Healthcare Improvement Scotland

Emergency Care Provision Staffing Level Tool

User Guide

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Contents

1. Introduction

The Emergency Care Provision Staffing level tool gathers workload data in Emergency Departments. This tool was designed by doctors and nurses working within NHS Scotland emergency departments.
The tool was previously known as the Emergency Department and Emergency Medical staffing level tool, EDEM.

The national working group recommended to apply this tool as minimum, twice a year. The current national recommendation is to run the tool at least once per year. This should be for two consecutive weeks. It should be run concurrently with the Professional Judgement Tool. However, Boards can apply the tool as often as they wish, to gather useful data over time.

Background information on staffing level tools can be found in Appendix A.

To aid accurate data collection in the Emergency Care Provision Staffing level tool, a data capture template is available here Emergency Care Provision Staffing level Data Capture Template, and in Appendix B of this Document.

Workload is recorded along with workload acuity, a recommended whole time equivalent (rWTE) based on the workload information is then calculated. Please see Appendix F.

The Emergency Care Provision tool measures all aspects of the emergency department multi-professional work:

- **Direct and Indirect Care**. This is all patient related work including:
  - Record keeping
  - Liaison
  - Communications, etc

- **Associated Work.** This includes general non-clinical workload such as:
  - Clerical
  - Administration
  - Cleaning
  - Stocking
  - Errands
  - Meetings etc.

- **Additional Activity**. This is for any rare, extraordinary events that cannot be planned for. Events that may occur that need extra resources for a period of time. Relevant additional activities were agreed by the national working group who developed the tool.

- Personal time.

There are four dependency levels built into the calculator. Each of these recognise a different measure of complexity of workload. See Appendix C for a detailed description of each level of care.

The tool collates the data entered into a report. Practitioners and managers can use this report to plan the allocation of resources to effectively meet the service or health board's priorities. This report can also aid managers to identify any risks that may exist in the service.

It is important to remember the report is only one element of the **Common Staffing Method** mandated by the Health and Care (Staffing) (Scotland) Act 2019 (Appendix A).
The report should be considered in conjunction with:

- Funded establishment
- The findings from the Professional Judgement Tool[1]
- Quality indicators and local context

This document will provide detailed information, from how to login, to how to finalise and submit data.

It will not provide information about the methodologies used to develop the tool or how best to use the reports obtained from the tool.

Access further information via the learning resources available on the Healthcare Improvement Scotland (HIS) Healthcare Staffing Programme (HSP) webpages:
Healthcare Staffing Programme (HSP) webpages

2. Logging in

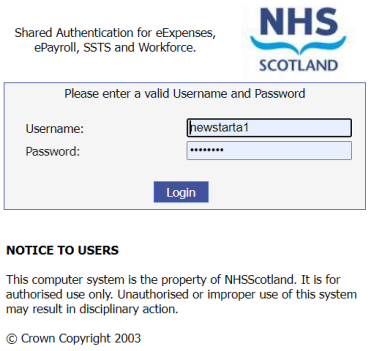
2.1 Accessing the Emergency Care Provision Tool

To gain access to the staffing level tool you will require access to the local SSTS platform. Please speak to your Workforce Lead and/or line manager about local processes to obtain this. Some staff may already have a SSTS access but will require additional permissions to access the staffing level tools.

Once the local SSTS manager has confirmed that your additional permissions are in place, you should use the link they provide to go to the login page.

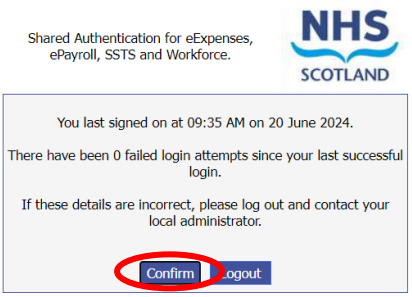
SSTS and the staffing level tools can only be accessed on a board approved computer or portable network.

Enter your username and password as they were provided to you and select **'Login'**



Passwords are case sensitive, and you will be prompted to change your password the first time you log in.

Click "confirm" to proceed.

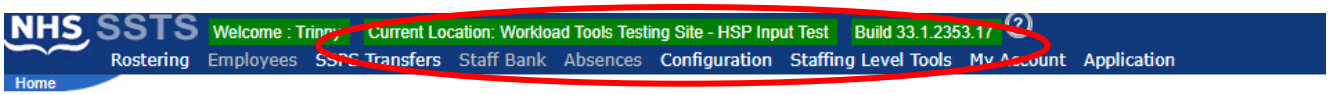


Then select "SSTS"

And then select **'SSTS'**

2.2 Changing Working Location

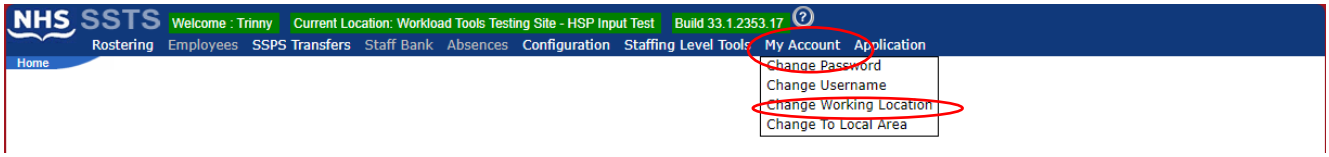
Once you have logged in you will be presented with the following screen:



Check the Current Location at the top of the screen. It is unlikely that you will need to change Working Location. However, if Working Location is incorrect, and you have the necessary permissions select **'My Account'** and then **'Change Working Location'**.

See below:

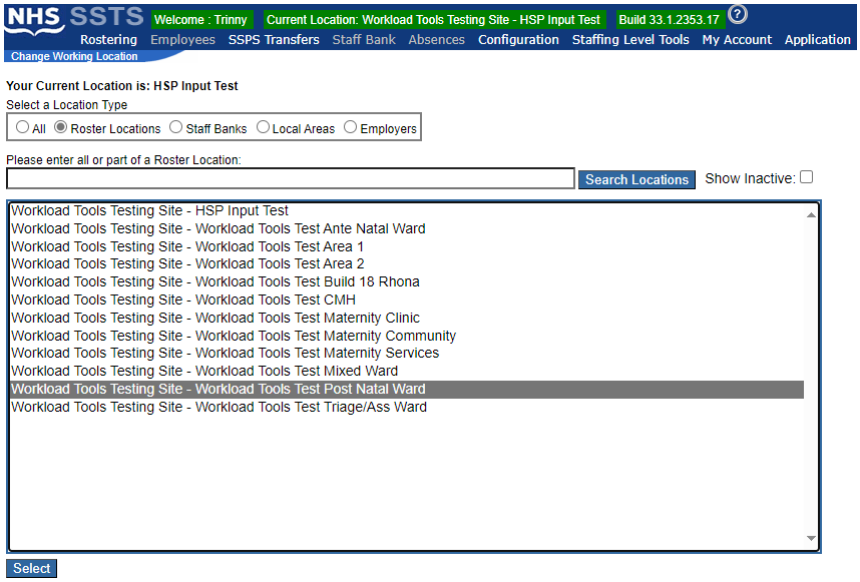
If you do not have these permissions, please contact your local Workforce lead or SSTS team.



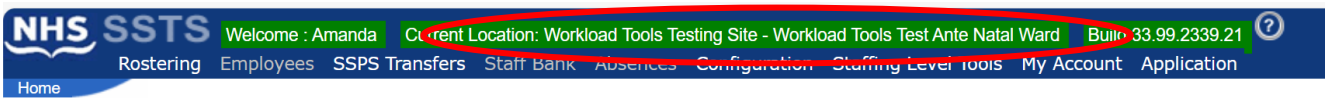
A Screen will then appear containing the ward and clinical area you have access to:

The ward/area can be searched for by roster location, staff bank, local area, or employer.

To choose a ward/area of interest, select it from the available list and then click **'Select'**



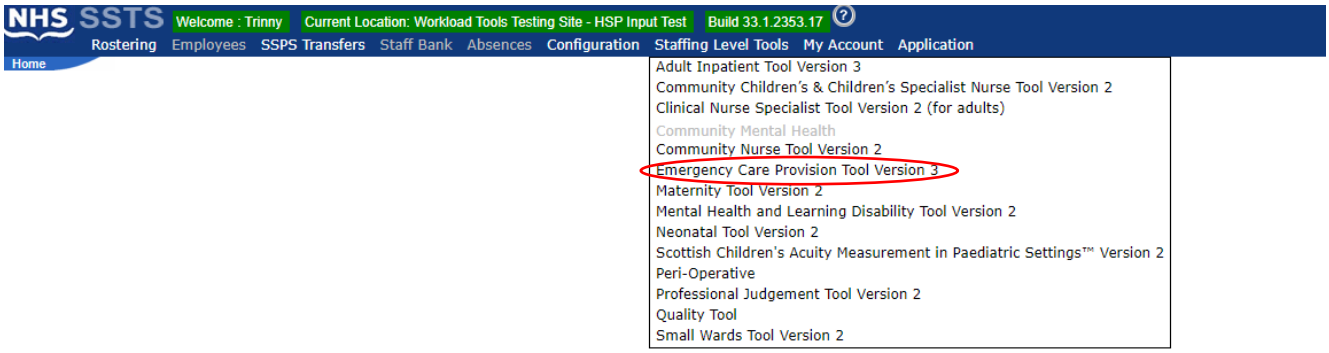
The location will then update on the toolbar:



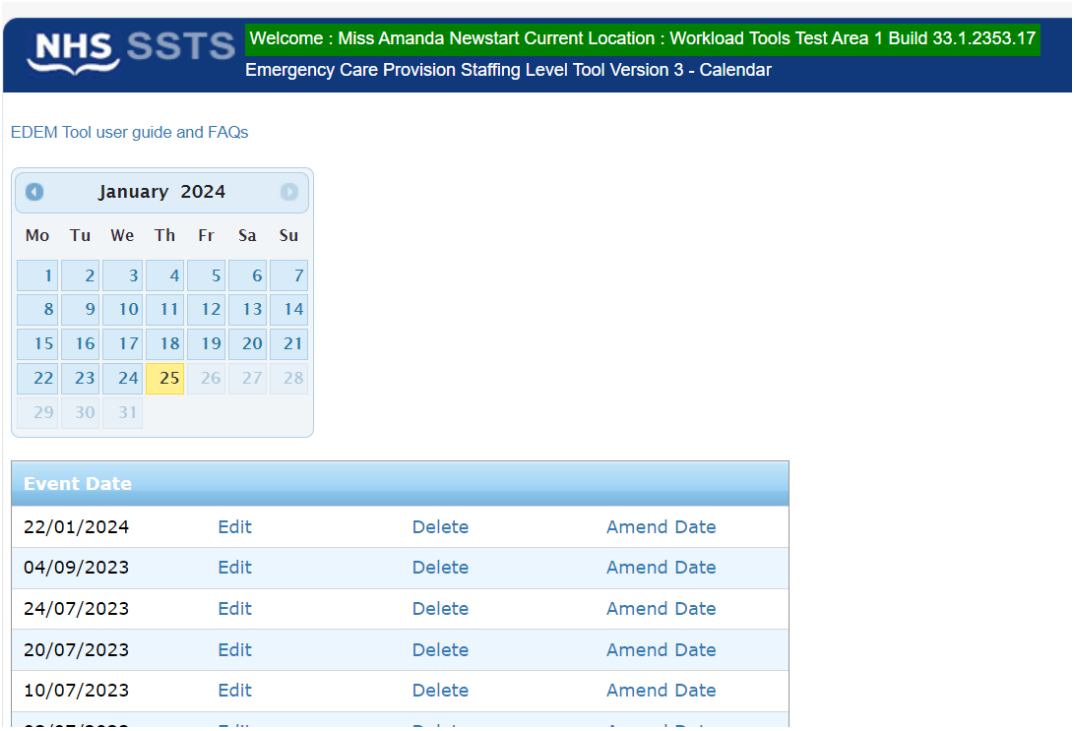
3. Creating/Editing Entries in Tool

3.1 Opening the tool

To open the Emergency care Provision Tool, select ‘Staffing Level Tools’ and then ‘Emergency Care Provision Tool Version 3’:

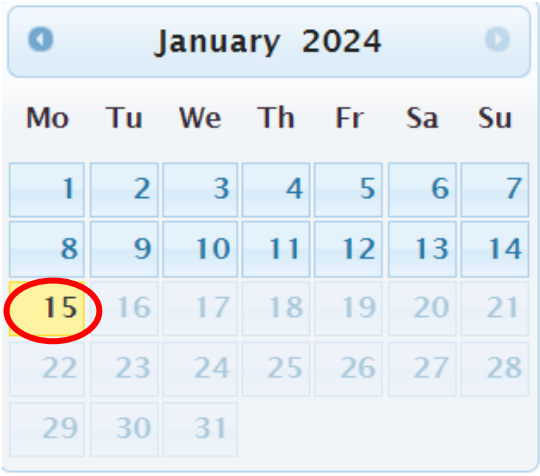


A screen like the one below will then appear:

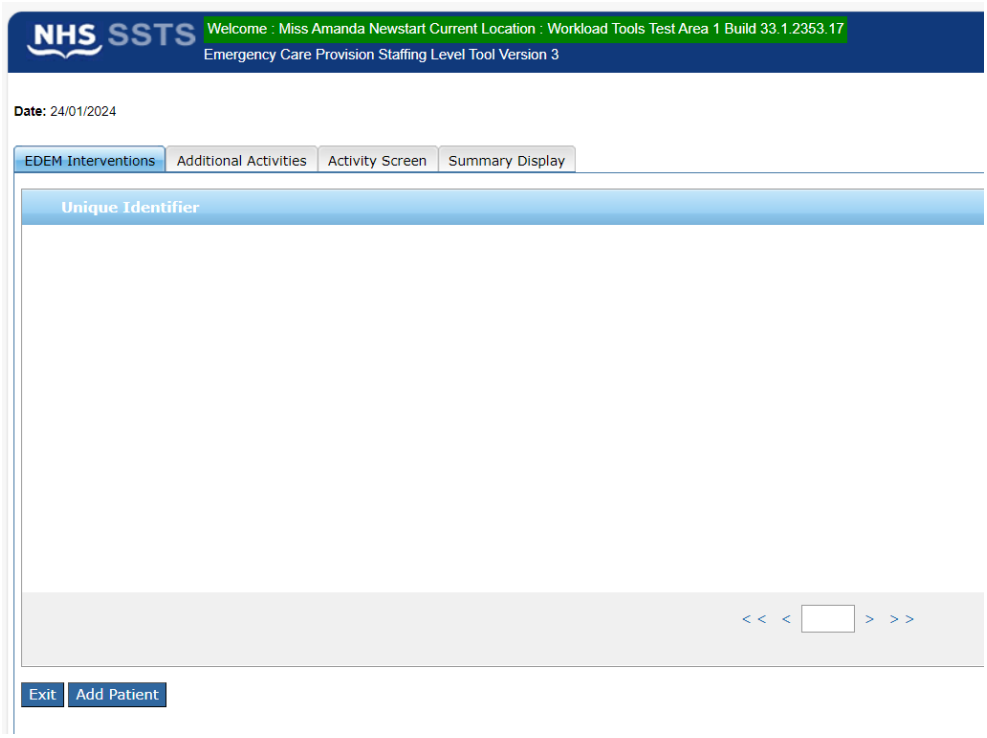


3.2 Entering Data

To add data, simply select the relevant date:



Then this screen will appear:



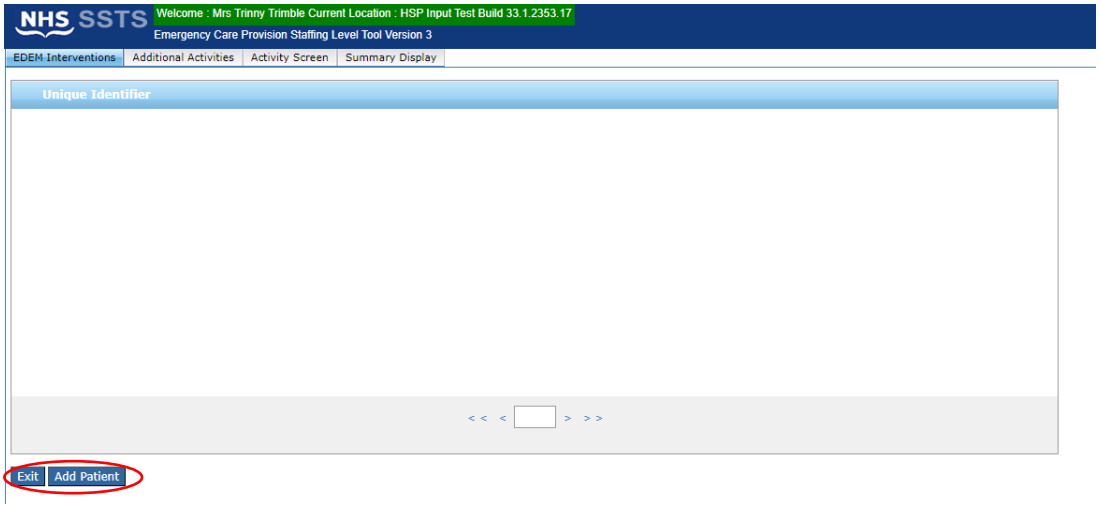
You can only create new records up to two months old

3.3 Adding a Direct Intervention

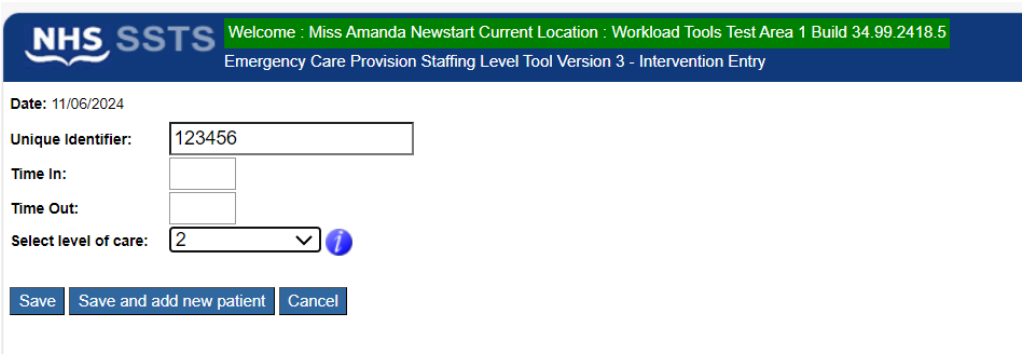
The default page when a new record is created is the EDEM Interventions tab. Here, you can enter data for individual patients.

