Healthcare Improvement Scotland

Healthcare Staffing Programme

Neonatal Staffing Level Tool

User Guide and FAQs

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1.0 Introduction

The neonatal Staffing Level Tool (SLT) is set up to enable nursing staff to record information on patients' levels of care, following the guidance from the British Association of Perinatal Medicine (BAPM). This will be used to calculate a recommended whole time equivalent (WTE) which will help inform workforce planning. There will be the option to document any additional activities performed throughout each census period, however these will not be included in the calculation for the recommended WTE. This information is completed a minimum of twice over a 24-hour period.

The national recommendation as outlined in the Health and Care (Staffing) (Scotland) Act 2019 (HCSA) (Appendix A) is that this neonatal SLT is run at least once per year for two consecutive weeks. For this two-week period, it is run concurrently with the Professional Judgement (PJ) tool which is hosted on the Scottish Standard Time System (SSTS).

However, the Neonatal SLT can be run as frequently as boards wish. NHS Boards can use more tool runs to gather data over time. Background information on staffing level tools can be found in Appendix A.

It is important to remember the recommended WTE is only one element of the Common Staffing Method (CSM). The application of the CSM is a legislative requirement under the HCSA for the specified types of healthcare services, locations and employee groups set out in Duty 12IK of the Act.

It is important to note that the output from the SLT and your PJ each represent only one component of the CSM. All elements of the CSM must be applied rigorously and consistently to ensure compliance with the legislation and to support safe, effective staffing decisions.

This user guide will provide detailed information on how to log in, how to finalise and submit data. It will not provide information about the methodologies used to develop the Neonatal SLT. That information can be accessed via the learning resources available on the Healthcare Staffing Programme webpages.

- Please note the screenshots within this user guide are from a SafeCare test environment and may differ from the live environment. These are being utilised with the permission of RLDatix.

2.0 Logging in

2.1 Accessing the tools

Staff responsible for recording patient acuity data should have access to the roster and ensure the relevant patient types and patient tasks have been configured prior to a tool run.

Please speak to your e-Roster lead, Workforce planning lead, line manager or equivalent individual in your board regarding local processes to obtain this access.

Some staff may already have access to SSTS but will require additional permissions to access the PJ tool.

- SSTS can only be accessed on an NHS board approved computer and network.

2.2 SafeCare

As shown below in image 1, enter your username and password and select “log in.”

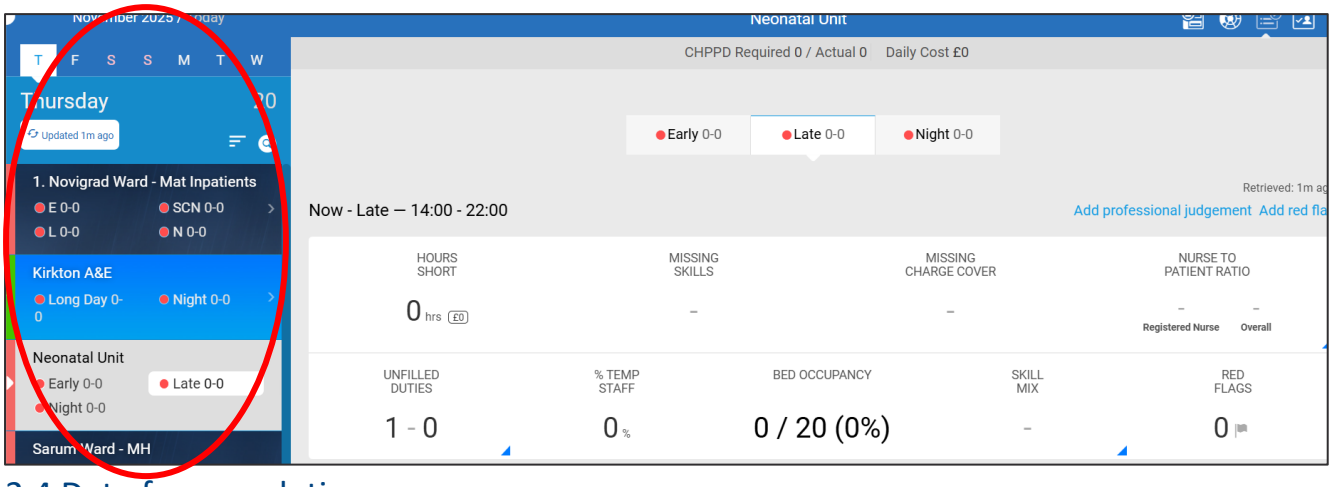
Image 1: Log in page for SafeCare

- Passwords are case sensitive

2.3 Landing page

As shown below in image 2, when you log in you will be taken directly to the landing page.

