard of care thus enabling healthcare staff to make improvements to reduce the risk to patients and their families. Similarly, eliciting the views of patients regularly enables healthcare staff to identify patients’ experience and perspectives on care received including cultural issues within the organisation and highlight potential or existing problems and how they can be improved.

This evaluation provides evidence that nursing and midwifery healthcare organisations should use a system of metrics to monitor and improve clinical care and to reassure the patient and the public on the quality of care provided. The implication of metrics for Nurse and Midwife leaders is that for the first time they have real time data on fundamental nursing and midwifery care. The availability of rapid feedback on metric results and trends means corrective action can be taken to address areas of poor performance and also ensure care is consistently improving and learning takes place. Nurse and Midwife leaders must be able to use metrics data to communicate about nursing and midwifery performance at hospital/board level. Quality information can be used by senior management to develop staff and provide education and training to address identified deficits. A dashboard of metrics can be used by hospital management to demonstrate a link between staffing levels and performance and where appropriate establish a case for needed resources to ensure quality nursing and midwifery care.

This evaluation has found that the introduction of a nursing and midwifery metrics system in all twelve healthcare organisations impacted on structures, processes and outcomes of care. The data gleaned also informed Directors of Nursing and Midwifery of systematic issues relating to service provision along with identifying education and continuous professional development requirements. Nursing and midwifery metrics is a labour intensive process if the appropriate IT hardware and software is unavailable, in the absence of these supports nurses and midwives will spend considerable time inputting data which will impact on time spent with patients. It is critical that an appropriate IT hardware and software system be employed to support the quality and safety agenda in healthcare. Maintaining a safer health care environment through nursing and midwifery metrics will provide transparency, openness and improved quality of care.

If as Berwick (2013) suggests that patient centred culture, no tolerance of non-compliance with fundamental standards, openness and transparency, candour to patients, strong cultural leadership and caring, compassionate nursing and useful accurate information about services are crucial elements in promoting the patient safety agenda within healthcare organisations then a metrics system will certainly contribute to achieving these outcomes.
Chapter 4: Methodology

4.1: Methodology and Methods

This section provides an overview of the methodology and methods employed during the evaluation of the development and implementation of a nursing and midwifery metrics system in HSE Dublin North Healthcare services. A descriptive qualitative approach was used utilising semi-structured focus groups for data collection. This chapter justifies the selection of the study’s design, methodology, and data analysis. Robustness of the study, ethical considerations and limitations of the evaluation are also discussed.

4.2: Project Design

Robson (2011) suggests that ‘what’ questions require a descriptive answer and call for a flexible design. Taking into account the desire to gain new knowledge on nursing and midwifery metrics and their impact on patient safety outcomes and to present an account of nurses’ and midwives’ perceptions/real life experience of metrics, a descriptive qualitative approach was used. Data collection was achieved through semi-structured focus groups.

4.3 Data Collection Method

Semi-structured focus group interviews were used to evaluate the development and implementation of a nursing and midwifery metrics system in HSE Dublin North Healthcare services. Semi-structured focus group interviews were chosen as the data collection technique as they can efficiently attain an extensive range of information about events from several people simultaneously (Sandelowski, 2000, Polit and Beck, 2006). Focus group interviews provide a rich source of qualitative data captured in a relatively unstructured way. Bryman and Bell (2011) argue that the ‘dynamic of group discussion’, which is a fundamental feature of focus groups, and the exchange of ideas has the potential to stimulate creativity and help produce innovative ideas and solutions.

All key nursing and midwifery personnel involved in implementing nursing and midwifery metrics within their organisation were invited to participate. Nine separate focus groups were conducted between March 2013 and August 2013. A total of 56 participants from the 12 participating healthcare organisations participated in the focus groups. The grade of focus group participants ranged from staff nurse/midwife to Director of Nursing and Midwifery with the majority at Clinical Nurse/Midwife Manager, Nurse/Midwife Practice Development Co-ordinators, Clinical Nurse/Midwife Specialists or Assistant Director of Nursing and Midwifery grade. One focus group included Directors of Nursing and Midwifery from participating pilot sites. Services represented in the focus groups included acute care, mental health, care of the older person, intellectual disability, children’s services and maternity services (Figure 4). To achieve data saturation and avoid disorder of the evaluation process the size of the focus groups ranged from 5 to 10 participants, with an average of 7 participants. This is consistent with Morgan’s recommendations (1998) who suggests that the size of a focus group would typically range between 6 and 10, with groups over 8 becoming increasingly difficult to facilitate (Blackburn and Stokes, 2000).
Focus group sessions lasted between 60 and 90 minutes and took place in 7 sites. To ensure consistency and reliability of approach, the sessions were facilitated by the same moderator. The moderator was independent of the pilot project, the NMPD and the public health system. The moderator’s role was to facilitate the focus group sessions and to collate the results. At the beginning of each session participants and the moderator introduced themselves and the purpose and format for the session was outlined. At the end of the session participants were thanked for their contribution and a brief explanation was provided on what would happen to the data collected.

Data were collected during the semi structured focus group sessions and recorded on flip charts by a scribe. As the information was recorded participants were asked to check and verify the information throughout the process to ensure that it was a true reflection of their comments. The sessions were designed to allow participants freedom to determine the direction of the discussion and to identify issues they considered significant and important; however discussions were guided in four key areas to establish:

- Participants perceptions of nursing and midwifery metrics
- What worked well during the implementation of a nursing and midwifery metrics system in HSE Dublin North Healthcare services
- The contribution that nursing and midwifery metrics has made to their organisation and to patient outcomes
- Areas to help develop and improve nursing and midwifery metrics

Participants’ perceptions were captured by using a brain storming analogy exercise. Each participant was asked to write the name of an animal on a post-it note that best represented nursing and midwifery metrics for them personally (Figure 5).
Participants were then each asked to place their post-it note onto a flip chart and provide an explanation for their selection. Comments were recorded as the participants talked about their perceptions of nursing and midwifery metrics. The two questions that related to ‘what worked well’ and ‘the contribution that nursing and midwifery metrics had made’ were used to prompt discussion and to invite participant’s comments on their experience and opinions of the project (Figure 6).
To capture areas for metrics development and improvement each participant was asked to write 5 areas for development on a sheet of paper. Within groups of 3-5 they exchanged their list with other group members. This exchange allowed the opportunity to view and comment on the suggestions of other participants.