The EDEM Interventions tab will initially contain no details when this screen is accessed for the first time.

To add a direct intervention, **"Add Patient"** should be selected at the bottom of the screen:



When the **Add Patient** button is clicked, it will open the box below.



Please be aware the start and end time for each day within the Emergency Care Provision Tool is 00:00 – 23:59. Patients should only be entered once, and this should be on the day they were **discharged**. There is no need to document a time in or out on SSTS.

Please note you need to document time out and changes to patients' levels of care on your Data Capture Sheet. This will help identify the day patients need to be entered into the staffing level tool and to help identify the patient's level of care. Patients level of care should be documented by the discharging clinician (medical or nursing) and reflect the level of care where the patient received most care at during this episode of care. There is an option to document time in – this is a local health board decision.

The blue information icons throughout the SSTS tool provide further descriptions of what is expected in that part of the tool. The one above shows the levels of care.

Enter the **Unique Identifier**.

A unique identifier is locally agreed and should meet GDPR requirements. It is used to track patients throughout their stay to ensure workload is documented.

Enter the patients Level of Care – Please note; at the patients discharge, the clinician (medical or nursing) must document the Level of Care that best reflects the patient's episode of care. If this Level of Care is not clear, then it is the clinicians responsibility to clinically judge what this level of care has been.

Please see example below for a patient who attended the Emergency department on the 23rd of July at 21:00 and left the department at 02:00 on the 24th of July. They will be recorded under the 24th of July (NOT 23rd July), and they received most care at level 2 (in minutes of clinical activity/clinical intervention) Please note the "time in" is there for use if deemed appropriate at a local level in your health board.

Emergency Care Provision Tool Data Capture Template

PATIENT FLOW DATA CAPTURE SHEET: Emergency Care Provision Staffing level Tool.

Date (record from 00:00-23:59) **IN: 23/7/24 21:00 OUT: 24/7/24 02:00**		**Hospital & ED Department**		**Motherwell City General Hospital**					
Patients Unique Identifier – Please ensure this sheet follows the patient on their journey though the department		**123456**							
Patients Level of Care									
Time In	**Time Out**	**Level of Care 1**		**Level of Care 2**		**Level of Care 3**		**Level of Care 4**	
		Duration of clinical **activity/intervention**		Duration of clinical **activity/intervention**		Duration of clinical **activity/intervention**		Duration of clinical **activity/intervention**	
21:00	22:30	30 mins	X						
22:30	23:00					30 mins	x		
23:00	02:00			90 mins	X				
Total time at level (mins)		**30 mins**		**90 mins**		**30 mins**		**0**	
Level of Care where most care was delivered (To document in SSTS)								**2**	

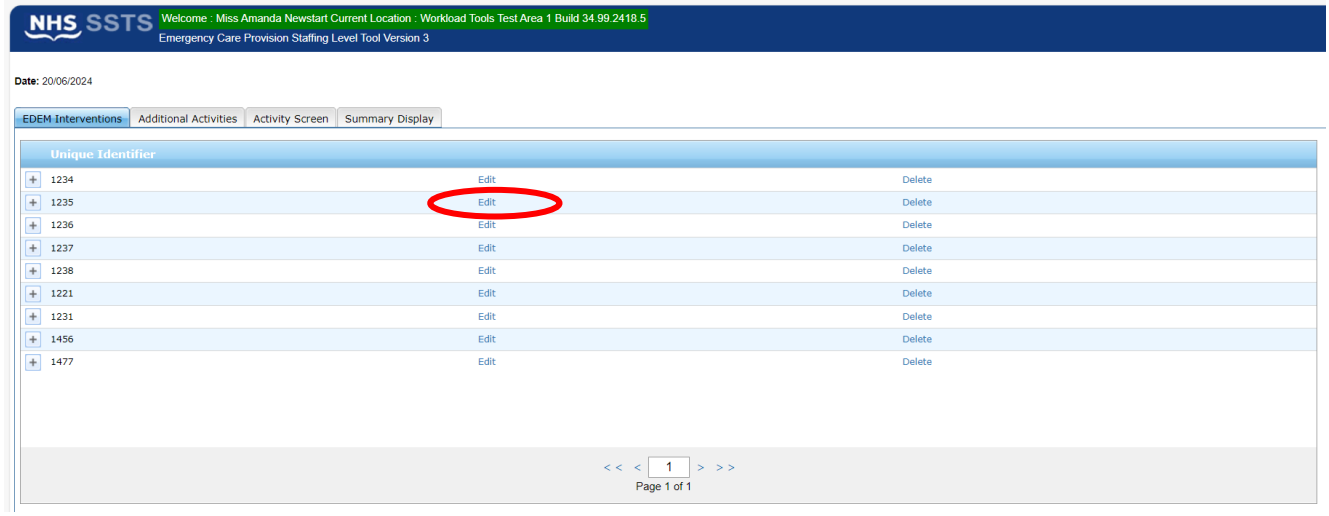
Note:

- ***Document patients on SSTS at their discharge date***
- ***Time in – this is a local decision to utilise or not***
- ***Document the level of care that best reflects this patient's episode of care – document in bottom left box***

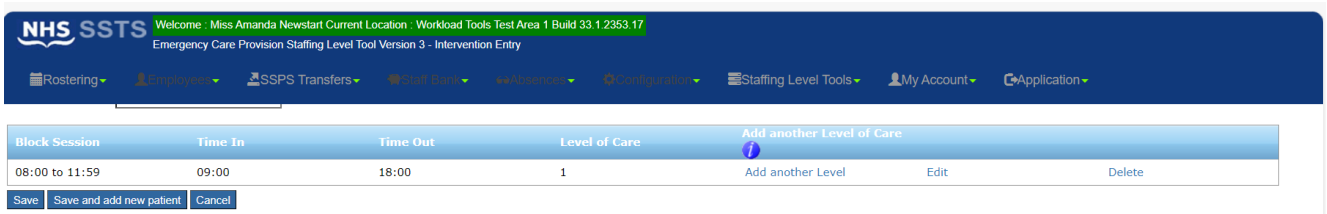
Click '**Save and add new patient**" to save the data and bring up a new screen to enter the next patient's information.
When you have completed entering and saving data for all patients in this way, click '**Save**' to save the data and return to the EDEM interventions tab, which should look similar to below, listing all patient's data has been entered for.

3.4 Editing an Intervention

To edit an intervention for a particular patient, click on 'Edit' beside the Unique Identifier:



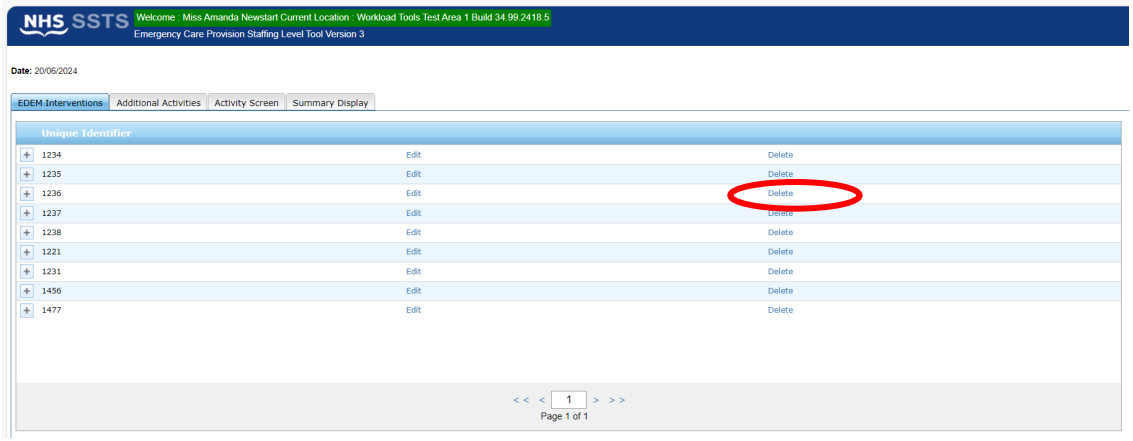
This will give you the following screen:



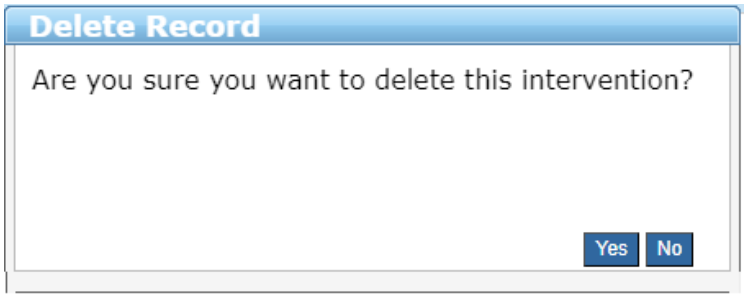
You can also edit the unique identifier on this screen.

3.5 Deleting Data

To delete an intervention for a particular patient, click on Delete, on the row for that unique identifier.



You will receive a text box asking if you are sure you want to delete this intervention. Select yes or no as appropriate.



