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| **Workbook 2023** |
| **Public Health Nursing (PHN) / Community Registered General Nurse (CRGN) Metrics and Definitions/2023** |

This workbook is to be used when entering 2023 primary care activity metrics. It provides the metric wording and definitions for all ages and care groups for return of clinical activity.

Metric returns capture **Caseload Activity** and should include all activity delivered over a seven-day service including bank holidays.

The Primary Care metrics software system (PCM) was introduced in 2021 to support the collection of primary care activity metrics by PHNs, CRGNs and HCA.s. Each nurse/HCA is assigned to a designated caseload within PCM and is issued with a unique username and password for that caseload. Activity can be entered using a desktop, laptop or smart phone. Daily activity entry is encouraged. PHNs or CRGNs working across several caseloads will have access to all relevant caseloads. Health Care Assistant (HCA) activity should be included where appropriate (where HCA under the governance of PHN service).

***All nurses (CRGNs and PHNs) are responsible to return their own activity in the caseload(s). The caseload holders account can be identified on the software system.***

In the event that an area is vacant due to annual leave or long term sick / maternity leave, agreement must be made with line management which caseload holder/s are responsible for entering the activity data into PCM for the cross cover period.

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Developed by PHN Metric Sub Group **Version 7 April 2023**

PHN/CRGN may also be required to make a separate return in respect of child and maternal services and clinical governance of home help services as these metrics do not record this work..**2nd tier specialist clinical activity** should continue to be returned as per local policy and **is not returned in primary care metric activity.**

| Primary Care – Public Health Nursing / Community Registered General Nurse Metrics and Definitions | | | | |
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| Age bands\* | | | | * 0 – 4 years i.e. 0-4 years 11 months * 5 –17 years i.e. 5 years to 17 years 11 months * 18 – 64 years i.e. 18 years to 64 years 11 months * 65 years and over i.e. 65 years and older. |
| Settings\*\* | | | | * Domiciliary setting * Primary care centre or health centre * Other settings to include: day centre, nursing home / acute hospital services, hotels and hostels etc. e.g. to complete a Common Summary Assessment Record (CSAR) / discharge planning. |
| **Care Group 65 Years and Over** | | | | |
|  | | **Number of patient referrals accepted** in the reporting month: 65 years and over | | 1. This is a count of the **number of patient referrals** aged 65 years and over\*, received and **accepted onto** the area PHN /CRGN **caseload** in the reporting month. Ensure that each patient referred is only counted once   Preliminary screening of referrals should be undertaken in a timely manner and prioritised following clinical judgement and according to National Policy: ‘Management of Referrals accepted to the PHN caseload.’  Include:   1. new referrals (including self-referrals) 2. re-referrals (i.e. previously discharged) 3. referrals for patients transferred from other service areas or teams.   **Exclude**   1. Duplicate referrals received for same patients eg referral from OT and acute hospital/only count as one referral 2. Don’t count referrals for patients already on the caseload eg from Physio for a continence assessment if patient already on the caseload.     Each referral should be date stamped on the day it is received and this is recorded as the referral date. Self-referrals should be documented in desk diary or alternative local systems. |
|  | | Number of patient **referrals not accepted:** 65 years and over | | This is a count of the **patient referrals**, aged 65 years and over\*, received in the reporting month that have **not been accepted** onto the caseload. Each referral should be date stamped on the day it is received and this is recorded as the referral date. Self-referrals should be documented in desk diary or alternative local systems. It may include:   * inappropriate referrals * referrals for patients that do not require a PHN service * referrals where the patient declines the service. |
|  | | \*Number of **new patients seen** in the reporting month (face to face contact\*): 65 years and over | | This is a count of the **number of new patients,** aged 65 years and over\*, **seen** (i.e. had face to face contact with the PHN / CRGN **by setting**\*\* in the reporting month.  A ‘new patient’ is defined as a patient who is not currently known to the service and is seen for the first time in this episode of care.  **Count** the number of **new patients only** not the number of patient contacts.  Include:   1. new patients, including self-referrals (i.e. not known to the service and seen for the first time in this episode of care) 2. re-referrals (i.e. previously discharged) 3. new patients who had a joint visit i.e. where two professionals visit a patient simultaneously.   **\***Reference in these metrics to being seen is inclusive of being seen face to face or by telephone, video or audio conferencing. |
|  | | Number of **existing patients** on caseload **seen** (face to face contact): 65 years and over | | This is a count of the **number of existing** patients aged 65 and over\*, already on the caseload who were **seen for the first time this month** (i.e. had face to face contact with the PHN / CRGN / HCA.  An ‘existing patient’ is defined as a patient who is currently in receipt of a PHN service from a PHN / CRGN / HCA and who receives a direct contact (face to face) service.  **Each individual patient / person from caseload is only counted once.**  **Total face to face contacts are counted in a separate metric.**  Include: patients who: (i) attended (a) individual appointments (b) group sessions (ii) had a joint visit i.e. where two professionals visit a patient simultaneously.  Exclude: new patients seen in the reporting month. |