The ninth semi-structured focus group/interview was conducted to gain understanding of the experience and opinions of Directors of Nursing and Midwifery in the implementation of a Nursing and Midwifery metrics system had assisted them at corporate executive level. This session was guided by the three following key questions:

- How has nursing and midwifery metrics assisted you in your role at executive level in your organisation?
- What contribution have nursing and midwifery metrics made to your organisation and to patient outcomes?
- How could nursing and midwifery metrics be improved and developed to meet the needs of Directors of Nursing and Midwifery?
4.4 Data Analysis (Qualitative Evaluation)

Data collected from the focus groups were textual data. Thematic analysis was used to identify patterns in the comments, suggestions and opinions of participants. Key themes were identified in the data. The process for analysing the data was guided by Saldana’s Six Phases of Thematic Analysis (Saldana, 2009). Saldana’s Six Phases of Thematic Analysis include becoming familiar with the data, initial coding and development of over-arching themes.

4.5 Ethical Considerations

Data generated from the focus group sessions were stored in compliance with the Data Protection Act 1988/2003. Ethical approval was not sought as the evaluation was conducted as part of an organisational quality/safety improvement initiative and not a research study. Participants were not considered or identified as a vulnerable group and permission to carry out the evaluation was obtained from the Director of Nursing and Midwifery in each participating organisation (Appendix 1). Participants completed an informed consent form at the start of each focus group session (Appendix 2). Anonymity of participants’ contributions to the focus group was maintained throughout. No record was made attributing statements or opinions to individual participants.
Chapter 5: Literature Review

5.1 Introduction to Literature Review
The literature review was conducted to critique and elicit what the literature says about the quality of nursing and midwifery care and the significance of nursing and midwifery metrics indicators in measuring nursing/midwifery care (Biondo-Wood and Haber 2006).

5.2 Search Strategy
A search of the publications was conducted using electronic databases and manual searches. Key words used for the research were nursing and midwifery metrics, process indicators, outcome indicators and quality care indicator. Themes emerging from literature review, which were used to support the implementation of nursing and midwifery metrics, are patient safety culture, the quality of nursing care, nursing metric care indicators, the use of a balanced scorecard and leadership.

5.3 Review of Literature Themes
5.3.1 Patient Safety Culture
Patient safety has dominated research literature on healthcare for centuries (Watcher 2010; Harris et al 2006). In recent years the issue has become a national and international imperative with increasing emphasis evident within policy reform and legislative changes together with the development of standards of care driven by quality improvement initiatives. In an age of financial austerity governments and healthcare policy makers are placing patient safety at the top of the agenda (Holmes 2009). The Berwick Report (2013) advocates that patient safety should be of paramount importance to all leaders concerned with healthcare. Studies of adverse patient events from numerous countries around the world demonstrate that between 4% and 16% of patients admitted to hospital experience one or more adverse event; of which up to half are preventable (DoH 2008). A more recent study carried out by Aiken (2014) reports that increasing a nurse’s workload by one patient increases the likelihood of an inpatient dying within 30 days admission by 7%. In order to develop strategies to prevent adverse patient outcomes it must first be understood how and why preventable errors in healthcare occur. A study by Duffield et al (2009) concluded that hospital executives, nurses and physicians had very different views on the extent to which patient safety is affected by nursing processes/care. The study found that nurses and physicians attributed more responsibility for patient safety to nurses than chief nurse executives and chief executive officers. Kalisch (2006) highlights a lack of assumption of accountability among nurses. Erwin (2009) and Watcher (2010) highlight that managers are required to hold staff accountable for performance related issues.

Here in Ireland, accreditation bodies such as, the National Patient Safety Association (NPSA), HIQA (2012a) and the MHC (2007) have developed leadership standards for measurement of patient safety culture and improvement. To encourage nurse accountability and to improve clinical performance Klazinga et al (2011) recommend embedding performance indicators in to healthcare governance and management systems. As nurses and midwives are at the frontline of healthcare provision, they are also at the frontline for the delivery of patient safety and quality improvement processes (Morath 2011). Nursing and midwifery care provision involves processes such as documentation (ABA 2002), involvement of service users (MHC

2007), provision of information (MHC 2007), medication management (ABA 2007), falls management (HiQA 2009b), implementation of the National Early Warning Score (HSE 2013) and pressure ulcer care management (HSE 2009).

The multifaceted dimension of nursing and midwifery care provision is examined in the research with frequently negatively results. There is a dearth of literature advocating that the Early Warning Score System to promote patient safety (HSE 2013; Mohammed et al 2009). Higgins et al (2008) highlight that failure to undertake routine observations on patients poses a potential clinical risk and the development of performance indicators is required to monitor improvements. The Berwick Report (2013) describes patient involvement as being crucial to the delivery of appropriate, meaningful and safe healthcare and is essential at every stage of the care cycle. Morris (2002) advocates clinical benchmarking to overcome disparity in care delivery particularly within the area of tissue viability. Healthcare professionals are increasingly being asked to account for their actions when pressure ulcers develop and to improve documentation on pressure ulcer care (Jordan O’ Brien 2011; Guy 2010; Culley 2001). Medication errors by nurses continue to dominate the gray/research literature with recommended practice being to monitor patient safety to lower the error rate (Athanakis 2012; Hicks et al 2012). Berwick (2013) suggests that patient centred culture, no tolerance of non-compliance with fundamental standards, openness and transparency, candour to patients, strong cultural leadership and caring, compassionate nursing and useful accurate information about services are crucial elements in promoting the patient safety agenda within healthcare organisations.