Image2: Landing page within SafeCare



2.4 Date for completion

When you have logged into SafeCare it will automatically open on today's date.

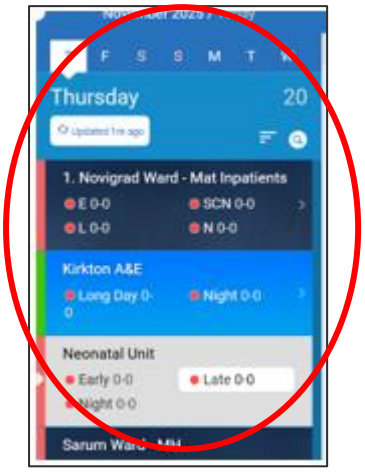
Image 3: Landing page in SafeCare highlighting the day of the week and shifts

2.5 Select ward or department

Select the correct ward or department from those listed on the left of the screen.

As previously mentioned, and shown below in image 4, you may have multiple wards or departments depending on your access.

Image 4: Numerous ward choices within SafeCare



3.0 Creating or editing entries in tool

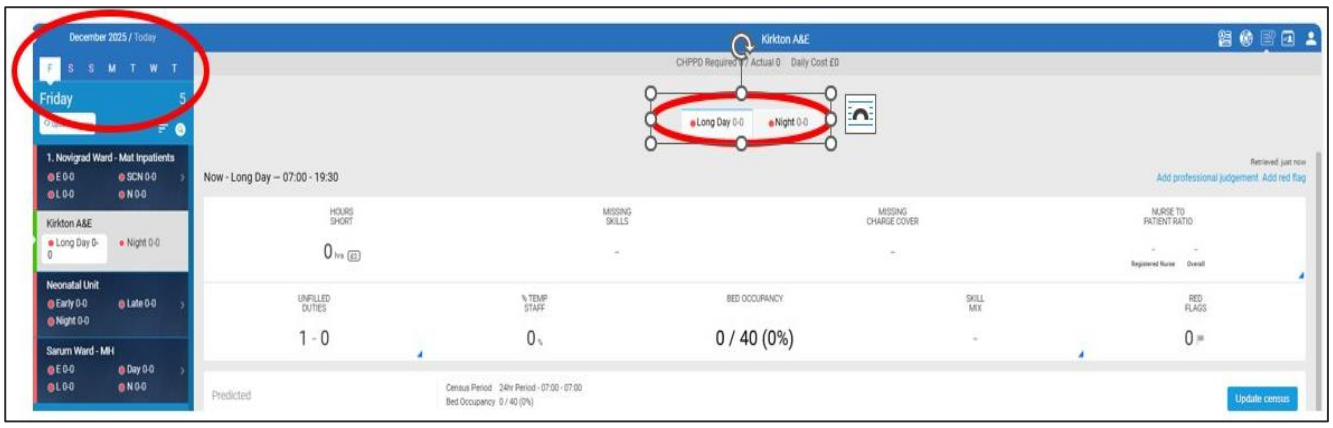
3.1 Landing page

When you have logged into SafeCare it will automatically open on today's date.

If this is incorrect then please select the correct day, as shown below in image 5, from the options at the top left of the screen and the correct shift from the middle of the screen.

It is important to ensure you have the correct shift selected for the census period you are entering data for eg early and day shifts may show the morning census period, whereas a late shift would show the afternoon census and a night shift would show the night census.