|  | | Number of **patients discharged**: 65 years and over | | This is a count of the **patients** aged 65 years and over\*, **discharged** from the PHN / CRGN caseload during the reporting month.  Patients are defined as being discharged when all episodes of care are concluded / their care plan is closed and there are no outstanding review dates It is. Important to record patient discharge as soon as information is available to the PHN / CRGN.  Include patients:   1. whose episodes of care are concluded / their care plans are closed with no outstanding review dates 2. admitted to acute services / long term care / secondary community support services e.g. community rehabilitation service 3. who have died.   Exclude patients:   1. admitted for respite care.   Note: The term ‘inactive caseload’ is no longer applicable; a case is either active or discharged. |
|  | | Number of new **patients accepted onto the caseload and seen** in the previous 12 weeks: 65 years and over.  (This data is required to calculate waiting list metric) | | This is a count of the number of new patients (aged 65 years and over\*) who have been **accepted** onto the caseload **and have been seen** by the PHN / CRGN in the previous 12 weeks (3 calendar months).  The total number equals all new patients accepted onto the caseload and seen in the reporting month plus all new patients accepted onto the caseload and seen in the preceding two months e.g. for the reporting month of March, add the new patients accepted onto the caseload and seen in March plus the new patients accepted onto the caseload and seen in February, plus the new patients accepted onto the caseload and seen in January, to give a 12 week total of new patients accepted and seen onto the caseload.  Note: for the purposes of calculating waiting list metric data a patient must be accepted onto the caseload and discharged to home. |
|  | | Number of new **patients accepted onto the caseload** in the previous 12 weeks: 65 years and over  (This data is required to calculate waiting list metric) | | This is a count of the number of new patients (aged 65 years and over\*) who have **been accepted onto the caseload** in the previous 12 weeks (3 calendar months).  The total number equals all new patients accepted onto the caseload in the reporting month plus all new patients accepted onto the caseload in the preceding two months e.g. for the reporting month of March, add the new patients accepted onto the caseload in March plus the new patients accepted onto the caseload in February, plus the new patients accepted onto the caseload in January, to give a 12 week total of new patients accepted onto the caseload. |
| **Care Group under 65 Years (Excludes Disabilities) Age Group 18 – 64 years** | | | | |
|  | Number of patient **referrals accepted** in the reporting month: 18 – 64 years | | | 1. This is a count of the **number of patient referrals** aged 18 – 64 years\*, received and **accepted onto** the area PHN / CRGN **caseload** in the reporting month. Preliminary screening of referrals should be undertaken in a timely manner and prioritised following clinical judgement and according to the National Policy: Management of Referrals accepted to the PHN caseload   Ensure that each patient referred is only counted once  Include:   1. new referrals (including self-referrals) 2. re-referrals (i.e. previously discharged) 3. referrals for patients transferred from other service areas or teams 4. referrals for post natal mothers   **Exclude:**   1. referrals for patients with a physical / sensory / intellectual disability, aged 18–64 years\* who are recorded in the patients with a disability 18–-64 years\* category. 2. Duplicate referrals received for same patients e.g. referral from OT and acute hospital/only count as one referral 3. Don’t count referrals for patients already on the caseload e.g. from Physio for a continence assessment if patient already on the caseload.   Each referral should be date stamped on the day it is received and this is recorded as the referral date. Self-referrals should be documented in desk diary or alternative local systems. |
|  | Number of patient **referrals not accepted**: 18 – 64 years | | | This is a count of the **patient referrals**, aged 18–64 years\*, received in the reporting month that have **not been accepted** onto the caseload. Each referral should be date stamped on the day it is received and this is used as the referral date. Self-referrals should be documented in desk diary or alternative local systems.  It may include:   * inappropriate referrals * referrals for patients that do not require a PHN service * referrals where the patient declines the service. |
|  | Number of **new patients seen** in the reporting month (face to face contact\*): 18 – 64 years | | | This is a count of the **number of new patients,** aged 18-64 years\*, **seen by setting** (i.e. had face to face contact with the PHN / CRGN) in the reporting month.  A ‘new patient’ is defined as a patient who is not currently known to the service and is seen for the first time in this episode of care.  **Count** the number of **new patients only** not the number of patient contacts.  Include:   * 1. new patients, including self referrals (i.e. not known to the service and seen for the first time in this episode of care)   2. re-referrals (i.e. previously discharged)   3. new patients who attended (a) individual appointments and (b) group sessions   4. new patients who had a joint visit i.e. where two professionals visit a patient simultaneously.   \*Reference in these metrics to being seen is inclusive of being seen face to face or by telephone, video or audio conferencing |
|  | Number of **existing patients** on caseload **seen** (face to face contact): 18 - 64 years | | | This is a count of the **number of existing patients**, aged 18 - 64 years\*, already on the caseload who were **seen for the first time this month** (i.e. had face to face contact with the PHN / CRGN/ HCA)  An ‘existing patient’ is defined as a patient who is currently in receipt of a PHN service from a PHN / CRGN and who receives a direct contact (face to face) service as part of an existing episode of care in the reporting month.  **Each individual person from caseload is only counted once. Total face to face contacts are counted in separate metric**  Include: patients who: (i) attended (a) individual appointments (b) group sessions  (ii) had a joint visit i.e. where two professionals visit a patient simultaneously.  Exclude: new patient seen in the reporting month. |
|  | Number of patients **discharged**: 18 - 64 years\* | | | This is a count of the **patients**, aged 18 - 64 years\*, **discharged** from the PHN / CRGN active caseload during the reporting month.  Patients are defined as being discharged when all episodes of care are concluded / their care plan is closed and there are no outstanding review dates. It is important to record patient discharge as soon as information is available to the PHN / CRGN.  Include patients:   1. whose episodes of care are concluded / their care plans are closed with no outstanding review dates including / post natal mothers discharged 2. admitted / transferred to acute services / long term care / secondary community support services e.g. community rehabilitation service 3. who have died.   Note: The term ‘inactive caseload’ is no longer applicable; a case is either active or discharged. |