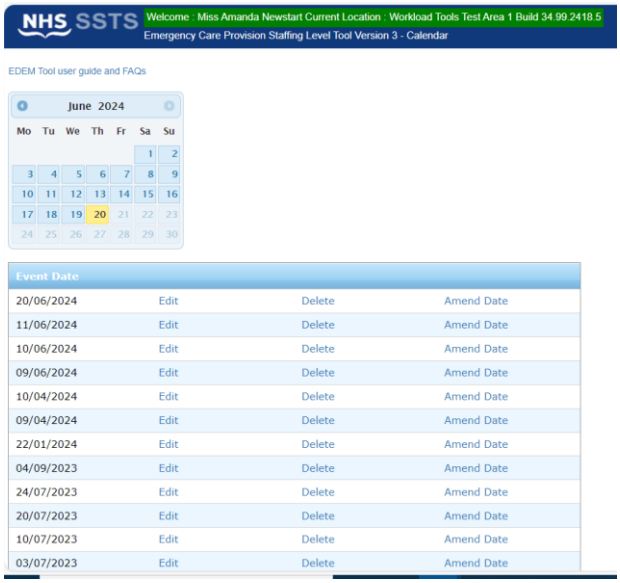
Once you have made the changes, click **'Save'** to save the changes and return to the EDEM Intervention screen.

Alternatively, click '**Save and add new patient'** to save the data and add data for a new patient.

'Cancel' will take you back to the previous screen without saving the changes.

3.6 Editing Existing Records

Existing records will be shown on the Event date table on the first page. The most recent records will be first.



If you have SSTS editor permissions, you may be able to edit or delete existing records.

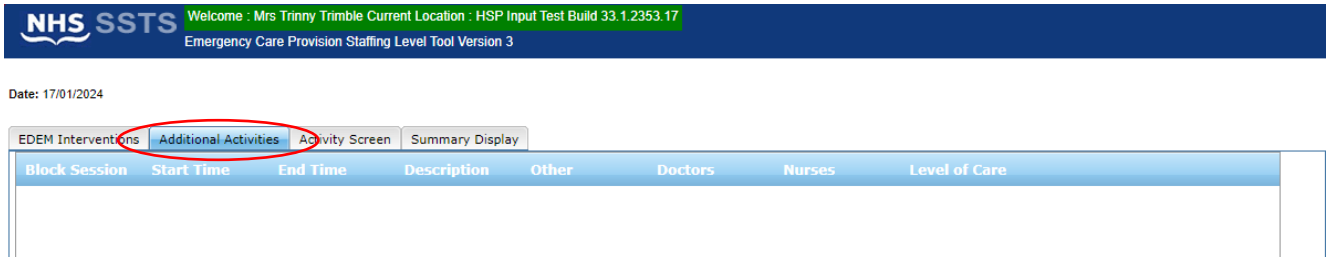
Click on Edit beside a date to amend individual patient data that has been recorded for that date.

Clicking on Delete or Amend Date will alter the information for all of the records that have been entered for that date. If you click on one of these options, you will be asked to confirm that you want to amend the date or delete the data.

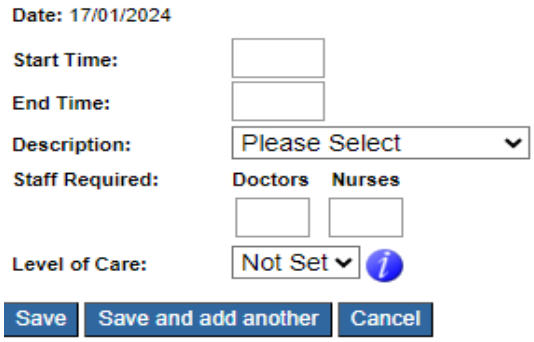
4. Additional Activities Tab

The additional activity section should only be used if there is a **rare event** that has a significant adverse effect on the Emergency Department (ED) resource, which requires the interventions of the rostered staff, for a specific period of time, out with the ED.

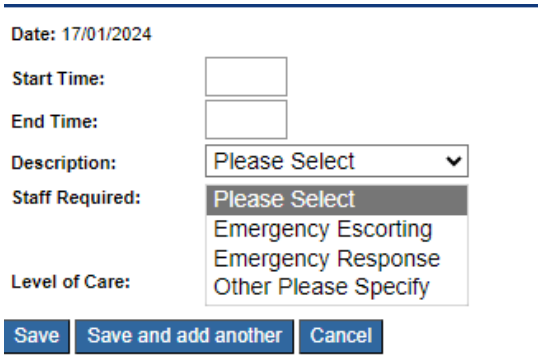
The Additional Activities screen will initially contain no details when you access this screen (and date) for the first time. To add an additional activity, select "**Add Additional Activity**":



The following screen appears, allowing you to enter the Start and End time, Description, Staff numbers required for the activity and the Level of Care (if appropriate):



The description box is a drop-down list that allows the user to select one of three options:



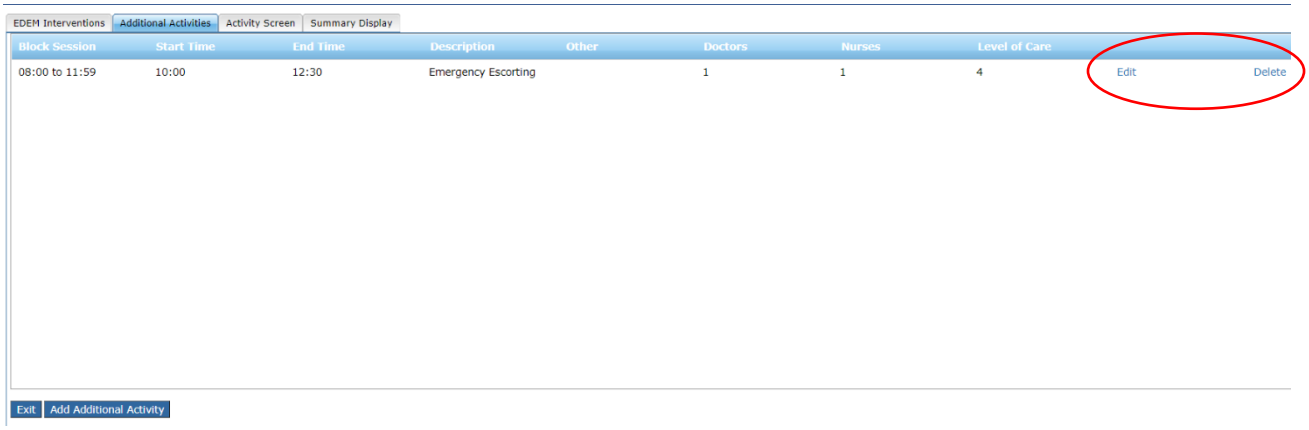
See below for examples of each option:

- Emergency Escorting: This is when one or more staff have to participate in an emergency escort out with their base hospital, i.e. a brain haemorrhage in a small ED department to the Neuro Institute in Glasgow. This is NOT internal transfers from ED to wards in the hospital.
- Emergency Response: This is when one or more staff have to leave the hospital to attend to a major incident i.e. 3 or 4 staff have to leave the department to attend on scene at a road traffic accident. It is not staff leaving to go to a 2222 call in the hospital.
- Other – please ensure this is used for rare, extraordinary events that are unforeseen i.e. a fire alarm resulting in evacuation of the department.

These examples are not exhaustive and are only a guide to help understand each option.

Click **'Save'** to save the data and return you to the Additional Activities screen, or **'Save and add another'** and enter more data.

Once the data entry has been completed and you have returned to the Additional Activities tab, you should now see a screen similar to the one below:



As discussed above to Edit or Delete data select the relevant option.

5. Activities Screen

Following on from the changes to Data Entry this tab is now for information only.