Image 5: SafeCare landing page highlighting date and census period

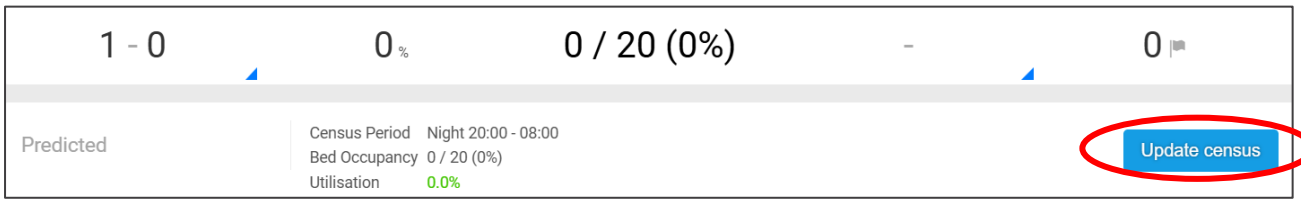


3.2 Entering census data

As shown below in image 6, please select "update census."

This is found at the bottom right of the page as seen in image 6 below.

Image 6: Update census tab within SafeCare



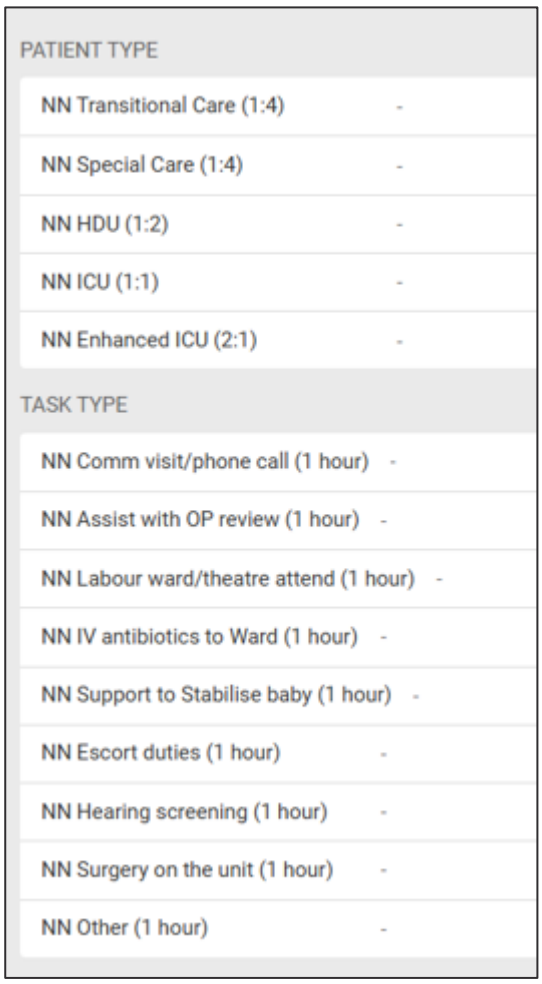
You will then be able to record the number of patients at each level of care. The levels of care are from the BAPM and are detailed in Appendix B. This data should represent the situation in your ward or department at that precise moment in time.

Time spent undertaking patient tasks can be added retrospectively to provide local supplementary information to your tool run. This information would need to be extracted locally as they will not form part of the tool runs outputs. There are data capture sheets available on the Healthcare

Staffing Programme website for collecting task type information. Ideally this information should be inputted daily.

As shown below in image 7 this is the section within SafeCare to input the number of patients per level of care or patient type and where to enter the retrospective data for patient tasks (as discussed above).

Image 7: Patient type and task type data entry within SafeCare

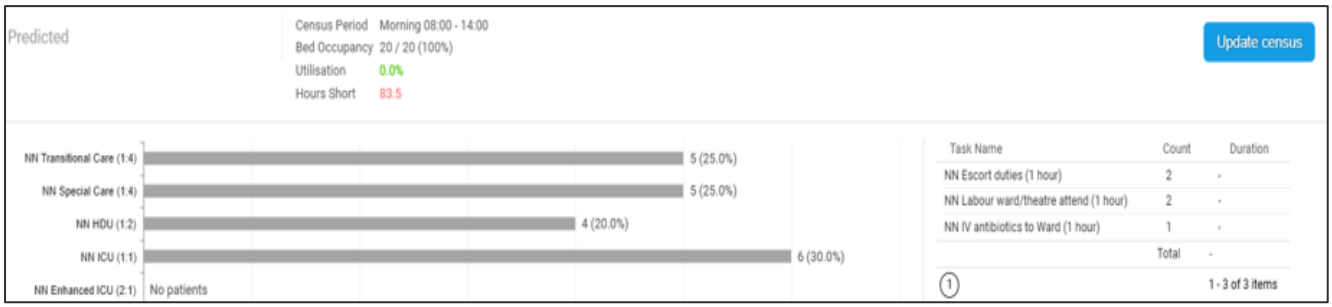


- Please note the Task Type is an accumulative total for every member of staff, documented in 1-hour increments.
- For example, if a nurse or midwife spent 2 hours on neonatal (NN) Escort Duties this would be documented as 2. If two nurses or midwife had spent 2 one-hour increments each on NN Labour ward or theatre attend this would be recorded as 2.