|  | Number of new patients **accepted onto the caseload and seen** in the previous 12 weeks: 18-64 years  (This data is required to calculate waiting list metric) | | | This is a count of the number of new patients (aged 18-64 years\*) who have been **accepted** onto the caseload **and have been seen** by the PHN / RGN in the previous 12 weeks (3 calendar months).  The total number equals all new patients accepted onto the caseload and seen in the reporting month plus all new patients accepted onto the caseload and seen in the preceding two months e.g. for the reporting month of March, add the new patients accepted onto the caseload and seen in March plus the new patients accepted onto the caseload and seen in February, plus the new patients accepted onto the caseload and seen in January, to give a 12 week total of new patients accepted and seen onto the caseload.  Note: for the purposes of calculating waiting list metric data a patient must be accepted to caseload and discharged to home. |
|  | Number of new patients **accepted onto the caseload** in the previous 12 weeks: 18 - 64 years  (This data is required to calculate waiting list metric) | | | This is a count of the number of new patients (aged 18-64 years\*) who have **been accepted onto the caseload** in the previous 12 weeks (3 calendar months).  The total number equals all new patients accepted onto the caseload in the reporting month and all new patients accepted in the preceding two months e.g. for the reporting month of March, add the new patients accepted onto the caseload in March plus the new patients accepted onto the caseload in February, plus the new patients accepted onto the caseload in January, to give a 12 week total of new patients accepted onto the caseload. |
| **Care Group under 65 Years (Excludes Disabilities) Age Group 5-17 years** | | | | |
|  | Number of patient referrals **accepted** in the reporting month: 5 – 17 years | | | 1. This is a count of the **patient referrals**, aged 15 – 17 years\*, received and **accepted onto** the area PHN / CRGN **caseload** in the reporting month. Preliminary screening of referrals should be undertaken in a timely manner and prioritised following clinical judgement and according to the National Policy: Management of Referrals accepted to the PHN caseload   . Ensure that each patient referred is only counted once  Include:   1. new referrals (including self-referrals) 2. re-referrals (i.e. previously discharged) 3. referrals for patients transferred from other service areas or teams 4. referrals of post-natal mothers   **Exclude:**   1. referrals for children under core screening programme 2. child welfare and protection referrals 3. referrals for patients with a physical / sensory / intellectual disability, aged 5 – 17 years\* who are recorded in the patients with a disability 5-17 years\* category. 4. Duplicate referrals received for same patients e.g. referral from OT and acute hospital/only count as one referral 5. Don’t count referrals for patients already on the caseload e.g. from Physio for a continence assessment if patient already on the caseload.   Each referral should be date stamped on the day it is received and this is recorded as the referral date. Self-referrals should be documented in desk diary or alternative local systems. |
|  | Number of patients referrals **not accepted**: 5 – 17 years | | | This is a count of the **patient referrals**, aged 5 – 17 years\*, received in the reporting month that have **not been accepted** onto the caseload.: Each referral should be date stamped on the day it is received and this is recorded as the referral date.  It may include   * inappropriate referrals * referrals for patients that do not require a PHN service * referrals where the patient / parent / guardian declines the service. |
|  | Number of **new patients seen** in the reporting month (face to face contact \*): 5 -17 years | | | This is a count of **the number of new patients,** aged 5 -17 years\*, **seen by setting** (i.e. had face to face contact with the PHN / CRGN) in the reporting month.  A ‘new patient’ is defined as a patient who is not currently known to the service and is seen for the first time in this episode of care.  **Count** the number of **new patients only** not the number of patient contacts.  Include:   1. new patients, including self-referrals (i.e. not known to the service and seen for the first time in this episode of care) 2. re-referrals (i.e. previously discharged) 3. new patients who had a joint visit i.e. where two professionals visit a patient simultaneously.   \*Reference in these metrics to being seen is inclusive of being seen face to face or by telephone, video or audio conferencing. |
|  | Number of **existing patients** on caseload **seen** (face to face contact): 5 – 17 years\* | | | This is a count of the **number of existing patients**, aged 5 – 17 years\*, already on the caseload who were **seen for the first time this month** (i.e. had face to face contact with the PHN / CRGN / HCA)  An ‘existing patient’ is defined as a patient / child who is currently in receipt of a PHN service from a PHN / CRGN and who receives a direct contact (face to face) service as part of an existing episode of care in the reporting month.  **Each individual person from caseload is only counted once. Total face to face contacts are counted in a separate metric.**  Include: patients who: (i) attended (a) individual appointments (b) group sessions (ii) had a joint visit i.e. where two professionals visit a patient simultaneously.  Exclude: new patients seen in the reporting month. |
|  | Number of patients **discharged**: 5- 17 years | | | This is a count of the **patients,** aged 5- 17 years\*, **discharged** from the PHN / CRGN caseload during the reporting month.  Patients are defined as being discharged when all episodes of care are concluded / their care plan is closed and there are no outstanding review dates. It is. Important to record patient discharge as soon as information is available to the PHN / CRGN.  Include patients:   1. whose episodes of care are concluded / their care plans are closed with no outstanding review dates including post natal mothers discharged 2. admitted / transferred to acute services 3. who have died.   Note: The term ‘inactive caseload’ is no longer applicable; a case is either active or discharged. |