5.3.2 Quality of Nursing/Midwifery Care

The literature review provides significant evidence of poor nursing care and variations in nursing practices (Lakeman, 2008; Duffin 2012; Phair and Heath 2012; White et al 2010). Duffin’s (2012) report turns the spotlight on fundamental care by highlighting that nurses did not carry out simple tasks, give vital medication and manage dehydration. Patients were let down by incompetent staff, poor communication in the absence of leadership. Kalisch (2006) identified nine elements of nursing care regularly missed in acute hospitals. Moreover nurses were in denial about care that was not completed adequately and they did not question reasons for inadequate care (Kalisch, 2006). This study is in congruence with Phair and Heath (2012) findings that nurses sometimes feel helpless to change the way care is delivered and that they can relieve their anxiety by convincing themselves that it is not wrong. Consequently, individuals do not speak up because they do not want to upset the status quo and poor care or patient neglect persists. Moreover it is vital for organisations to create a culture where healthcare workers can speak up (Phair and Heath 2012). Berwick (2013) in his report recommends that each organisation should be expected to listen to the voice of staff such as through department and ward level cultural and team work safety surveys to help monitor the safety and quality of care and variation among units. Scott et al (2014) RN4CAST study identified levels of necessary work left undone due to nurses time constraints, such tasks included skin care, oral hygiene, pain management, comfort/talk with patients, educating patients and families, preparing patients for hospital discharge, adequate documentation of care provision and frequent changing of patient position.
5.3.3 Nursing and Midwifery Metrics Care Indicators

The concept of the word “metric” was borrowed from the industrial world of business and finance to measure how successful a business was at meeting targets. However, Hauser and Katz (1998) claims that the journey to choosing the right metric is marred with pitfalls and unanticipated outcomes. Evident from the literature review is that nursing care indicators are generally developed from evidence based practice using consensus methodology and a grading system or Delphi approach (HIQA 2013b; Maben et al 2012; Griffiths et al 2008; Anderson-Elverson et al 2012; McCance et al 2011). However, Anderson-Elverson et al (2012) and McCance et al (2011) in their research detail that generating indicators that are sensitive to nursing is challenging because of the indiscernible nature of nursing and midwifery care.

There is substantial literature on the use of clinical indicators and nursing and midwifery metrics, there is less evidence relating to indicators that reflect important aspects of the patient experience beyond the functional and transactional aspects of their care (Maben et al 2012). Public and professional concerns about loss of compassion and expressions of caring may not easily be addressed by measures that only focus on clinical processes and outcomes. It is therefore important to more closely link nursing quality measures to patient experiences of care, including patients experiences of respect, dignity, information about treatment/medicines, involvement in decision making, care planning and cleanliness of ward/environment (Bergh et al 2011).

The literature review identifies that there are numerous studies reflecting nurse sensitive indicators for within the acute settings for falls, nutrition, pressure area care, pain management, medication and infection prevention and control, patient satisfaction and patient outcomes (Kavanagh et al 2012; Gaies et al 2012; Foulkes 2011; White et al 2010). Additionally, McCance et al (2011) identified eight indicators to measure patient experience. These indicators seek to measure such factors as patient’s confidence, their sense of safety and respect from the nurse/midwife for the patient’s preference. As evident from the literature review, healthcare organisations can generate metrics to measure key aspects of fundamental nursing care like documentation, tissue viability, medication, provision of information and early warning score observation indicators (Maben et al 2012; White et al 2010).

5.3.4 Balanced Score Card

There is need for a different kind of nurse in the future who will steer their way through the intricacies of the technical environment to measure performance, collect data and support quality patient care (Maben et al 2012; Harrison 2011; Salmela et al 2011; Shanley 2007). In 1995 the American Nurses Association launched a safety and quality initiative and supported the development of a National Data base of Nursing Quality Indicators (NDNQI). In California 1996 the California Nursing Outcomes Coalition database was set up to operate and test nurse indicators. In the UK, some degree of standardisation of how hospital are performing and monitoring patient safety is collected through the NHS Safety Thermometer database (Maben et al 2012). The HSE has set up the Quality and patient Safety directorate (2012) to use data and evidence to monitor quality of healthcare delivered. Collecting metrics data and using quality dashboards allows hospital managers to monitor performance across the organisation using evidence based practice to maintain quality in relation to safety, effectiveness and patient experience (Maben et al 2012).
Malin (2006) research concludes that using business metrics in healthcare identifies areas for improvement through centralised planning and elimination of duplication. In support, the Royal College of Nursing (2011) publication and Johnson (2006) recommend clinical dashboards to provide real time data on nursing quality. Storer Brown et al (2010) alludes that benchmarking at hospital level within the same unit allows performance to be compared.

5.3.5 Leadership
Effective leadership is critical in delivering high quality care, ensuring patient safety and facilitating positive staff development. Underpinning the delivery of our healthcare services is the commitment from leaders in ensuring the delivery of high quality care and enhancing patient safety. Leadership can be defined as a multi-faceted process of identifying a goal or target, motivating other people to act and providing support and motivation to achieve mutually negotiated goals (Porter-O Grady, 2003). Berwick (2013) identified that leadership is about mobilising the vision, attention, resources and practices of others towards particular goals, values or outcomes. The continual reduction of adverse patient harm requires transparency and reliability of purpose among all leaders, from the Director of Nursing and Midwifery to the front-line staff and across the whole healthcare system. Leadership requires presence and visibility. Leaders need first-hand knowledge of the reality of the system at the front line, and they need to learn directly from and remain connected with those for whom they are responsible (Berwick 2013). Creating a culture change and maintaining continual improvement is what leaders do, through their commitment, encouragement, compassion and modelling of appropriate behaviours. Leadership is required from Senior Management at every level of the HSE and DoH to support the implementation of nursing and midwifery metrics.

5.3.6 Implications for the Change Project
The literature provides evidence to support the introduction of a nursing and midwifery metrics system. These themes as discussed above provide an infrastructure and road map for the development of nursing and midwifery metrics as a change project. The themes highlight that there are challenges and pitfalls to developing nursing indicators which are sensitive to nursing. Furthermore the literature provides evidence highlighting the use of international data bases of nursing indicators and supports the use of balanced score cards to manage and represent data and thus improve performance across organisations.
Chapter 6: The Change Process

Leading change in uncertain times means that many of the tools and models of change like planned models that were devised to fit old management systems are no longer suitable. Unfortunately, models of change that acknowledge uncertainty and complexity are hard to find (Cameron and Green 2012). For the purpose of the change process, the Nursing and Midwifery Planning and Development (NMPD) chose the HSE (2008) model of change to implement the nursing and midwifery metrics project. The HSE’s change model has 4 key stages; initiation, planning, and implementation and mainstreaming as outlined in Figure 7. The purpose of this toolkit is to help organisations with the change associated with implementing a nursing and midwifery metrics system within the HSE.