6. Summary Display Tab

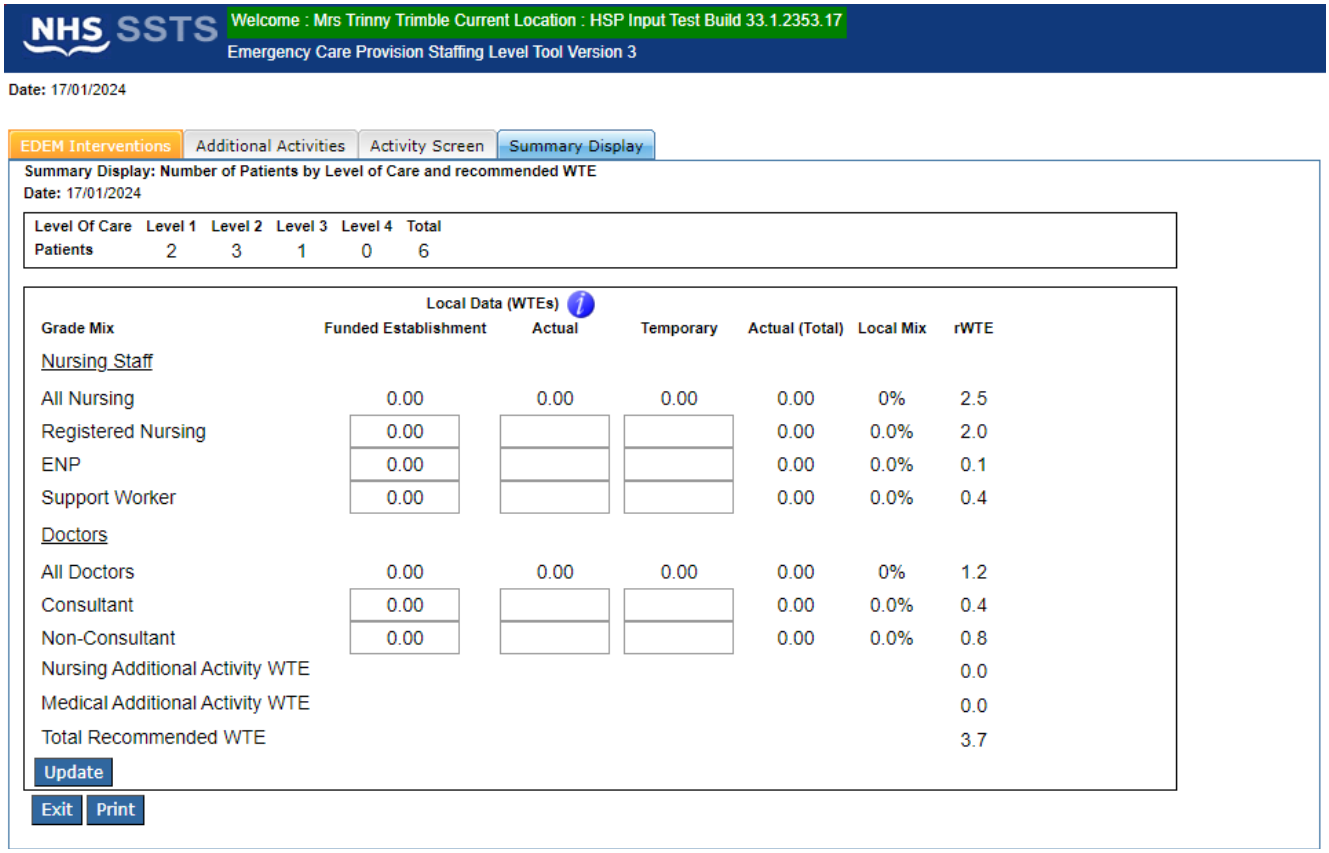
6.1 Summary Screen

The summary Display tab is only available for users with Editor permissions. Users with data entry only permissions cannot see or access this tab.

Please contact your local SSTS team to ensure you have the correct permissions.

The Summary Display tab only needs to be completed once.

This should be done on day 14 or the last day of the tool run.



The top of the Summary Display tab shows a count of the number of patients for the day.

The rWTEs column shows the rWTE based on the patient data entered into the workload tool for that date. This is calculated automatically to the tool.

The rWTE is broken down by nursing staff and doctors, and by different staff roles.

The rWTE needed to cover the Additional Activity is shown separately.

The Total rWTE includes the rWTE for all nursing and medical staff, including Additional Activity WTE.

The rWTE for each day of the tool run are pulled through to the BOXI report for comparison with the other local data entered at the end of the tool run and the professional judgement data.

6.2 Local Data Calculations

PLEASE NOTE – the current rWTE are against a 37.5 working week, this calculation has been rectified within the BOXI report you will receive. Currently the BOXI report will reflect the reduction in the working week to 37 hours.

Local Data can be added under the Funded Establishment, Actual and Temporary columns.

Funded WTE - Funded establishment. This information can be provided by the SSTS team.

Actual WTE - The Actual staff hours worked during the tool run period.

-This includes PAA

-This would not include those staff who are normally rostered to work but are absent e.g. sickness, absence, leave, etc.

Temporary WTE - extra hours, bank hours, overtime, agency/locum worked during the tool run. This does not include Predicted Absence Allowance, referred to moving forward as PAA

The local data should only be entered on the summary tab on day 14 of the tool run.

This tab can be left blank for all other days of the tool run.

The Actual hours worked need to be collected separately for each job family and job type as set out in the summary display tab. The same should be done for any Temporary hours worked.

To calculate your actual staffing:

1. Add together the actual hours worked by all staff members of each job type for each night and day shift.

On Monday:

Day shift:

5 staff worked an 11 hour shift, and

2 staff worked a 7.5 hour shift

Total staff hours on Monday day shift

= (5 x 11) + (2 x 7.5)

= **70 hours**

Night shift:

6 staff worked an 11 hour shift,

2 staff worked a 7.5 hour shift, and 1 staff member worked a 4 hour shift

Total staff hours on Monday night shift

= (6 x 11) + (2 x 7.5) + (1 x 4)
= **85 hours**

Total Registered nursing staff hours for Monday = day shift hours + night shift hours
= 70 + 85 = 155 hours

2. Add the number of registered nursing staff hours for the full week.
   For example:

Week 1	Mon	Tues	Wed	Thurs	Fri	Sat	Sun	Total
Day and night, 7 days	155	126.5	138	138	138	161	138	994.5

3. Do the same calculation for Week 2

4. Add the total registered nursing staff hours for Week 1 and Week 2 For example:
   - Total staff hours Week 1 = **994.5**
   - Total staff hours Week 2 = **1005.5**
   - Week 1 staff hours + Week 2 staff hours = 994.5 + 1005.5 = **2000**

5. Divide by 2 to get the average weekly hours. For example: 2000 ÷ 2 = 1000

6. Divide by standard weekly working hours (WTE), i.e.
   • 37.5 for nursing staff

   1000 ÷ 37.5 = 26.67

7. Add a percentage for Predictable Absence Allowance (PAA) of 22.5% for nursing staff
Please check this is what is used locally.

26.67 x 1.225 = 32.67

If the staff were medical staff 25% PAA should be added: 25 x 1.25 = 31.25
Please check this is what is used locally.

8. Enter the average weekly WTE of 32.67 into Registered nursing Actual Column on day 14 of the Emergency Care Provision tool.

EDEM Interventions | Additional Activities | Activity Screen | Summary Display

Summary Display: Number of Patients by Level of Care and recommended WTE
Date: 14/07/2023

Level Of Care	Level 1	Level 2	Level 3	Level 4	Total
Patients	1	3	4	5	13

	Local Data (WTEs)					
Grade Mix	Funded Establishment	Actual	Temporary	Actual (Total)	Local Mix	rWTE
Nursing Staff						
All Nursing	19.00	19.00	1.00	20.00	100%	11.2
Registered Nursing	10.00	9.00	1.00	10.00	50.0%	8.9
ENP	5.00	5.00	0.00	5.00	25.0%	0.6
Support Worker	4.00	5.00	0.00	5.00	25.0%	1.7
Doctors						
All Doctors	7.00	5.00	1.00	6.00	100%	5.6
Consultant	2.00	1.00	1.00	2.00	33.3%	1.8
Non-Consultant	5.00	4.00	0.00	4.00	66.7%	3.8
Nursing Additional Activity WTE						0.2
Medical Additional Activity WTE						0.1
Total Recommended WTE						17.0

Update

Exit | Print

Use the same method of calculation for each type of nursing staff specified in the summary tab

Temporary staffing should be calculated using the same method of calculation for each type of nursing staff and doctors specified in the summary tab, with the exception of step 7. No PAA is added for temporary staff.

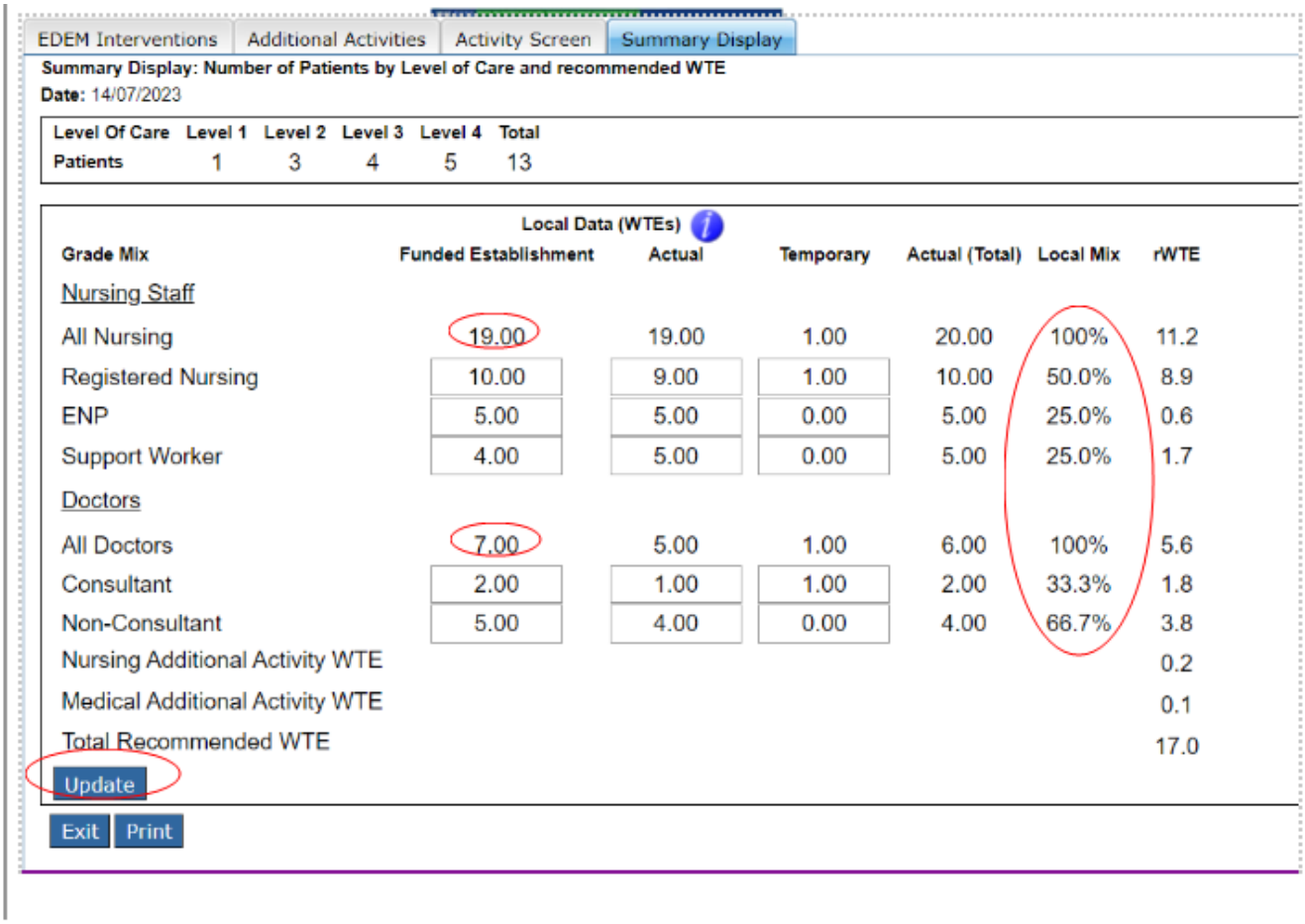
For Doctors, use the same method of calculation for both consultant and non-consultant doctors, with the following amendments:

· Step 6: Standard WTE hours are 40. So, divide the average weekly hours by 40 e.g. if the average weekly hours for consultants was 1000: 1000÷40 = 25

· Step 7: The PAA is 25. E.g 25 x 1.25 = 31.25

Once you have entered all of the funded establishment local and temporary staffing information, click the **Update** button.

The “All Nursing”, “All Doctors” “Actual (Total)”and “Local Mix” columns will then be calculated, as shown in the example below:



EDEM Interventions | Additional Activities | Activity Screen | Summary Display

Summary Display: Number of Patients by Level of Care and recommended WTE

Date: 14/07/2023

Level Of Care	Level 1	Level 2	Level 3	Level 4	Total
Patients	1	3	4	5	13

Grade Mix	Local Data (WTEs) Funded Establishment	Actual	Temporary	Actual (Total)	Local Mix	rWTE
Nursing Staff						
All Nursing	19.00	19.00	1.00	20.00	100%	11.2
Registered Nursing	10.00	9.00	1.00	10.00	50.0%	8.9
ENP	5.00	5.00	0.00	5.00	25.0%	0.6
Support Worker	4.00	5.00	0.00	5.00	25.0%	1.7
Doctors						
All Doctors	7.00	5.00	1.00	6.00	100%	5.6
Consultant	2.00	1.00	1.00	2.00	33.3%	1.8
Non-Consultant	5.00	4.00	0.00	4.00	66.7%	3.8
Nursing Additional Activity WTE						0.2
Medical Additional Activity WTE						0.1
Total Recommended WTE						17.0

Update

Exit | Print

The Actual (Total) column is the sum of the Actual and Temporary columns.

The local mix % is the mix of nursing and doctors in the department.

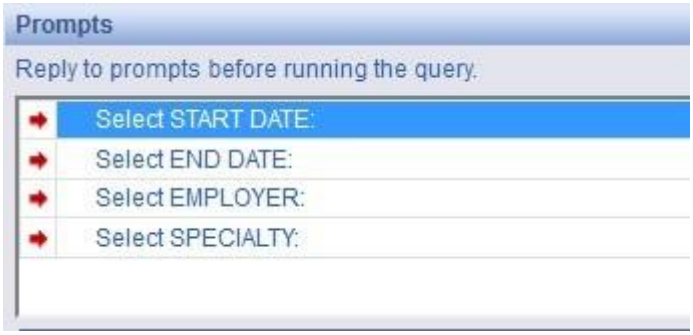
The comparison can then be seen between the recommended WTE for each role, the budget WTE/ funded establishment and the actual (total) staff in each role.

7. Business Objects Report (BOXI)

After Emergency Care Provision and corresponding Professional Judgement data entry into SSTS is complete, please use the Emergency Care Provision standard report developed in Business Objects (BOXI) to view and extract information for a selected period of time.

These reports were created by the national team and has a series of built-in prompts to generate customised outputs locally.

For Example,



Access to BOXI reports requires a login and password. Local processes for BOXI access can vary. Typically, BOXI access can be granted by your local SSTS Manager, line manager or Workforce Lead. Access is requested using the same access permission request form as the one for SSTS access.

ⓘ Please seek your line managers permission and authorisation before contacting your local SSTS manager.

Appendix A

Background

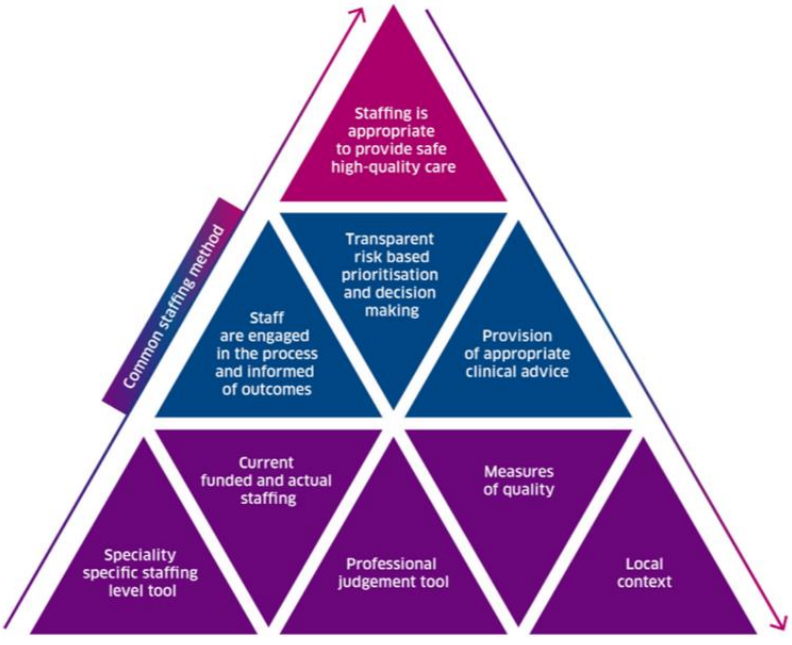
Nursing & Midwifery workload tools are an essential part of the Health and Care (Staffing) (Scotland) Act 2019 aimed at ensuring health & social care staffing is at the level required to deliver safe, quality focused care to people using the services. The tools are designed to give staff the platform on which to record information about the actual work they do. This is to collate the activities in a manner that supports decisions about staffing, resource allocation and service design as part of a triangulated process of planning.

To find out more about this, please refer to the HSP website and learning resources:

To find out more about this, please refer to the HSP website and learning resources:
Healthcare Staffing Programme (HSP) webpages.

The political commitment in Scotland is that, through application of a common staffing method (Figure 1) health services will be staffed to the level required to provide safe, high quality care. To ensure this, each NHS Scotland Board and the services therein, are responsible for having effective planning processes, informed by the activities captured through the mandated use of workload tools. The Small Wards tool is one of national workload tools available for this purpose.

Figure 1 – The common staffing method



Appendix B

Data Capture Sheet

Emergency Care Provision Tool Data Capture Template

PATIENT FLOW DATA CAPTURE SHEET: Emergency Care Provision Staffing level Tool.

Date (record from 00:00-23:59) **IN:** **OUT:**	**Hospital & ED Department**	
Patients Unique Identifier – Please ensure this sheet follows the patient on their journey though the department		

Patients Level of Care									
Time In	**Time Out**	**Level of Care 1**		**Level of Care 2**		**Level of Care 3**		**Level of Care 4**	
		Duration of clinical activity/intervention		Duration of clinical activity/intervention		Duration of clinical activity/intervention		Duration of clinical activity/intervention	
Total time at level (mins)									
Level of Care where most care was delivered (To document in SSTS)									

Note:

- ***Document patients on SSTS at their discharge date***
- ***Time in – this is a local decision to utilise or not***
- ***Document the level of care that best reflects this patient's episode of care – document in bottom left box***

20240906 HSP Emergency Care Provision Tool Data Capture Template v6.0

Professional Judgement Data Capture Sheet: Medical

Professional Judgement Data Capture Template: MEDICAL STAFFING: Emergency Care Provision Staffing Level Tool

Area/Location	Day:	Date:	
Time Period		Medical Category	Head count	Comments – In this column, general and variation - e.g. Emergency situation, complexity social and or physical, specific demands, care of the dying
00:00-04:00	Staffing required to meet workload	Senior Doctor		
		Middle Doctor		
		Junior Doctor		
04:00-08:00	Staffing required to meet workload	Senior Doctor		
		Middle Doctor		
		Junior Doctor		
08:00-12:00	Staffing required to meet workload	Senior Doctor		
		Middle Doctor		
		Junior Doctor		
12:00-16:00	Staffing required to meet workload	Senior Doctor		
		Middle Doctor		
		Junior Doctor		
16:00-20:00	Staffing required to meet workload	Senior Doctor		
		Middle Doctor		
		Junior Doctor		
20:00-23:59	Staffing required to meet workload	Senior Doctor		
		Middle Doctor		
		Junior Doctor		

Professional Judgement Data Capture Template: MEDICAL STAFFING: Emergency Care Provision Staffing Level Tool

- To be completed by Medical Staff, Team leader/ Manager or designated individual for a 2 week period.
- Professional judgement sheet to be completed as 'live' as possible retrospectively for each time block i.e. morning / afternoon etc
- Discuss the workload in the time period with staff.
- State how many **Senior/Middle/Junior grade** staff in the section of the table that you would **require** on duty to cover the **workload** using your own professional judgement. This is **not** what you had rostered but what staff were needed to undertake the workload.
- Staff should make a note of their shift on the Professional judgement sheet on each day of the 2 week data collection to facilitate team discussion and judgement with Medical Staff, Team Leader / Manager completing the Professional Judgement tool on SSTS.
- Comments should record any additional workload pressures such as complex social cases, non English speaking patients, physical issues/ transfers/ care of the dying. This is times when in your professional judgement more staff were required in the clinical area.
- If the number of staff required is different from your actual staffing write reasons in the comments box.
- Queries about what information should be recorded in the tool or the proforma please contact your line manager or workforce planning co-ordinator.