|  | Number of new patients **accepted onto the caseload and seen** in the previous 12 weeks: 5-17 years  (This data is required to calculate waiting list metric) | | | This is a count of the number of new patients (aged 5-17 years\*) who have been **accepted** onto the caseload **and have been seen** by the PHN / CRGN in the previous 12 weeks (3 calendar months).  The total number equals all new patients accepted onto the caseload and seen in the reporting month plus all new patients accepted onto the caseload and seen in the preceding two months e.g. for the reporting month of March, add the new patients accepted onto the caseload and seen in March plus the new patients accepted onto the caseload and seen in February, plus the new patients accepted onto the caseload and seen in January, to give a 12 week total of new patients accepted and seen onto the caseload.  Note: for the purposes of calculating waiting list metric data a patient must be accepted to caseload and discharged to home. |
|  | Number of new patients **accepted onto the caseload** in the previous 12 weeks: 5-17 years  (This data is required to calculate waiting list metric) | | | This is a count of the number of new patients (aged 5-17 years\*) who have **been accepted onto the caseload** in the previous 12 weeks (3 calendar months).  The total number equals all new patients accepted onto the caseload in the reporting month plus all new patients accepted in the preceding two months e.g. for the reporting month of March, add the new patients accepted onto the caseload in March plus the new patients accepted onto the caseload in February, plus the new patients accepted onto the caseload in January, to give a 12 week total of new patients accepted onto the caseload. |
| **Patients with a disability (physical / sensory / intellectual) Aged 18 - 64 years**\* | | | | |
|  | Number of **patient referrals**  with a disability **accepted** in the reporting month: 18 – 64 years | | | 1. This is a count of the **number of patient referrals**, with a formal diagnosis of physical / sensory / intellectual disability, aged 18 – 64 years\*, received and **accepted onto** the area PHN / CRGN caseloadin the reporting month. Preliminary screening of referrals should be undertaken in a timely manner and prioritised following clinical judgement and according to the National Policy: Management of Referrals accepted to the PHN caseload. 2. Ensure that each patient referred is only counted once   **Include:**   1. new referrals (including new self-referrals) 2. re-referrals (i.e. previously discharged) 3. referrals for patients transferred from other service areas or teams.   **Exclude**   1. Duplicate referrals received for same patients e.g. referral from OT and acute hospital/only count as one referral 2. Don’t count referrals for patients already on the caseload e.g. from Physio for a continence assessment if patient already on the caseload.   Each referral should be date stamped on the day it is received and this is recorded as the referral date. Self-referrals should be documented in desk diary or alternative local systems. |
|  | Number of **patient referrals** with a disability **not accepted**: 18 – 64 years | | | This is a count of **patient referrals**, with a formal diagnosis of physical / sensory / intellectual disability, aged 18 – 64 years\*, received in the reporting month that **have not been accepted** onto the caseload. It may include:   * inappropriate referrals * referrals for patients that do not require a PHN service * referrals where the patient declines the service.   Each referral should be date stamped on the day it is received and this is recorded as the referral date. Self-referrals should be documented in desk diary or alternative local systems. |
|  | Number of **new patients** with a disability **seen** in the reporting month (face to face contact\*):18 – 64 years | | | This is a count of the **number of new patients,** with a formal diagnosis of physical / sensory / intellectual disability, aged 18– 64 years\*, **seen** **by setting** (i.e. had face to face contact with the PHN / CRGN) in the reporting month.  A ‘new patient’ is defined as a patient who is not currently known to the service and is seen for the first time in this episode of care.  **Count** the number of **new patients only** not the number of patient contacts.  Include:   1. new patients, including self-referrals (i.e. not known to the service and seen for the first time in this episode of care) 2. re-referrals (i.e. previously discharged) 3. new patients who attended (a) individual appointments and (b) group sessions 4. new patients who had a joint visit i.e. where two professionals visit a patient simultaneously.   \*Reference in these metrics to being seen is inclusive of being seen face to face or by telephone, video or audio conferencing. |
|  | Number of **existing patients** on caseload with a disability **seen** (face to face contact): 18 – 64 years | | | This is a count of the **number of existing patients**, with a formal diagnosis of physical / sensory / intellectual disability, aged 18 – 64 years\*, already on the caseload who **were seen for the first time this month** (i.e. had face to face contact with the PHN / CRGN / HCA)  An ‘existing patient’ is defined as a patient who is currently in receipt of a PHN service from a PHN / CRGN / HCA and who receives a direct contact (face to face) service as part of an existing episode of care in the reporting month.  **Each individual person from caseload is only counted once. Total face to face contacts are counted in a separate metric.**  Include: patients who: (i) attended (a) individual appointments (b) group sessions  (ii) had a joint visit i.e. where two professionals visit a patient simultaneously.  Exclude: new patient seen in the reporting month. |
|  | Number of patientswith a disability **discharged:** 18 – 64 years | | | This is a count of the **patients**, with a formal diagnosis of physical / sensory / intellectual disability, aged 18 – 64 years\*, **discharged** from the PHN / CRGN caseload during the reporting month.  Patients are defined as being discharged when all episodes of care are concluded / their care plan is closed and there are no outstanding review dates. It is. Important to record patient discharge as soon as information is available to the PHN / CRGN.  Include patients:   1. whose episodes of care are concluded / their care plans are closed with no outstanding review dates 2. admitted to acute services / long term care / secondary community support services e.g. community rehabilitation service 3. patients who have died.   Exclude patients:   1. admitted for respite care.   Note: The term ‘inactive caseload’ is no longer applicable; a case is either active or discharged. |