6.1 Initiation Phase:

The initiation stage entailed scoping out a case for change to highlight the rationale for change, the leadership required, agreeing the mandate across twelve healthcare services, establishing a sense of shared responsibility, the organisations readiness for change and the objectives for change (Korst et al 2011; HSE 2008). The Director of Nursing in the NMPD initiated the implementation of the nursing and midwifery metrics project by hosting a Master Class and inviting international experts and the Chief Nursing Officer from the Heart of England Trust to speak with senior managers in the HSE Dublin North Region on “their journey and experiences of implementing Nursing and Midwifery metrics within the NHS”. Information and metrics data showed how their Hospital Trust improved fundamental nursing care provision and consequently reduced complaints from patients and their families. A very convincing argument was put forward to support the introduction of nursing and midwifery metrics as a pilot project in healthcare organisations in Ireland (Cialdini 2001).
The Director of the NMPD in HSE Dublin North wrote to Director’s of Nursing and Midwifery in all healthcare organisations in the region inviting them to engage in the implementation of the nursing and midwifery metrics project. Twelve Directors’ of Nursing and Midwifery expressed their willingness to engage in the project. Two Project Officers were appointed to facilitate the implementation of the project. The Project Officers responsibilities were to communicate and facilitate the vision for change to key stakeholders and unite them as regional groups to engage with the change process (Kotter 2008). The Project Officers gave presentations to corporate and key stakeholder leads in each hospital on the benefits of using nursing and midwifery metrics to measure nursing care (Figure 8). Leadership was required from the hospital executive, senior managers and staff to participate in the change process and build a knowledge base on how to read and interpret data and track quality outcomes (Korst et al 2005; HSE 2008).

Figure 8: Benefits of Using Nursing and Midwifery Metrics

6.2 Planning Phase:

The regional Project Officers worked with identified ‘Metric Leads’ in each healthcare organisation to agree organisational readiness to engage in the change process. An organisation’s readiness for change depends on the strength of organisational leadership to foster a culture for quality improvement (NHS 2012; Trerise 2010; HSE 2008). The culture of the healthcare service has been identified as an important impact on improving the quality and safety of the care provided. HIQA advocates that a ‘quality and safety culture’ ensures that quality and safety is seen as fundamental to every person working within that service including clinical and non-clinical staff, healthcare managers and the board or equivalent of an organisation. This culture places the interests of service users and patients at the centre of care and supports behaviours that are respectful of service users and others. It promotes openness and transparency, teamwork, open and effective communication and a supportive environment within which both service users and providers can raise issues of concern and feel confident that this will not have a negative impact on how they are dealt with.
Regional groups were set up to generate and develop nursing and midwifery metrics. Clinical experts developed and generated a suite of metrics relevant to their area of care and this provided “buy in and ownership” of nursing and midwifery metrics from the onset. Communication, negotiation and agreement on wording was achieved through numerous meetings, emails and via telephone conferencing with key staff. Agreement using consensus methodology was reached on a number of care indicators across the six disciplines.

6.3 Implementing the Project

The NMPD Project Officers provided education and training to metric data collectors across all 12 healthcare services. Key staff in all hospitals participated in a “Train the Trainer” programme. Training was given to key stakeholders in each healthcare service on key issues pertaining to the individual metrics, data collection methods and analysis. Data was analysed and displayed on the software package TestYourCare using the traffic light system (HIQA 2013b; HIQA 2013c). Metric auditors were provided with training and education and provided with usernames and passwords for the TestYourCare system. Training and education included the metric care indicators and how to interpret the data and results. Their role in discussing results with clinical nurse/midwife managers was clearly defined and a guiding framework was provided to all healthcare services implementing the project.

6.4 Sustaining and Monitoring the Project

The Project Officers set up a regional stakeholders’ group across 12 services consisting of stakeholders from all hospitals. The purpose of the group was to create a forum to feedback and evaluate the change process (NICE 2007). Part of the evaluation involved carrying out a SWOT analysis. The SWOT analysis was carried out to identify and to provide information on what was working in the change process and identify the weaknesses and threats to the nursing and midwifery metrics project (Iles and Sutherland 2001). SWOT is an acronym for examining an organisation’s strengths, weaknesses, opportunities, and threats (Phal and Richter 2007). The SWOT analysis was completed twelve weeks after the change was piloted as the staff were not familiar with metrics at the initiation stage. The SWOT analysis report indicated that stakeholders had a positive attitude to nursing and midwifery metrics. Consistent with McLean (2011), the HSE (2008) change model advocates celebrating “short-term wins”.

6.5: Mainstreaming the Project

Mainstreaming includes embedding in the organisation the new reality of change in measuring nursing and midwifery care through metrics (HSE 2008). Kotter (2008) stresses the importance of anchoring the project into the organisation’s culture and communication of the new behaviours and organisational success. Consistent with emergent change, the organisation and individuals involved in change need to be in a constant state of readiness to respond to issues and unexpected events that may arise during the change process (Johnson 2006).

Strengths of the project were mainly related to the fact that all twelve services positively engaged with the change process. The benefits of having real time data to highlight areas of good practices and identify areas for improvement were acknowledged. The quality of nursing and midwifery care is now recognised at nursing and midwifery governance level and at the hospital board level through the use of real time data
results presented via a dashboard. The project supported the return of senior nurses “back to the floor” to engage in collecting data and taking corrective action to manage results appropriately. “Wins” in the project were celebrated such as improvement in performance, acknowledgement of the hospitals for buying into the culture change required for collecting monthly metrics on nursing and midwifery care and senior nurses/midwives having real time data regarding quality of care for discussion at corporate board meetings.