3.3 Viewing data

As shown below in image 8, following completion of the above steps you will see that your landing page has updated.

Image 8: Updated landing page within SafeCare



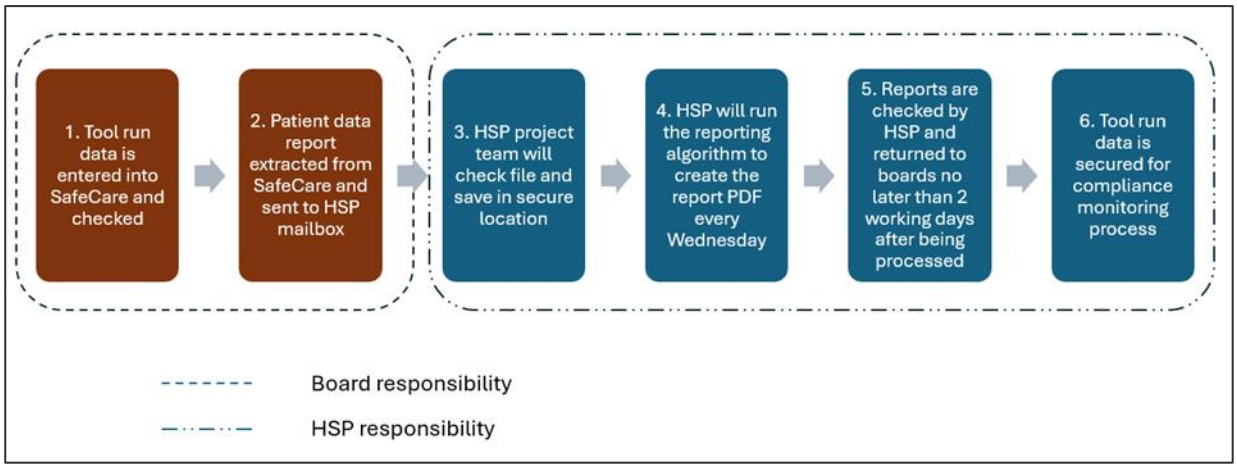
Please always sense check that the data that has been inputted is correct.

- PJ within SafeCare refers to real time staffing–please continue to utilise the PJ tool via SSTS.

4.0 Reporting

The process for delivering an interim reporting solution is described in image 9 below. Boards have the responsibility to provide accurate data from SafeCare in the form of the Patient Data report. The Healthcare Staffing Programme (HSP) will process this report and return a rWTE to the user in a timely manner. This is described further below.

Image 9: Process for interim reporting from SafeCare

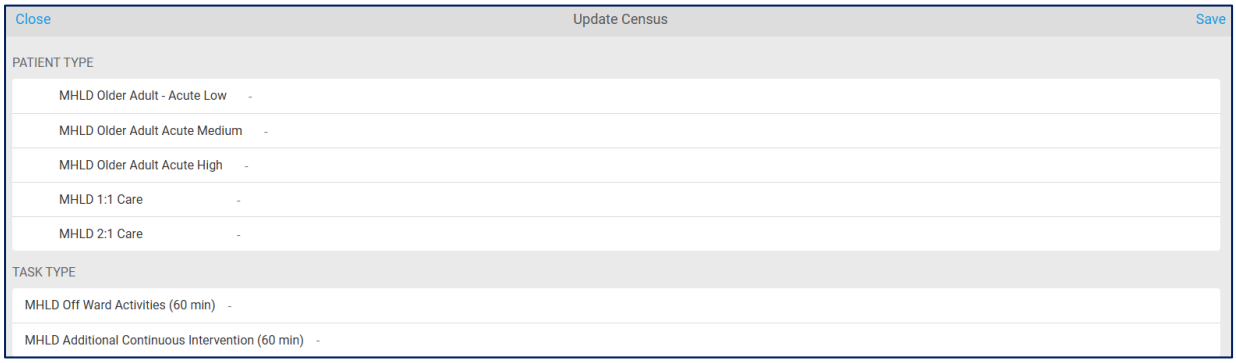


Please see the steps to extract the data for the Healthcare Staffing Programme:

1. Tool run data is entered into SafeCare and checked by the boards

Ward areas should enter their data as per the associated tool run guidance shared from HIS when the specialty specific tool was implemented in SafeCare as shown in image 10 below.

Image 10: SafeCare tool run.

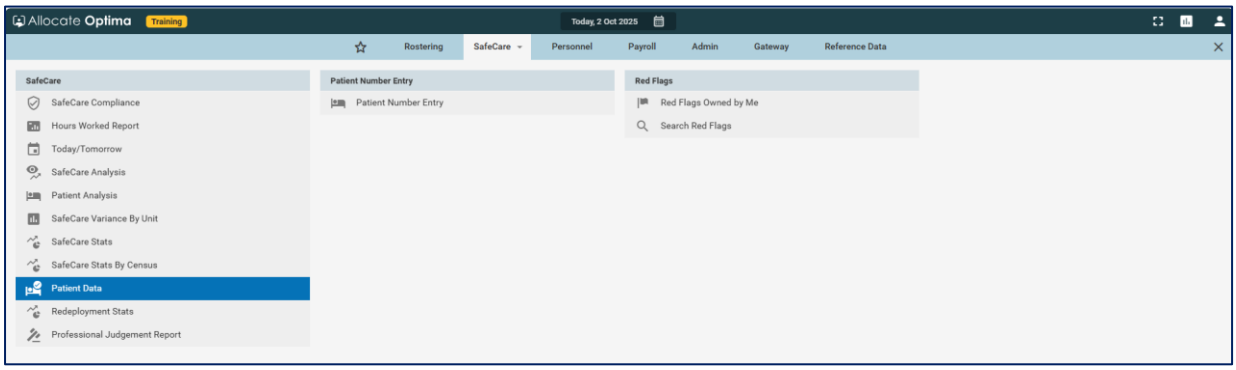


Data should be entered every day for a 2-week period. It is recommended that all data entered has been checked for accuracy.

2. Board runs the Patient Data report, exports it and sends it to HSP mailbox

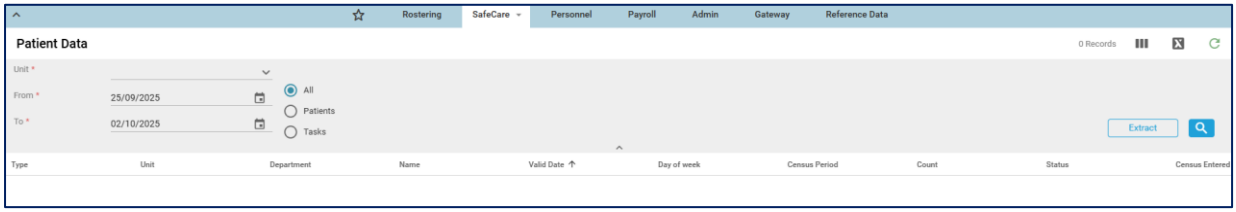
The Patient Data report is available in Optima as shown below in image 11.

Image 11: Patient Data Report



Enter the 2-week period of the tool run in the section shown below in image 12.

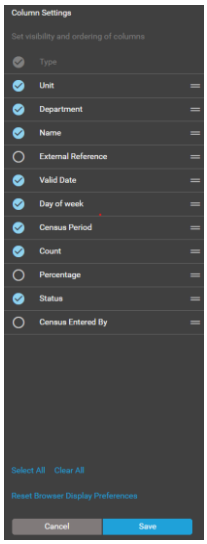
Image 12: A 2-week period of a tool run.