|  | Number of new patients with a disability **accepted onto the caseload and seen** in the previous 12 weeks: 18 - 64 years  (This data is required to calculate waiting list metric) | | | This is a count of the number of new patients with a formal diagnosis of disability (aged 18-64 years\*) who have been **accepted** onto the caseload **and have been seen** by the PHN / CRGN in the previous 12 weeks (3 calendar months).  The total number equals all new patients accepted onto the caseload and seen in the reporting month plus all new patients accepted onto the caseload and seen in the preceding two months e.g. for the reporting month of March, add the new patients accepted onto the caseload and seen in March plus the new patients accepted onto the caseload and seen in February, plus the new patients accepted onto the caseload and seen in January, to give a 12 week total of new patients accepted and seen onto the caseload.  Note: for the purposes of calculating waiting list metric data a patient must be accepted to caseload and discharged to home. |
|  | Number of new patients with a disability **accepted onto the caseload** in the previous 12 weeks: 18 - 64 years  (This data is required to calculate waiting list metric) | | | This is a count of the number of new patients with a formal diagnosis of disability (aged 18 - 64 years\*) who have **been accepted onto the caseload** in the previous 12 weeks (3 calendar months).  The total number equals all new patients accepted onto the caseload in the reporting month plus all new patients accepted onto the caseload in the preceding two months e.g. for the reporting month of March, add the new patients accepted onto the caseload in March plus the new patients accepted onto the caseload in February, plus the new patients accepted onto the caseload in January, to give a 12 week total of new patients accepted onto the caseload. |
| **Patients with a disability under 65 years of age (physical / sensory / intellectual) Aged 5 -17 years** | | | | |
|  | Number of **patient referrals** with a disability **accepted** in the reporting month: 5 – 17 years | | | 1. This is a count of the **number of patient referrals** with a formal diagnosis of physical / sensory / intellectual disability, aged 5 – 17 years\*, received and **accepted onto** the area PHN / CRGN **caseload** in the reporting month. Preliminary screening of referrals should be undertaken in a timely manner and prioritised following clinical judgement. Ensure that each patient referred and according to the National Policy: Management of Referrals accepted to the PHN caseload.      1. is only counted once   I**nclude:**   1. new referrals (including new self-referrals) 2. re-referrals (i.e. previously discharged) 3. referrals for patients transferred from other service areas or teams.   **Exclude:**   1. Child welfare and protection referrals 2. Duplicate referrals received for same patients e.g. referral from OT and acute hospital/only count as one referral 3. Don’t count referrals for patients already on the caseload e.g. from Physio for a continence assessment if patient already on the caseload.   Each accepted referral should be date stamped on the day it is received and this is recorded as the referral date. Self-referrals should be documented in desk diary or alternative local systems. |
|  | Number of patient referralswith a disability **not accepted**: 5 – 17 years | | | This is a count of the **patient referrals** with a formal diagnosis of physical / sensory / intellectual disability, aged 5 – 17 years\*, received in the reporting month that **have not been accepted** onto the caseload.  It may include:   * inappropriate referrals * referrals for patients that do not require a PHN service * referrals where the patient / parent / guardian declines the service.   Each referral should be date stamped on the day it is received and this is recorded as the referral date. Self-referrals should be documented in desk diary or alternative local systems. |
|  | Number of **new patients** with a disability **seen** in the reporting month (face to face contact\*): 5 -17 years | | | This is a count of the **number of new patients,** with a formal diagnosis of physical / sensory / intellectual disability, aged 5 – 17 years\*, **seen** **by setting** (i.e. had face to face contact with the PHN / CRGN) in the reporting month.  A ‘new patient’ is defined as a patient who is not currently known to the service and is seen for the first time in this episode of care.  **Count** the number of **new patients only** not the number of patient contacts.  Include:   1. new patients, including self-referrals (i.e. not known to the service and seen for the first time in this episode of care) 2. re-referrals (i.e. previously discharged) 3. new patients who attended (a) individual appointments and (b) group sessions 4. new patients who had a joint visit i.e. where two professionals visit a patient simultaneously.   \*Reference in these metrics to being seen is inclusive of being seen face to face or by telephone, video or audio conferencing. |
|  | Number of **existing patients** on caseload with a disability **seen** (face to face contact): 5 – 17 years | | | This is a count of the **number of existing patients**, with a formal diagnosis of physical / sensory / intellectual disability, aged 5 – 17 years\*, already on the caseload who were **seen for the first time this month** (i.e. had face to face contact with the PHN / CRGN / HCA)  An ‘existing patient’ is defined as a patient / child who is currently in receipt of a PHN service from a PHN / CRGN and who receives a direct contact (face to face) service as part of an existing episode of care in the reporting month.  **Each individual person from caseload is only counted once. Total face to face contacts are counted in separate metric.**  Include: patients who: (i) attended (a) individual appointments (b) group sessions (ii) had a joint visit i.e. where two professionals visit a patient simultaneously.  Exclude: new patient seen in the reporting month |