An important limitation of the project is the availability of resources to collect metrics every month. The collecting of process metrics is labour intensive and with budget constraints, senior manager’s first priority is to ensure that nurses and midwives are available to support direct patient care. Another limitation included having no Irish IT system that could be used to collect and analyse data.
Chapter 7: Findings from the Focus Groups

This chapter outlines the key themes that emerged from the data collected from the focus groups. Five themes emerged from the first 8 focus groups (indicated as A-H in the analysis) and 1 key theme emerged from the Directors of Nursing and Midwifery focus group. The themes are discussed below;

7.1: Key themes

1. Governance & Leadership
2. Communication
3. Quality & Standards
4. Engagement
5. Outcomes
6. Usage of the metrics system

7.1.1: Theme 1: Governance & Leadership (Directors of Nursing and Midwifery Evaluation)

The aim of this focus group was to elicit the experience and views of Directors of Nursing and Midwifery on the pilot nursing and midwifery metrics project. The focus group was held at the HSE Business Campus in Swords and was attended by 6 Directors of Nursing and Midwifery and 7 Assistant Directors from 11 organisations. A number of the Directors had already actively participated in focus group session in their own organisations. However, the focus of this session was to gain greater insight into how nursing and midwifery metrics had contributed to discussions at executive levels within participating organisations. To help guide the discussion the key questions were orientated around 3 key areas.

- What worked well with nursing and midwifery metrics?
- What could be developed?
- What contribution had nursing and midwifery metrics made to Directors of Nursing and Midwifery at an executive level?

There was significant variation regarding the extent to which participants had an opportunity to make use of metrics at executive level. As one participant succinctly put it, she takes nursing metric results with her to Board meetings, another described how they utilise metrics to provide evidence of the quality of care at corporate level. They went on to outline how metrics provided a language to talk about nursing and midwifery care at corporate level and assisted in the development of the strategic leadership capabilities of Directors of Nursing and Midwifery. While, another participant described how access to metric results alerted her at an early stage when ‘care is dipping’ which enabled a more “proactive response”. Another outlined how they had used nursing and midwifery metrics to inform discussions about a range of strategic issues such as quality and patient safety, finance, human resources, risk management and national services plans. Nursing and midwifery metrics has, even during the pilot phase, been used to inform the corporate team both formally and informally about care, performance and to ‘see at a glance where improvements have been made’. It was also seen to have ‘allowed/forced’ Directors of Nursing and Midwifery to refocus on nursing and midwifery care as their primary concern, rather than being caught up totally in finance and business issues.
In contrast a number of participants had not had the opportunity to make use of nursing and midwifery metrics at executive level. The reason given was that some organisations are at an earlier stage of implementation and require more time to integrate metrics and to be confident that they provide valid and reliable data. In addition one participant outlined that one of the challenges of using nursing and midwifery metrics at executive level was that they “… can be seen as very narrow in an multi-disciplinary team (MDT) environment”. They suggested that consideration should be given to changing the name to ‘Quality Assurance Metrics’ as a means of gaining the attention of the corporate team. They felt that metrics were not a ‘nursing’ measure but more a ‘patient care’ measure. It was argued that this change in language would be more influential at corporate level and that it was important to ‘find the right language to talk about ‘patients’ at the corporate table.

One participant indicated that in two wards/units involved in the pilot the issues highlighted as needing attention as a result of nursing and midwifery metrics were related to and highlighted systematic issues which needed corporate review and decisions.

Overwhelmingly, participants welcomed nursing and midwifery metrics and felt that they had made a significant contribution to gaining greater insight into quality of care and a catalyst to encourage staff engagement. In some organisations nursing and midwifery metrics had already contributed to quality of care. Access to metric data and the use of a standardised and ‘consistent’ approach provided transparent information to identify issues of concern and to prompt changes to practice. An example included greater service user involvement in mental health services which increases engagement and greater family involvement. It also resulted in service users using language such as care plans and recovery. In addition changes in documentation was highlighted as a key area that nursing and midwifery metrics had identified a need for improvement. One participant described how previously ‘we reacted to incidents as they occurred’ but ‘metrics helped to improve the system so that incidents didn’t occur’. Nursing and midwifery metrics were also identified as contributing to professional development by ensuring professional standards and policies were implemented. Nursing and midwifery metrics was also found to facilitate discussions about quality at all levels. It acted as a motivator for staff by encouraging them to participate in meetings to discuss and examine nursing and midwifery metrics data.

Access to ICT was the only issue highlighted as a limitation to fully implementing nursing and midwifery metrics.

7.1.2: Theme 2: Communication

Communication was a theme covered by all 9 focus groups (A – I). The theme relates to communication both internally within the organisation and externally with other services and professional and regulatory bodies. The theme incorporates 4 elements that are detailed in Table 1. The focus of the comments was related to sharing nursing and midwifery metrics information with ward/unit staff and communicating results to organisational committees.

Table 1: Communication Theme

| Communication with organisational committees (14) |
| Sharing information with ward/unit staff (35) |
| Sharing information between organisations (3) |
| Sharing information across professional boundaries (4) |
Common to all of the groups was the recognition of the importance of communication as an integral part of the nursing and midwifery metrics process. This involved both communicating the nursing and midwifery metrics approach and the results throughout the organisation from clinical staff to senior organisational managers, such as the Director of Nursing and Midwifery and Chief Executive Officer or General Manager (E). Transparency and accessibility of the ‘metric report’ (B) to staff was seen as fundamental to make a meaningful difference. Group C were clear that ‘information goes on the board for all staff to see’. This group described how they had ‘debated at the beginning if they should publicise results’ but after presenting the results at a team meeting ‘everyone got behind metrics and it brought the team together’. It also created a context that they described as one that ‘challenged us as nurses to lay ourselves bare’. Group A developed this argument in that openness ‘allows everyone in the organisation to see if we are up or down’ in our nursing metric scores. Group H outlined how the Assistant Director of Nursing had actively shared nursing and midwifery metrics with other clinical areas to help raise awareness and show case the work that had been undertaken.