To ensure successful report generation the following mandatory columns must be included in the Patient Data report (listed below and in image 13 to the right):

- Type
- Unit
- Department
- Name
- Valid Date
- Day of week
- Census Period
- Count
- Status

Image 13: Mandatory Columns



When the report has been run successfully, it should be exported into Excel and named as the Ward/Unit name e.g. if the ward area that has ran the Staffing Level Tool is Ward 3A, the file should be named Ward 3A.xlsx. This file should then be emailed to the HSP mailbox his.hsp@nhs.scot

3. HSP check the file and save it in a secure location ensuring naming conventions are adhered to

HSP will check that the file has been attached to the email from Boards and save the file in the appropriate folder on the shared drive. The naming of the folder and Excel file is critical to ensure that the model runs correctly without errors.

- **Folder Name**: Represents the **Board** e.g., NHS Greater Glasgow and Clyde.
- **Excel File Name**: Represents the **Ward/Unit** being analysed e.g., Ward 3A.

The final dashboard report will be displayed in the Power BI App.

4. HSP will update the data models in the Power BI dashboard

Every Wednesday, the model will be refreshed to ensure the pipeline structure includes the mandatory fields and aggregates and transforms the data ready for analysis. A recommended Whole Time Equivalent is generated, along with summary tables and graphs in the Power BI Desktop

5. Data files are processed and published to the Power BI dashboards

HSP will check the model for completion and publish to live in Power BI by the Friday of the same week. This will allow for variation in the volume of reports requiring to be processed.

Any data files which contain errors or are otherwise unable to be processed will be returned to the user with an explanation of the issue.

6. Tool run data is secured for compliance monitoring process

On publication of the Power BI dashboard, the data model is made available to inform HSP's Monitoring Board Compliance duty under legislation. This is saved securely using user-based access functionality.

Further guidance and information relating to access to these dashboards can be found on the Healthcare Staffing Programme Webpage. Each speciality specific tool with have a document; Interim Reporting from SafeCare, Guidance for Boards.

Appendix A

Background

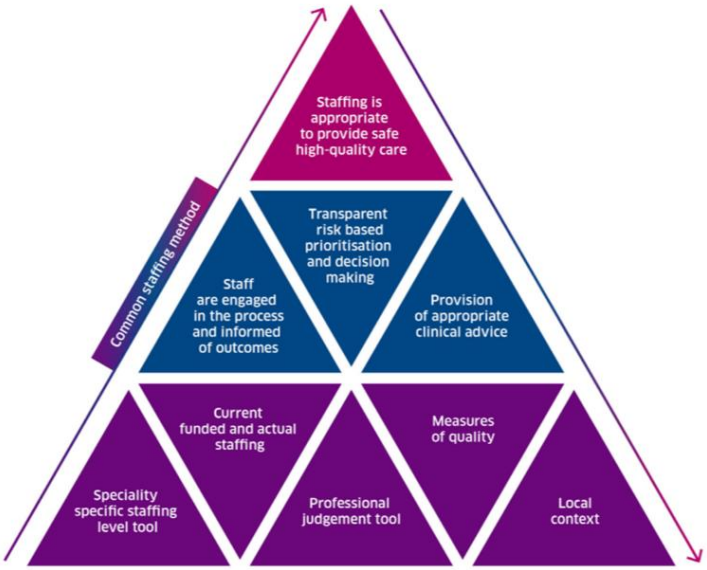
The Health and Care (Staffing) (Scotland) Act 2019 came in to effect on 1 April 2024. It stipulates that Health Boards have a duty to utilise staffing level tools named within legislation and a requirement to follow the CSM (Figure 1 below). The Neonatal SLT is one of a suite of national staffing level tools available for this purpose. The purpose of the staffing level tools is to provide information and a recommended WTE based on workload.

The outputs from the staffing level tools should not be used in isolation and the CSM sets out a process, including the use of the relevant SLT and the PJ tool and a range of other considerations, which must be applied rigorously and consistently to inform workforce planning.

The application of the CSM will support NHS Boards to ensure appropriate staffing, the health, wellbeing and safety of patients and the provision of safe and high-quality care. It will form part of the evidence that relevant organisations submit to demonstrate how they have complied with the Act. The frequency of applying the CSM has been defined as once per financial year as a minimum.

To find out more about this, please refer to the Healthcare Staffing Programme website and learning resources.