|  | Number of patientswith a disability **discharged**: 5 - 17 years | | | This is a count of the **number of patients,** with a formal diagnosis physical / sensory / intellectual disability, aged 5 – 17 years\*, **discharged** from the PHN / CRGN caseload during the reporting month.  Patients are defined as being discharged when all episodes of care are concluded / their care plan is closed and there are no outstanding review dates. It is important to record patient discharge as soon as information is available to the PHN / CRGN.  Include patients:   1. whose episodes of care are concluded / their care plans are closed with no outstanding review dates 2. admitted to acute services /residential care 3. who have died.   Exclude patients:   1. admitted for respite care.   Note: The term ‘inactive caseload’ is no longer applicable; a case is either active or discharged. |
|  | Number of new patients with a disability **accepted onto the caseload and seen** in the previous 12 weeks: 5-17 years  (This data is required to calculate waiting list metric) | | | This is a count of the number of new patients with a disability (aged 5 -17 years\*) who have been **accepted** onto the caseload **and have been seen** by the PHN /CRGN in the previous 12 weeks (3 calendar months).  The total number equals all new patients accepted onto the caseload and seen in the reporting month plus all new patients accepted onto the caseload and seen in the preceding two months e.g. for the reporting month of March, add the new patients accepted onto the caseload and seen in March plus the new patients accepted onto the caseload and seen in February, plus the new patients accepted onto the caseload and seen in January, to give a 12 week total of new patients accepted and seen onto the caseload.  Note: for the purposes of calculating waiting list metric data a patient must be accepted to caseload and discharged to home. |
|  | Number of new patients with a disability **accepted onto the caseload** in the previous 12 weeks: 5-17 years  (This data is required to calculate waiting list metric) | | | This is a count of the number of new patients with a disability (aged 5-17 years\*) who have **been accepted onto the caseload** in the previous 12 weeks (3 calendar months).  The total number equals all new patients accepted onto the caseload in the reporting month plus all new patients accepted onto the caseload in the preceding two months e.g. for the reporting month of March, add the new patients accepted onto the caseload in March plus the new patients accepted onto the caseload in February, plus the new patients accepted onto the caseload in January, to give a 12 week total of new patients accepted onto the caseload. |
| **Clinical Nursing Activity for Sick Children Aged 0 to 4 Years and 11 months of Age** | | | | |
|  | Number of **children** requiring clinical nursing **accepted** in the reporting month: 0 - 4 years | | | 1. This is a count of the **number of patient referral** with clinical nursing needs, aged 0-4 years\*, received and **accepted onto** the area PHN / CRGN **caseload** in the reporting month. Preliminary screening of referrals should be undertaken in a timely manner and prioritised following clinical judgement and according to the National Policy: Management of referrals accepted to the PHN caseload.   . Ensure that each patient referred is only counted once  Include:   1. new referrals 2. re-referrals (i.e. previously discharged) 3. referrals for children transferred from other service areas or teams.   Exclude:   1. referrals for children under core child health screening and surveillance programme / child welfare and protection. 2. New Born Bloodspot Screening. 3. Exclude children with minor ailments/sticky eyes, sticky cords, jaundice review etc 4. Duplicate referrals received for same patients e.g. referral from OT and acute hospital/only count as one referral 5. Don’t count referrals for patients already on the caseload e.g. from Physio for a continence assessment if patient already on the caseload.   Each accepted referral should be date stamped on the day it is received and this is recorded as the referral date. |
|  | Number of **children** requiring clinical nursing referred not accepted in the reporting month**:** 0 - 4 years | | | This is a count of **referrals** for children requiring clinical nursing, aged 0-4 years\*, received in the reporting month that **have not been accepted** onto the caseload.  Each accepted referral should be date stamped on the day it is received and this is recorded as the referral date.  It may include:   * inappropriate referrals * referrals for children that do not require a PHN service * referrals where the child / parent / guardian declines the service. |
|  | Number of **new** children requiring clinical nursing **seen** in the reporting month (face to face contact\*): 0 - 4 years | | | This is a count of the **number of** **new** children requiring clinical nursing, aged 0-4 years\*, **seen by setting** (i.e. had face to face contact with the PHN / CRGN in the reporting month.  A ‘new child’ is defined as a child who is not currently known to the service and is seen for the first time in this episode of care.  **Count** the number of **new children only** not the number of child contacts.  Include:   * 1. new children (i.e. not known to the service and seen for the first time in this episode of care)   2. re-referrals (i.e. previously discharged)   3. new children who had a joint visit i.e. where two professionals visit a child simultaneously.   \*Reference in these metrics to being seen is inclusive of being seen face to face or by telephone, video or audio conferencing. |
|  | Number of **existing** children requiring clinical nursing on caseload **seen** (face to face contact) in the reporting month: 0 - 4 years | | | This is a count of the **number of existing children** requiring clinical nursing, aged 0-4 years\*, already on the caseload who were **seen for the first time this month** (i.e. had face to face contact with the PHN / CRGN / HCA)  An ‘existing child’ is defined as a child who is currently in receipt of a PHN service from a PHN / RGN / HCA and who receives a direct contact (face to face) service as part of an existing episode of care in the reporting month.  **Each individual child from caseload is only counted once.**  **Total face to face contacts are counted in a separate metric.**  Include: children who: (i) attended (a) individual appointments (b) group sessions (ii) had a joint visit i.e. where two professionals visit a patient simultaneously.  Exclude: new patients seen in the reporting month. |