Information about nursing and midwifery metrics and results were most often displayed on a notice-board in the ward or unit office. More detailed information was provided in separate folders (C) and specific information recorded using other methods, such as the ‘communication book’. Verbal feedback was provided to staff, generally by the clinical nurse manager during report (D, G), to small groups and on a one-to-one basis (C). Group D described how the focus of these meeting is to ‘talk about areas for improvement’ and how the ‘face-to-face feedback had been beneficial’. Group G found that ‘general feedback was not getting through’ but feedback provided on a one-to-one or with small groups of 2-3 nurse was a more effective approach. The approach adopted was usually informal and was described by one group as ‘when doing metrics we stop and chat with staff’ about metric scores (H). This was seen to provide an opportunity to work with staff in developing and communicating action plans. Group G contrasted this approach with the previous system where results were ‘never fed back on time’.

The nursing and midwifery metrics results were communicated to organisational committees with clinical oversight (A, C, D) and to strategic level management committees (B-G). Group D described how they make information available to the drugs and therapeutics committee, quality and safety, tissue viability, and the falls prevention committee. Group C indicated that this was important due to the multi-disciplinary nature of the committees and that it was an opportunity for ‘everyone to hear what is going on’. However, it was acknowledge by one group that the limitations of nursing and midwifery metrics was the uni-disciplinary focus (F) and that there was a need for a more ‘generic way’ to inform other disciplines. In contrast Group D has already been sharing nursing and midwifery metrics information with medical colleagues including GPs in an effort to develop practice.

A number of the groups highlighted the importance of communicating results to the ‘Board of Management’ within the organisation (F, G). Nursing and Midwifery metrics were also described as a fast continuous flow of quick, easily understood information to the Director of Nursing and Midwifery and this brings the Director of Nursing and Midwifery down to ward level immediately and bring patient care into the board room (F). Nursing and Midwifery metrics was considered to have the potential of providing assurance of the quality and standard of care within the organisation (G). It was highlighted that the introduction of nursing and midwifery metrics was still at an early stage in some organisations and that there was ‘not enough to report on to influence the executive team’ (F). However, this group did indicate that the ‘executive team’ were ‘happy’ with metric being introduced and were ‘looking forward to [receiving] quarterly reports’. Sharing information and learning from other organisations was also a feature indicated by some groups (A, H). Group H described how they had organised information mornings that were delivered in other organisations.
7.1.3. Theme 3: Quality & Standards

This theme covers issues raised by the focus groups that related to both external and internal organisational quality and standards. All groups with the exception of Group E included information on this issue. The elements for this theme are listed in Table 2.

Table 2: Quality & Standards Theme

<table>
<thead>
<tr>
<th>Element</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIQA standards mentioned</td>
<td>9</td>
</tr>
<tr>
<td>KPI mentioned</td>
<td></td>
</tr>
<tr>
<td>MHC mentioned</td>
<td>2</td>
</tr>
<tr>
<td>ABA standards mentioned</td>
<td>1</td>
</tr>
<tr>
<td>Link with Early Warning Score</td>
<td>2</td>
</tr>
<tr>
<td>Internal organisational audit</td>
<td>9</td>
</tr>
<tr>
<td>Standardisation across organisations</td>
<td>9</td>
</tr>
<tr>
<td>General comments about quality</td>
<td>11</td>
</tr>
</tbody>
</table>

This theme can be broadly split between internal and external processes or requirements for quality and standards within healthcare.

Most of the groups made general statements about quality of care and the role of nursing and midwifery metrics. For example Group A stated that one of the key contributions that metrics had made is the ability to identify if they are ‘doing well or not’. This was similar to Group B who argued that metrics enable them to establish ‘where we [they] are at, at this moment in time’ and to highlight ‘good and poor practice’. Group B and C focused on the positive and motivational dimensions and felt metrics ‘identifies where you do well’ (C) and ‘celebrates what is good’ (B). Nursing and midwifery metrics were also described as a ‘great quality tool’ that can be ‘linked to other measures’ (B). The ability to link metrics with other quality measures and approaches was highlighted by a number of groups (B, C, F, G, H).

A clear connection was made between nursing and midwifery metrics and its role in assisting organisations to meet statutory or regulatory requirements for quality and standards. Nursing and midwifery metrics was seen as a useful approach for demonstrating compliance with required national standards and quality indicators such as HIQA, HSE KPIs, Mental Health Commission, Early Warning Scores and the Nursing and Midwifery Board of Ireland. Group A felt that the standardised approach of the metrics enabled them to compare with other hospitals and to move from their ‘own interpretation of evidenced based practice to what is agreed at regional and national level’. The working together and sharing of information was considered important by Group H as enabling them to take the ‘good elements’ from different organisations.

HIQA standards were mentioned by two of the groups (C, D). Group C believed that nursing and midwifery metrics was a ‘good tool to measure practice’ and could ‘help the team in achieving [HIQA] standards’. Group D indicated that staff were eager to use the metrics to demonstrate to HIQA ‘where they are doing well, like action plans’ they also indicated that HIQA ‘have asked for metric results’. They also stated ‘we fear that HIQA will punish us for areas that we not doing well in’. Other groups highlighted bodies specific
to their own discipline or most relevant to their current needs. Group H had provided the metric results as evidence of quality of care to the Mental Health Commission and also link metrics to the HSE KPIs used to measure organisational performance. When comparing KPIs with nursing and midwifery metrics, Group D found that metrics to be more helpful. Group B focused on Early Warning Scores and found nursing and midwifery metrics to compliment this approach.

Standards play a pivotal role in safeguarding patients and delivering continuous improvement in the quality of care provided (HIQA 2012). Standards promote responsibility and accountability for the quality and safety of services provided.

7.1.4: Theme 4: Engagement

The engagement theme relates to focus group participants’ involvement, participation and enthusiasm based on their experience of being involved in the nursing and midwifery metrics project. This theme reflects the generally positive experience of participants and was made up of five components (Table 3). The contents for this theme were drawn from the 9 focus groups.