Figure 1–The Common Staffing Method



Appendix B

BAPM guidelines for levels of care

With the transition to SafeCare, staff will adopt a self-assessed approach to categorising the level of care for each baby. This will be based on the British Association of Perinatal Medicine (BAPM) standards (2021) and Turas real time staffing definitions that were agreed by the National neonatal Expert Working Group, detailed below:

Enhanced Intensive Care (Ratio 2:1)

Following discussion with the Scottish Neonatal Nursing Group and Royal College of Nursing there is a necessity for the need for the provision of 2:1 care. This was previously referred to as 2:1 (ECMO) however not all neonatal units have the facility to provide Extracorporeal Membrane Oxygenation (ECMO) however can still provide 2:1 care because of the complex acuity needs of both the baby and their family.

Intensive Care (Ratio 1:1)

As a result of the complex needs of both the baby and their family the ratio of neonatal nurses qualified in specialty to baby should be 1 nurse: 1 baby.

This nurse should have no other managerial responsibilities during the time of clinical care but may be involved in the support of a less experienced nurse working alongside them in caring for the same baby.

Please see some examples of what this may include, please note this is not an exhaustive list.

- invasive Ventilation via a tracheal tube
- non-invasive ventilation eg, nasal Continuous Positive Airway Pressure (CPAP), Synchronised Inspiratory positive Airway Pressure (SIPAP), Biphasic Positive Airway Pressure (BIPAP), High Flow Nasal Cannula (HFNC/Vapotherm)
- parental Nutrition
- day of surgery including laser therapy for Retinopathy of Prematurity (ROP)
- day of death
- presence of invasive cannula
- complex pharmaceutical support

High Dependency Care (Ratio 1:2)

The ratio of neonatal nurses, qualified in speciality, responsible for the care of babies requiring high dependency care should be 1 nurse: 2 babies.

More stable and less dependent babies may be cared for by registered nurses not qualified in speciality, but who are under the direct supervision and responsibility of a neonatal nurse (qualified in speciality).

Please see some examples of what this may include, please note this is not an exhaustive list.

- non-invasive ventilation eg nasal CPAP, SIPAP, BIPAP, High Flow Nasal Cannula (HFNC/Vapotherm)
- parenteral Nutrition
- central venous line or long line (Peripheral Inserted Central Cannula (PICC))
- Tracheostomy
- urethral or suprapubic catheter

Special Care (Ratio 1:4)

The ratio of nurses looking after special care babies should be at least one nurse: 4 babies.

Registered nurses and non-registered clinical staff may care for these babies under the direct supervision and responsibility of a neonatal nurse (qualified in speciality).

Staffing in special care must be sufficient to ensure that discharge is properly planned and organised, including adequate support for parents.

Please see some examples of what this may include, please note this is not an exhaustive list.

- nasal cannula for oxygen therapy
- nasogastric, jejunal tube or gastrostomy tube feeding
- continuous physiological monitoring, excluding apnoea monitors
- only) and observations at least four hourly
- presence of IV cannula
- baby receiving phototherapy

Neonatal transitional care (Ratio 1:4)

Following recommendations from the Neonatal Tool Review Expert Working Group and as part of the transition, the HSP propose the addition of transitional care as a level of care

The ratio of staff looking after transitional care babies should be at least one staff: 4 babies.

Non-registered clinical staff may care for these babies under the direct supervision and responsibility of a registered nurse or midwife.

Staffing must be sufficient to ensure support for parents with all care for their baby including enteral tube feeding, low flow oxygen administration and any other additional needs.

Please refer to the BAPM Service and Quality Standards for Provision of Neonatal Care in the UK, November 2022

Appendix C

Frequently asked questions and answers

Q1 What do I need to do before I start using the tool?

You need to make sure you are familiar with the Neonatal SLT.

There are video guides on the HSP webpages: Healthcare Staffing Programme webpages.

Training and support will be provided via your local workforce lead. Please make sure you understand all the information provided, the responsibilities and expectations for you and your team.

Q2 Why am I being asked to use two tools?

You are being asked to use the PJ tool hosted SSTS along with the Neonatal SLT. This forms part of the CSM approach mentioned above which is a requirement within the HCSA (Appendix A).

Q3 Some neonatal areas or wards are less than 16 beds. Can the neonatal tool continue to be used?

Yes, the Neonatal SLT should be used. The Neonatal SLT has been developed to measure patient or task types in all neonatal inpatient settings.