|  | **Number of** children requiring clinical nursing **discharged**: 0 - 4 years | | | This is a count of the **number of children** requiring clinical nursing, aged 0-4 years\*, **discharged** from the PHN / CRGN caseload during the reporting month.  Children are defined as being discharged when all episodes of care are concluded / their care plan is closed and there are no outstanding review dates. It is important to record patient discharge as soon as information is available to the PHN / CRGN.  Include children:   1. whose episodes of care are concluded / their care plans are closed with no outstanding review dates 2. admitted to acute services / residential care 3. who have died.   Exclude children:   1. admitted for respite care.   Note: The term ‘inactive caseload’ is no longer applicable; a case is either active or discharged. |
|  | Number of new children requiring clinical nursing **accepted onto the caseload and seen** in the previous 12 weeks: 0-4 years  (This data is required to calculate waiting list metric) | | | This is a count of the number of new children requiring clinical nursing (aged 0 -4 years\*) who have been **accepted** onto the caseload **and have been seen** by the PHN / CRGN in the previous 12 weeks (3 calendar months).  The total number equals all new children accepted onto the caseload and seen in the reporting month plus all new children accepted onto the caseload and seen in the preceding two months e.g. for the reporting month of March, add the new children accepted onto the caseload and seen in March plus the new children accepted onto the caseload and seen in February, plus the new children accepted onto the caseload and seen in January, to give a 12 week total of new children accepted and seen onto the caseload.  Note: for the purposes of calculating waiting list metric data a child must be accepted to caseload and discharged to home. |
|  | Number of new children requiring clinical nursing **accepted onto the caseload** in the previous 12 weeks: 0-4 years  (This data is required to calculate waiting list metric) | | | This is a count of the number of new children requiring clinical nursing (aged 0 -4 years\*) who have **been accepted onto the caseload** in the previous 12 weeks (3 calendar months).  The total number equals all new children accepted onto the caseload in the reporting month plus all new children accepted onto the caseload in the preceding two months e.g. for the reporting month of March, add the new children accepted onto the caseload in March plus the new children accepted onto the caseload in February, plus the new children accepted onto the caseload in January, to give a 12 week total of new children accepted onto the caseload. |
| **Contact Visits (Face to Face) All Ages and Care Groups Existing Patients** | | | | |
|  | | | Number of **face to face contacts** that took place in the reporting month by setting | This is a count of the total number of **direct face to face contacts with patients, by setting**\*\*, that took place in the reporting month.  Direct face to face contacts are contacts with a patient where there is interaction in a direct way and not via a phone video or audio conferencing or, e-mail, etc. Contacts may be on an individual, group or joint basis. A joint visit is defined as a visit where two professionals visit a patient simultaneously. If two nurses attend a patient count as two contacts, but one patient If the contact is with a new patient accepted to the caseload only count one patient accepted.  Group contacts i.e. contacts that take place in a group setting e.g. a health promotion group with 6 older persons is recorded as 6 contacts. If the group is facilitated by two nurses the 6 contacts may be divided and activity returned by the two nurses ensuring avoidance of any double counting i.e. recording not to exceed 6.  Contacts include:   * individual, group or joint visit contacts * return contacts (including multiple contacts in the same day) * contacts at weekends / bank holidays undertaken by weekend PHN / CRGN * preliminary face to face screening of referrals not yet accepted onto the nursing caseload * contacts in respect of each individual on a caseload seen as part of a home visit * contacts as part of a multi-disciplinary assessment * contacts in a Day Centre * postnatal contacts (including postnatal depression screening / listening visits) * contacts with children with clinical nursing needs * contacts by HCA / Attendant (HSE employed and under governance of PHN service) for care delegated by PHN / CRGN to HCA / Attendant. * Nursing Interventions includes assessment/planning provision of a nursing intervention/evaluation/review/referrals to other services   Exclude:   * contacts for first time assessment (recorded as new patients seen) * specialist service contacts including:   + those performed within the school screening or school immunisation programme   + breastfeeding support groups and antenatal classes * 2nd level clinics e.g. specialist leg ulcer and specialist continence clinics. |
|  | | | **Phone Video or Audio conferencing contacts (all ages and care groups) Existing patients** | |
|  | | | Number of PHN contacts with patients by phone, video or audio conferencing | A PHN telephone, video or audio conferencing contact is a patient contact delivered by telephone / video / audio conferencing (e.g. Attend Anywhere, Webex, etc) for the purposes of undertaking an assessment / intervention or / follow up.  Include telephone, video or audio conferencing contacts:   * for the purpose of undertaking assessments / intervention for new patients * for the purpose of undertaking re-assessment, interventions or follow up actions for existing patients * for scheduled patient review. * with a mother as per maternal care plan relating to maternal health issues as   part of:   1. the maternal postnatal visit 2. 3-month visit 3. listening visits 4. follow up visits.   Exclude   * Any face to face contacts * Contacts by telephone, video or audio conferencing with the patient or with family   member’s / team members / other professionals etc.inrelation to that patient  solely for the purposes of:  (i) arranging appointments  (ii) ordering or organising resources / equipment  (iii) liaising with other agencies e.g. home support agencies or private care providers  (iv) liaising with hospitals regarding admission or discharge   1. preparing written letters or reports.eg social report re vulnerable adult   ***(return all above as indirect interventions)*** |
| **Indirect Interventions / All Ages and Care Groups** | | | | |