Table 3: Engagement Theme

| Staff feeling of accountability, ownership, control or involvement (22) |
| Availability of support (3) |
| ‘Buy in’ from staff (4) |
| Providing information and education about metrics (9) |
| Staff reaction to metrics, accessibility (8) |

One of the largest sub-sections for this theme related to staff involvement in nursing and midwifery metrics and included issues related to accountability, ownership and control. Staff involvement in nursing and midwifery metrics was considered fundamental to its sustainability and success. Part of this process was to challenge staff to look at their practice (F). Involvement spanned all key stakeholders from staff nurses, nurse managers and Director of Nursing and Midwifery(C, E, G, H). Group H went further and even suggested service user involvement; ‘listening to the views of the service users through the patient experience metric enables the voice of the service user to be heard at all levels’. Involvement in nursing and midwifery metrics was linked to accountability for care at all levels of the organisation (G) including the need for results to be discussed by the nursing and midwifery executive and the hospital CEO. This linked closely to the idea of ownership outlined by Group H who described how staff were willing to put the work into metrics if they felt ownership. The involvement of staff included contributing to the development of the specific metrics, developing action plans (H) and implementing change in practice. Group D described how staff felt that they had some degree of control over metrics that allowed them to learn ‘where we are going wrong and where we can improve’. This level of control was illustrated by Group A and H who described how staff were now involved in checking each other’s work to find out ‘why metrics are down’ and also in getting other staff involved. This extended further to staff delivering information session about metrics to other services, such as mental health day hospitals.
Nursing and midwifery metrics was seen as a vehicle that enabled nurses to discuss issues such as documentation (G) and facilitated a change in behaviour. Group C outlined that as a result of the engagement of staff that they were now recording information.

Group D emphasised the importance of the availability of support from the nursing and midwifery metrics project officer and their ability to provide facilitation for the nursing team. This was seen as crucial to staff motivation and enthusiasm for nursing and midwifery metrics. The term ‘buy-in’ was used by two groups (C, E) and related to the importance of gaining support from ward staff and from other key stakeholders such as practice development (C). This was achieved by creating a culture of greater awareness of nursing and midwifery metrics and areas for improvement. This was supported by the facilitation of reflective practice as part of the process and a non-punitive approach to analysis and interpretation of results. Group D felt that it was important to ensure that nursing and midwifery metrics was not seen as ‘a tool to beat staff with but a tool to educate and find areas for improvement’. This was considered fundamental to creating an environment of trust and ‘buy-in’. Staff communication and education were identified as approaches to enhance the potential for nursing and midwifery metrics. Groups C and D felt that one-to-one meetings with staff were very beneficial in building support within the team. While groups G and H highlighted how nursing and midwifery metric results identified educational requirements and professional development deficits (G).

Overall, staff in each of the organisations had been seen to react positively to the introduction of nursing and midwifery metrics. This was clearly stated by Group D who described the nursing staff in their organisation as ‘very positive and happy with metrics’. However, Group F had experienced a mixed reaction, which appeared to be related to reported delay in starting the nursing and midwifery metrics process, limited reporting back to individuals at staff meetings and that they had not had enough time to fully engage. The issue of access to metrics reports was seen as a motivating factor by two group (B, C). Group C clearly stated that ‘access to the results was considered an important aspect of nursing staff engagement with nursing and midwifery metrics’.

Two groups (D, H) described how initially there was a negative reaction at the start that got better as the introduction of nursing and midwifery metrics progressed. Group D described how they had anticipated that this would be the case and were not surprised by the initial reaction. Group H described how the resistance they experienced at the beginning resulted from ‘old school people’ who didn’t like change. This was managed by creating a culture of ownership and linking the metrics back to what they called ‘making our service the best we can’. Staff were said to appreciate the link made to HIQA standards and they felt good about ‘what they were doing well’ (H). The ‘showing’ and ‘seen’ what was being ‘done well’ was echoed by other groups (C, F).

### 7.1.5: Theme 5: Outcomes

This theme reflected the cluster of comments that related to clinical practice; including the planning of care and nursing process issues. The content for this theme was drawn from all 9 focus groups and represented a significant feature of the content from group C, D and H. Seven components were identified in this theme (Table 4), with the key elements relating to recording and documentation along with changes in clinical practice. A common thread throughout this theme was the contribution that nursing and midwifery metrics made in identifying areas for development and improvement including performance and continuous professional development.
Table 4: Outcomes

| Changes to documentation, forms or recording of information (32) |
| User engagement and participation (11) |
| Changes in clinical practice (27) |
| Improvement of clinical outcomes (6) |
| Informing the planning of improvements (7) |
| Organisational culture (3) |
| Training and professional development (3) |

The most evident outcome of the introduction of nursing and midwifery metrics appeared to be related to nursing documentation and records. The results had highlighted a number of areas where care was not recorded or where the record was not consistent with the requirements of the metric standard. Participants indicated that staff were often surprised when the metrics indicated a lower than expected score. Group A indicated that their ‘... results on wound care were poor’ and similarly Groups D, E and F highlighted issues of ‘bad practice’ (D) in pressure area care. On investigation it was often discovered that results reflected issues of documentation and recording and not necessarily the quality care. Metrics were also seen as a mechanism for providing feedback for staff on ‘good performance’ and practice (F).

Nursing and midwifery metrics was seen as a stimulus for reviewing and updating documentation. An example of the type of comments recorded included nursing and midwifery metrics ‘highlighted areas in documentation we need to improve’ (B) and that it provided ‘opportunity to look at documentation and question’ (G). Areas for improvement also included streamlining documentation (C) to make it more relevant to service users (C, H, G). Group C reported how metrics had contributed to changes in user, family and key worker involvement in care. In addition it had a positive impact on cross disciplinary working. Group F explained how issues had been identified between nursing and occupational therapist documentation. This resulted in discussion and collaboration on development of new forms. An example was also provided by Group G on how documentation related to dialysis has been changed. The nursing and midwifery metrics process had highlighted the difficulty in finding required information as there were ‘sheets and sheets’ of information.

The development of new practice and documentation also encouraged staff to reference any changes to ensure compliance with the Nursing and Midwifery Board of Ireland and other regularly requirements (F).

Changes in documentation transferred into changes in behaviour and approach to care. Examples provided included changes in how consent was obtained, the role of advocacy and the identification and honouring of the ‘rights of service users’ (C, H). Medication management was also identified as an area where practice was changed in an effort to ‘reduce errors’ (D). Group D described how nursing and midwifery metrics had helped to identify issues related to patients ‘not being discontinued from medications’. The participants described how they had been ‘struggling with doctors’ prescriptions’. Metrics provided ‘evidence to support better practice (D) and to ‘get doctors to take the issue seriously’. This resulted in a change in practice and changes to medication charts.