Professional Judgement Data Capture Sheet: Nursing

Professional Judgement Data Capture Template: NURSING Emergency Care Provision Staffing Level Tool

Area/Location		Day:	Date:	
Time Period		Nurse/Midwife	Head count	Comments – In this column, general and variation - e.g. Transfers, Escorts, Emergency situation, Complexity social and or physical, Specific demands, Theatre Lists, 121 care, care of the dying
00:00-04:00	Staffing required to meet workload	Registered		
		Non-Registered		
		ENP		
04:00-08:00	Staffing required to meet workload	Registered		
		Non-Registered		
		ENP		
08:00-12:00	Staffing required to meet workload	Registered		
		Non-Registered		
		ENP		
12:00-16:00	Staffing required to meet workload	Registered		
		Non-Registered		
		ENP		
16:00-20:00	Staffing required to meet workload	Registered		
		Non-Registered		
		ENP		
20:00-23:59	Staffing required to meet workload	Registered		
		Non-Registered		
		ENP		

20240620 HSP Professional Judgement Data Capture Template NURSING Emergency Care Provision Staffing Level Tool V5.0

Professional Judgement Tool Guidance

- This tool runs for 2 concurrent weeks, commencing on a Monday and completed daily.
- To be completed by Senior Charge Nurse / Midwife or recognised leader of each time period / shift.
- The sheet to be completed as 'live' as possible retrospectively at the end of each 4 hourly segment.
- Discuss how the time went with staff and record in the comment section; record any additional workload pressures such as complex social cases, non-English speaking patients, physical issues/ transfers, complex 1-2-1 patients that may not be in labour, bereavement etc. These are the times when in your professional judgement more staff were required.
- Document the actual amount of staff that you required to meet the workload, registered and non-registered in each of the sections, and this can vary over the day due to peaks and troughs in workload i.e. emergencies etc.
- If the available rostered staff in your team exceeds the workload activity please record to indicate this accordingly.
- Queries about what information should be recorded in the tool or the proforma please contact your line manager or workforce planning co-ordinator.
- Data should be input into SSTS timeously once the data is discussed and quality assured in partnership with senior clinical staff and colleagues.
- Ensure the SSTS configuration reflects either 8, 12 or 24 hour services

Appendix C

Emergency Care Provision levels of Care Descriptor Code List

The Emergency Care Provision Tool was developed to define the time and intensity of patient's demands on medical, nursing and support worker staff in this environment.
There are different levels of classifications used to identify the differing levels of complexity in the demands made on staff.
The classifications range from Level 1 - routine care where there is minimal dependence on staff to Level 4 where there is total dependence on staff requiring 1:1 or continuous care.

The symbol indicates criteria or guidance relating to children.

Level 1 ***(Require routine intervention and care)***

Level 1 Description	Inclusion Criteria	Guidance on Care Required
Individual requires assessment. **May require investigation and treatment.** **Needs met with routine care.** **Discharged home**.	Any individual presenting with a minor injury or illness whose condition is stable and requires only minimal intervention. Parent, relative, carer, police/security may be present	• Requires routine clinical assistance • Routine observation (may be frequent for a short period) • Requires simple treatment e.g. wound closure, fracture immobilisation, soft-tissue support • Requires advice and simple instruction on self or follow up care • Parent, relative, carer requires advice and simple instruction on behalf of patient or follow up care • May require social work/other agency intervention

		 ○ (This would put this in level 2 if children's)

Level 2 ***(Require moderate increase in interventions and care and/or may involve the Consultant or more than one person for a specific period of time)***

Level 2 Description	Inclusion Criteria	Guidance on Care Required
Non- life threatening, acutely ill/ injured individual requiring clinical intervention **Or** **Those who are medically unstable with a greater potential to deteriorate** **Or** **Individual who requires increased clinical intervention/ assistance with specific aspects of care**	Patients requiring urgent but not emergency assessment or intervention May require admission to inpatient care • Is in stable condition but with increased acuity and/or potential to deteriorate • Requires more than routine care, but can be managed in ED • Increasing parental/ relative/ carer reassurance and emotional support required • Difficulties, Acute trauma, confusion • Relative, carer and staff support required due to increased anxieties / behaviours	Instability requiring frequent, but not continuous observation i.e. #Neck of Femur May require some or all of the following • Frequent monitoring in view of potential emergent deteriorating condition or fluctuating Vital Signs • Neurological monitoring in view of potential emergent deteriorating condition or fluctuating level of Consciousness GCS • ECG monitoring • Fluid management • Oxygen therapy 24 – 40% • 0_2 Saturation monitoring • Invasive monitoring • Pain Control

	of parents / carers / relatives  ○ Mild respiratory distress ○ Poor fluid intake e.g. due to D&V • Restricted mobility; spinal instability/ mobility difficulties • Pain • Psychological support with anxiety/ agitation/ psychosis or considered safety risk • Vulnerability risk factors e.g. drug/alcohol abuse • Suspect domestic abuse requiring constant input and supervision • Requires increased clinical input due to intensive therapy and invasive procedures • Has complicated care needs, requiring constant clinical attention during stay • May be agitated/aggressive due to underlying drugs/alcohol intoxication ○  Has complicated emotional and/or social family/ carer support needs e.g. ill child or young person, child protection issues,	• Increasing demands on clinical time • Requires frequent monitoring • Constant observation due to risk of harm/ flight or agitiation/ confusion from organic illness, dementia, mental illness or poisoning • Pain management requiring IV analgesia • Psychological support • Challenging behaviour • Parents, relatives or carers require increasing support • Parents, relatives or carers increasing anxiety and/or behaviours causing concern within clinical area • May require social work or other intervention agency

	learning disability, acute trauma, confused ○ Challenging complex child protection concerns requiring facilitation within ED	

Level 3 ***(Requires complicated invasive interventions and constant but not continuous care)***

Level 3 Descriptors	Inclusion Criteria	Guidance on Care required
Individual who is seriously ill with uncorrected major physiological abnormalities **and/or** **clinically deteriorating**	• Severe infection; sepsis • Complex wound management • Compromised immune system • Psychological support with severe anxiety/ distress • Severe psychosis or considered flight or safety risk, requiring continual supervision. • Spinal instability / mobility difficulties. Will require admission to inpatient and ongoing care: • Needing advanced respiratory support • Individuals who require 1 to 1	• Individual requiring non-invasive ventilation/ respiratory support e.g. re-breathe mask/ head box • nasal CPAP (child) • Respiratory or CNS depression/ compromise requires mechanical/ invasive ventilation • Airway obstruction / intervention / nebulised adrenaline / prolonged apnoea /severe asthma IV medications and hourly nebulisers • Requires a range of therapeutic interventions including: • Continuous oxygen therapy • • or High flow 02

	supervision but not dedicated 1:1 care /or constant but not continuous care. • Is seriously ill and at risk of deteriorating, requiring constant monitoring and more detailed monitoring • Challenging complex concerns requiring facilitation within the ED • Requires direct senior medical input/decisions • Challenging complex concerns requiring multi-disciplinary and specialist team facilitation within the ED • Challenging co-existing neurological impairment • Increasing and demanding parental and staff support and reassurance required during this period to manage increased anxieties and concerns ○  Requires complex emotional and/or social family/carer support, e.g. ill child or young person, child protection issues, learning difficulties, acute trauma, confused	• ECG / invasive pressure monitoring • ECG / non invasive monitoring • Vasoactive drug infusions (amiodarone, potassium, inotropes, nitrocine, magnesium) • Haemodynamically unstable or who hav • e CNS • depression and loss of airway & protective reflexes and require neurological observation • Treatment of hypovolaemia/haemorrhage/ sepsis or neurological protection • Frequent arterial blood gas analysis • Insertion and care of central lines / chest drains • Complex drug regimes • Complex fluid regimes • Ketoacidosis /electrolyte imbalance • Fluid resuscitation 10-30mls/kg • Acute renal failure • CNS Depression, GCS 8-12 • Providing emotional support to highly anxious parents, relatives, carers • Vulnerable family requiring support

	greater part of their stay ○ Challenging complex child protection concerns requiring facilitation within the ED	• May require social work intervention • Increasing demands on nursing time • Requires frequent monitoring • Constant observation due to risk of harm/flight or agitation /confusion from organic illness, dementia, mental illness or poisoning • Pain management requiring IV analgesia and/or psychological support • Challenging behaviour • Parents, relatives or carer's require increasing support • Parents, relatives or carer's increasing anxiety and/or behaviours causing concern within clinical area • May require social work/other agency intervention.