|  | Number of **indirect interventions** in the reporting month | | | This is a count of the number of **indirect interventions** relating to patients **provided in all settings\***\* in the reporting/ month.  Indirect interventions:   1. can be non-face to face in nature i.e. via phone, video, audio conferencing or, e-mail, written, etc. 2. face to face with families, carers or home support staff etc. 3. are **meaningful** interventions i.e. **require recording in a patient file** as they are regarded as significant / important in relation to the patient whose case is active or pending, or where a referral to the service is pending 4. should be at least of **15 minutes’ duration**   Include:   1. report writing e.g. written report for social workers / vulnerable adult services 2. equipment organisation and ordering for individual patients 3. phone call discussions relating to a named patient with team members / other professionals / family member etc. 4. liaison with other agencies e.g. voluntary or private home care agencies 5. liaison with hospital pre and post discharge 6. attendance at primary care meetings and professional meetings / case discussions 7. contacts by individuals attending at primary care centres / health centres for information / advice   (viii) no access for planned domiciliary visits.  Exclude:   1. casual conversations / discussions about a patient 2. client assessment 3. care planning 4. referrals / arranging appointments by phone / mail   (v) completion of the Common Summary Assessment Record form. However any  communications with therapists etc as part of this process can be counted as  indirect interventions.  (vi) general administration e.g. ordering and management of stock orders, filing of  records.  To ensure accuracy, the number of indirect interventions should be captured daily in a desk diary or directly onto the metric collection template. |
| **Total Caseload Size / All Ages and Care Groups** | | | | |
|  | Total **number of patients** on the **active nursing caseload** on the last day of the reporting month | | | This is a count of **the total number of patients on the active nursing caseload** on the last day of the reporting month.  An active caseload is defined as the number of patients admitted to a caseload who:   * require continuing nursing care * have a current nursing care plan and * have a date for review by the PHN / CRGN within the next 12 months.   Caseload includes patients: within all categories and care groups: over 65, under 65, clients with disability, children from birth to 4 years 11 months with clinical needs and patients:   * in receipt of home help support / home care package who may have no direct nursing needs but require a regular nursing review in line with national and local policies * in receipt of continence products as they require regular continence reviews in line with local policy * postnatal mothers * children receiving clinical care.   Caseload excludes:   * patients who have been discharged from the caseload this month.   **Discharge**  Discharge patients when all episodes of care are concluded / care plan is closed and there are no outstanding review dates.  Note: The term ‘inactive caseload’ is no longer applicable; a case is either active or discharged. |
| **Reviews within the Caseload** | | | | |
|  | **Number of existing patients (within PHN/CRGN caseload) with reviews outstanding at month end** | | | **Definition:** A patient review  is defined as a planned face to face/phone , video or audio conferencing re-evaluation of an existing   patient  in a scheduled   specific month  recorded in the nursing care plan   e.g. Home Support Services reviews, Continence Reviews etc  **Include**:   1. All planned **re assessments/re-evaluations** due to be completed this month by the PHN /CRGN in clinic or home/other setting 2. Telephone/Video/audio reviews with the patient (based on nurse judgement and clinical need) 3. Reviews still outstanding from previous months   **Exclude**  Planned nursing Interventions as part of an ongoing current episode of care (eg wound care/ administration of medications) |
|  | **Wound Care KPI** | | |  |
|  | Number of patients on the PHN/CRGN caseload with a chronic lower limb wound that requires active treatment. | | | **Include**   1. Patients with chronic lower leg wound attending a leg ulcer clinic/wound care clinic that may or may not be directly receiving wound care by area PHN/CRGN but this patient is on the PHN caseload as they remain the responsibility of the caseload holder 2. Include patients receiving treatment from other service i.e. TVN, Leg ulcer clinic and who remain on PHN/CRGN caseload 3. Patients’ discharged/RIP/transferred out or chronic lower leg wound healed in the reporting month.   **Exclude Patients who do not have a chronic lower limb wound.**   1. Lower leg wounds that are on a healing trajectory and expect to be healed within 4 weeks of commencement of treatment by PHN (more than 50% healed) 2. New referrals into PHN service for lower leg wound treatment in the current month. (data is collected a month in arrears). 3. Patients with diabetic foot disease/follow Model of Care for the Diabetic Foot (HSE 2011) " 4. A client with a lower limb pressure ulcer, as defined in the HSE National Wound Care Guidelines (2018; pg127), are excluded from this KPI". |
|  | Number of patients with a chronic lower limb wound referred onwards for further assessment of lower limb wound. | | | *I****nclude***   1. Patients who are on caseload and included in KPI cohort and who decline referral onward (record patients who decline referral as a not referred) 2. Patients discharged/RIP/transferred out this month 3. Lower leg wounds not healed within 4 weeks of commencement of treatment by PHN/CRGN   ***Referral onwards may be to one of the following:***  *A* PHN/CRGN competent in vascular assessment  Vascular Assessment Clinic  Leg ulcer clinic /TVN specialist clinic  GP (for onward vascular referral)  Direct to Vascular Consultant  **Exclude: healed or expected to heal within 4 weeks (already excluded in total caseload)** |

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|  | Cross Cover |  |
|  | Number of **minutes of cross cover provided by PHN /caseload holder** in the reporting month | This is a count of the **total number of minutes of cross cover** provided by a PHN / CRGN caseload holder in the reporting month.  Include:   1. all cross cover time periods, for all care groups and age groups (including child   health and child protection)   1. travel time 2. cross cover periods for both clinic and domiciliary settings.   Exclude:   1. week-end and bank holiday duty. |