The mental health service participants described how nursing metrics has had a significant impact on practice and has even ‘influenced the model of care’ in use. This has resulted in a move away from a medical
model towards a biopsychosocial model of care (H). Nursing and midwifery metrics highlighted issues around the recording and documentation of care and also the interaction between the service and the user. Nursing and midwifery metrics was seen as playing a pivotal role in stimulating discussion and reflection on core issues around service user involvement in care, capturing information on family involvement and advocacy. Changes in practice include the introduction of care contracts with service users to ensure they are ‘now in charge of their journey’ (H), raising user knowledge about advocacy, and recording of focus group participation. This was seen to have contributed to a change in culture that made service users more visible and listened too. Group H also described how the complaints procedure has now changed and that ‘complaints are now dealt with better’ (H).

Nursing and midwifery metrics were seen as a tool to identify clinical knowledge and training needs (C) within an organisation. In addition Group H also used metrics as a tool to help inform and enhance student learning (H).

The reporting of metrics was seen to have raised greater awareness of nursing and midwifery practice issues and was a catalyst for discussion and reflection amongst nurses/midwives (C, F, G). This theme is summed up by the following statements - ‘metrics is driving improvements in documentation’ (G) and that ‘when results are down, we now ask why, and what are we doing?’ (H)

7.1.6: Theme 6: Usage of metrics system

This theme focused on participants’ experience of using the metrics system and was made up of 6 components (Table 5). The content of this theme was evident in 6 of the 9 focus group sessions.

Table 5: Usage of metrics system

<table>
<thead>
<tr>
<th>Component</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ease of use (5)</td>
<td></td>
</tr>
<tr>
<td>Visual presentation of information (3)</td>
<td></td>
</tr>
<tr>
<td>Speed of access to results /Timeliness of information (12)</td>
<td></td>
</tr>
<tr>
<td>Comparison with previous methods of collecting similar information (6)</td>
<td></td>
</tr>
<tr>
<td>Organisation of results (3)</td>
<td></td>
</tr>
<tr>
<td>Features (6)</td>
<td></td>
</tr>
</tbody>
</table>

Overall, participants expressed a positive experience of using the nursing and midwifery metrics system and would often compare it more favourably than the previous paper based system of audit in place within their organisation. The key areas identified were related to speed of access to results and timeliness of information. Greater efficiency in time and feedback of metric results were integrated into the activity on the ward/unit and results were feedback immediately ensuring the data had meaning and relevance to clinical practice. Examples of the type of comments made included ‘a smooth process that speeds up information in a timely manner … much quicker; print off results and calculations are done… questions are simplistic and user friendly’ (A), ‘… concise, easy to do’ (D) and ‘time saving..’ (E). Due to the ease and localised nature of data collection Group D felt that it wasn’t seen as ‘double jobbing’ as the metrics
were integrated into what happening on the ward. However, Group D indicated that there was a ‘time commitment’ and initially using the metrics was ‘time consuming’ but they indicated that they ‘became faster at doing it’ over time. When comparing it with the previous systems in use within their organisation Group G stated that ‘compared to the previous approach audit and information was available immediately and in real time’. They argued that previously information was ‘never fed back on time’ and that this resulting in the data losing its meaning and relevance. This limited the opportunities for change whereas nursing and midwifery metrics allowed them to ‘properly’ close the ‘loop’. Group G like the fact that it provided information on a monthly rather than a six monthly basis. When describing the ‘old system’, Group A used terms such as ‘ineffective’, ‘laborious’ and ‘tedious’, taking ‘too much time’ and lacking the ‘… appropriate tools to calculate results’. Other groups described the previous system as ‘subjective’ and data collection as ‘piecemeal’ (G). This view was echoed by Group C who argued that nursing and midwifery metrics were a more ‘structured measurement tool’ to measure practice. The features that were highlighted in the nursing and midwifery metrics system were the ability to display monthly charts and graphs (D), that results were all together (A), and the use of percentages in the results (C).
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Appendix 1: Director of Nursing and Midwifery - Consent Form

Nursing and Midwifery Metrics

Consent form

Project: The Nursing and Midwifery Planning & Development NMPD, HSE Dublin North are piloting nursing and midwifery metrics in 12 hospitals within HSE Dublin North. The NMPDU would like to invite healthcare services to participate in an evaluation of the nursing and midwifery metrics pilot project to inform future roll out.

Lead Investigator: Eithne Cusack

Project Officer: Caroline Kavanagh and Dolores Dempsey Ryan

Declaration:
I am happy for my service to participate in the evaluation of nursing and midwifery metrics using qualitative data from our service. No participating service will be identifiable during this study and all data collected will be treated and stored with the strictest of confidence.

Director of Nursing: .......................................................... .......................................................... .......................................................... ..........................................................

Name of Service: .......................................................... .......................................................... .......................................................... ..........................................................

Date: ..........................................................
Appendix 2: Participant Consent Form

Nursing and Midwifery Metrics

Consent form - Focus groups

Project: The Nursing and Midwifery Planning and Development at the HSE Dublin North are piloting nursing and midwifery metrics in 12 hospitals. Collecting nursing and midwifery metrics data provides opportunities for nurses and midwives to deliver a particular standard of care that is safe, evidence based and congruent with legislative and national policies. The NMPD would like to invite relevant nursing staff to participate in a qualitative evaluation of the nursing and midwifery metrics pilot project.

Lead Investigator: Eithne Cusack

Project Officer: Caroline Kavanagh and Dolores Dempsey Ryan

Declaration:
I have read, or had read to me, the information letter and I understand the contents. I have had the opportunity to ask questions and my questions have been answered to my satisfaction. I freely and voluntarily agree to be part of this study, through without prejudice to my legal and ethical rights. I understand that I may withdraw from the study at any time.

Participant name: .................................................................................................................................

Email Address: ........................................................................................................................................

Participant’s signature: ............................................................................................................................

Date: ........................................................................