Level 4

Level 4 Descriptor	Inclusion Criteria	Guidance on Care Required
Individual with life threatening trauma/illness who needs advanced respiratory support **<u>and/or</u>**	• Intensive monitoring and supportive therapy for compromised or multi system organ failure • Severe Cardiovascular instability (rhythm abnormalities e.g.	• The emphasis at this level is on the multifaceted nature and complexity of care required. • The majority of adults, children and young people at this level will require high intensity

invasively ventilated and intensive therapeutic intervention **Bereavement care to the individual and family**	frequent defibrillation required), • at risk of Organ failure developing • neurologically unstable requiring (invasive) monitoring and therapeutic intervention, ○ •  Severe asthmatic child • Circulatory and respiratory compromised child • Neurologically impaired child • Will require; • Extensive intervention for the resuscitation and/or stabilisation of the critically ill • Admission to inpatient area/transfer and ongoing care • Direct senior medical input/decisions • Advanced respiratory support • Intensive and invasive cardiac monitoring • Extensive assessment and monitoring of the individuals physiological responses • Dedicated 1:1 care/or continuous care, may require more than 1:1 care for periods of time • Extensive support and care of family • Complex emotional and/or social	nursing and medical care during the period of care in the ED. • • The emphasis at this level is on the multifaceted nature and complexity of care required. The majority of adults, children and young people at this level will require high intensity nursing and medical care during the period of care in the ED • • Individual requiring non-invasive ventilation/ respiratory support e.g. re-breathe mask/ head box  ○ • nasal CPAP (child) • Respiratory or CNS depression/ compromise requires mechanical/ invasive ventilation • Airway obstruction / intervention / nebulised adrenaline / prolonged apnoeas /severe asthma IV medications and hourly nebulisers • Extubation • Requires a range of therapeutic interventions including: • Continuous oxygen therapy ECG / invasive pressure monitoring

	parental, family/carer, staff support, e.g. ill child or young person • Bereavement care and support of parent, relative, carer, discuss organ donation • Management of; •  • Challenging and highly complex child protection issues • Challenging complex concerns requiring multi-disciplinary and specialist team facilitation within the ED • Challenging co-existing neurological impairment • Frequent measurement of challenging physiological abnormalities • Complex neurological needs	• ECG / non invasive monitoring • Vasoactive drug infusions (amiodarone, potassium, inotropes, nitrocine, magnesium) • Haemodynamically unstable or who have CNS depression and loss of airway & protective reflexes and require neurological observation • Treatment of hypovolaemia/ haemorrhage/ sepsis or neurological protection • Airway compromise • Major scald/burn • Major sepsis • Acute obstruction • CFAM Monitoring • Patients who are non-invasively ventilated but showing signs of deterioration • Frequent blood gas analysis •  Insertion and care of central lines / chest drains ○ • Intra - Osseus needles • Complex drug regimes • Complex fluid regimes • Ketoacidosis /electrolyte imbalance

		• Fluid resuscitation 10-30mls/kg • Acute renal failure • CNS Depression • Providing emotional support to highly anxious parents, relatives, carers • Challenging behaviour / potential for self-harm • Bereavement care and support of parent, relative, carer, discuss organ donation • Any disruption to ABC requiring ongoing support and treatment

Appendix D

Frequently Asked Questions and Answers

The purpose of this section is to give some quick guidance about completing the EDEM tool and to provide examples. This quick guide has adopted a question/answer format and should be used in conjunction with earlier parts of the user guide

Emergency Care Provision Staffing Level Tool **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 staffing level tool. 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. Please also refer to the: Quality Assurance Checklist:
Q2	**Why am I being asked to use two tools?**
	You are being asked to use the Professional Judgement Tool (PJ) along with the Emergency care provision staffing level tool. This forms part of the Common Staffing Method approach mentioned above. The staffing level tool provides rWTE information on staffing needs that is considered alongside other local information, such as the PJ WTE staffing outcomes, which is based on your judgement of needs for the workload at that time, before decisions on staffing can be made.
Q3	**Does the tool consider mandatory training requirements?**
	The recommended whole-time equivalent includes a Predicted Absence Allowance. The Allowance is to support time out such as Staff training, holiday, sickness, maternity and special leave. A national Predicted Absence Allowance of 22.5% for nursing staff and 25% for medical staff is included in the Emergency Care Provision Tool. 2% of this total is for study leave. Please always check your local policy for your specific PAA percentages.
Q4	**How does the tool capture all aspects and complexity of my work?**
	The tool was developed by ED clinicians, nurses and doctors, across Scotland who have agreed that the tool broadly represents what they do.

	Levels of Care have been developed within the tool to recognise the workload required for the most straightforward care to the most critical care. The differing Levels of Care reflect the varying complexity. The levels of care are outlined in Appendix C The staffing level tool is incorporated into a national programme of work, which will be reviewed and refreshed to ensure that, as far as is possible, all workload, changes and new developments are included. Remember the level of care to be documented is the level where most care was delivered, Not the level the patient spent the longest at.
Q5	**Why are we only recording the patient on discharge.**
	This is to match the National A&E statistics; they document the patient once – on their admission. We are asking for them to be recorded at discharge so clinicians can document the level of care that best reflects the patient's episode of care. If this level of care is not clear then the clinician must professionally judge where this patient has received most care.
Q6	**Why do we no longer need to document time in and out on SSTS, but are being asked to document this on the Data capture template.**
	Within SSTS time and time out does not influence the outcome for rWTE so we are advising not to document this to minimise data entry burden, however for staffs ease we are advising to document time in and out on the data capture template to enable the clinician to accurately document the level of care that best reflects the patient's episode of care – from admission to discharge.
Q7	**Why has the time of data entry changed?**
	This has been changed to enable accurate data capture of 14, 24-hour periods
Q8	**Additional activities**
	These have been clarified on the documented to enable accurate documentation of the actual workload within this staffing level tool.

Appendix E

Trouble shooting

Emergency Care Provision Level Tool **Troubleshooting guide**
1. **SSTS**
I am getting an error message when trying to login to SSTS. What should I do?
SSTS and the staffing level tools can only be accessed on a Board approved computer network or portable network. If you are experiencing login problems when using a board approved network, contact your local SSTS team for advice
What should I do if I lose my login details?
Contact your local SSTS Team.
The staffing level tool I need to access is greyed out. What do I do?
Double check that you are trying to access the correct tool Contact your local SSTS manager to change your permissions if you are unable to access the correct tool
The working location shown is incorrect – how do I change this?
See Section 2.0
My service area/ working location isn't shown on the list. What do I do?
Contact your local SSTS manager to ensure that you have the right permissions to access the tool for your specialty.
What happens if the internet goes down whilst during data entry to SSTS?
You will have to re-enter any unsaved data once you are able to access SSTS again
What happens if I enter the wrong information by mistake e.g. wrong dates or level of care?
You will be able to amend any unsaved data while still logged into SSTS If you have Editor permissions, you should be able to amend the entry even after it has been saved using the edit function

Why won't the EDEM intervention entry screen let me "save" or "save and add another"?
Make sure you have added data into all 4 of the data entry cells. This should then let you save your data and open the next screen
Why can't I amend the "time in" when a patient's level of care changes?
Please do not input time in for patients or document changes in level of care in the SSTS tool, ONLY within the Data Capture Template. Please see questions in the FAQ document above.
The categories of additional activity do not reflect the additional activity that was recorded on the shift. What should I do?
There is an option to choose "other" and add a description of the activity. Please ensure the additional activities added are of a rare and extraordinary nature, not anything included/expected within your working day. See Additional Activities.
Why cant I access the Summary display screen?
Only those with SSTS editor permission access can access the summary display screen. If you believe you should have access to this screen, please discuss this with your manager and/ or the local Work Force Lead.
2. **The Staffing Level Tool**
I can't download the paper data capture template. What do I do?
1. You can try using a different web browser to download the template 2. You can print Appendix B from this document 3. You can speak to the local IT team as permissions may be needed for accessing and downloading documents 4. Speak to your workforce lead and they should be able to assist in providing paper copies of the template
There are data capture sheets missing for some of the shifts – what should I do?
Double check with the teams working on the shifts where data is missing, as they may still have the sheets You should enter the data you do have onto SSTS and this will pull through to the BOXI report. Gaps will show in the charts for any dates you do not have any data for.

The SCN is off sick. Who takes responsibility for the data collection and SSTS entry now?
The Nurse in charge of the shift should always make sure the data is collected for their shift. The completed data capture templates should be filed securely in the agreed location for quality checking and SSTS upload. SSTS entry can be done after the tool run is complete. There is a time limit of 2 calendar months to enter the data The workforce lead will be able to provide support with completing the tool run in the absence of SCN
The rWTE is much higher/ lower than our actual/FE. What should I do?
This may simply be a reflection of your workload. However, it is worth quality assuring the data, in particular, that you have selected the correct specialty for the roster area, and that patient have been inputted on day of discharge and have their level of care documented as the level they received most care at. It is also worth checking that you have the most up to date FE for the service and the calculations for actual and additional staff have been completed correctly on the summary screen.

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We are happy to consider requests for other languages or formats.
Please contact our Equality and Diversity Advisor on 0141 225 6999 or email contactpublicinvolvement.his@nhs.net

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