Q4 Does the tool consider mandatory training requirements?

A national Predicted Absence Allowance of 22.5 % is included in the SLT.

2 % of this total is for study leave.

Q5 Can this tool be used in a community setting?

No–The Neonatal SLT is intended for use only in Inpatient neonatal wards.

Q6 How often should the information be entered onto SafeCare?

Best practice is a census period per core shift pattern. During your specialty specific SLT run this should be a minimum of two census periods in twenty-four hours.'

Patient census data should be entered at the start of each census period.

Patient tasks should be entered at the end of each census period.

Please note that your census periods will be set prior to your use of SafeCare, for example, one, two or three census periods. If you find a large fluctuation in numbers of patients and levels of care, you may wish to increase the number of census periods you have. This can only be done by the e-Roster team.

There is no limit to the number of census periods you can use, this would be a local NHS board decision

Q8 Who do I contact if I require help and support with this tool?

Please contact your local workforce lead or eRostering Lead in the first instance should you require support with any aspect of the tool or tool run.

Q9 Within transitional care, how do you record or capture workload for mums?

At present transitional care ratio of 1:4 is purely for babies. At present this additional workload should be captured within your PJ.

Q10 If nursing and midwifery staff must attend Resuscitation (RESUS) within labour wards, how is this captured in the numbers as the staff could be out with the department for a significant length of time?

This would be addressed within the PJ tool completed alongside the Neonatal SLT

Q11 In terms of going back retrospectively, what does that cover and what is the governance associated with that?

Reports within the system can indicate what ward has missed census period, to update this retrospectively. This will enable staff to ensure they are compliant and they do not have to restart the tool tun and not be compliant for the sake of one missed census period.

Q12 There is PJ available within SafeCare currently, should we be trialling this?

PJ within SafeCare is different from the PJ tool that is required as part of the legislation. Within SafeCare this determines a Red Amber Green (RAG) status based on rota and can be used to support the real time staffing element. This is complex to set up within SafeCare and HSP are seeking advice from the SafeCare national group regarding this.

This could be misleading as it does serve a completely different function. The PJ tool when transitioned to SafeCare will be within a different section. Once SSTS is no longer active and all transitioned to SafeCare, it will be clearer as there will be one point of contact.

Appendix D

Trouble Shooting–SafeCare

Q1 I am getting an error message when trying to login to SafeCare. What should I do?

Contact your local eRostering Team.

Q2 What should I do if I lose my login details?

Contact your local eRostering Team.

Q3 What happens if the internet goes down whilst during data entry to SafeCare?

You will have to re-enter any unsaved data once you are able to access SafeCare again.

Q4 What happens if I enter the wrong information by mistake eg wrong dates or patient activity?

Census data can be amended before or after saving, however you can only go back as far as 1 week in SafeCare.

Please ensure you quality assure the information in a timely manner.

The SLT

Q1 The Senior Charge Nurse or Midwife is off sick. Who takes responsibility for the data collection and SafeCare entry now?

The nurse or midwife in charge of the shift should always make sure the data is collected for their census period. A deputy for the Senior Charge Nurse or Midwife should be identified to enable continuation of data entry.

Q2 The recommended WTE is much higher pr lower than our actual or Funded Establishment. What should I do?

This may simply reflect your workload. However, it is worth quality assuring the data, in particular, that you have captured all the workload and have logged it in the Neonatal SLT rather than reflecting this in PJ comments.

Appendix E

Data capture template

Neonatal SLT Data Capture Template-Patient Task Types

Appendix F

Glossary of terms

Acronym	Definition
BAPM	British Association of Perinatal Medicine
BIPAP	Biphasic Positive Airway Pressure
CPAP	Continuous Positive Airway Pressure
ECMO	Extracorporeal Membrane Oxygenation
FAQ	Frequently Asked Questions
HDU	High Dependency Unit
HHFNC	Humidified High Flow Nasal Cannula
ICU	Intensive Care Unit
IV	Intravenous
PDF	Portable Document Format
PICC	Peripherally Inserted Central Catheters
PN	Parenteral Nutrition
RCN	Royal College of Nursing
ROP	Retinopathy of Prematurity
SIPAP	Synchronised Inspiratory Positive Airway Pressure
SSTS	Scottish Standard Time System

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