The Safer Nursing Care Tool

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Content

Context

Setting the baseline establishment

The Safer Nursing Care Tool - development

The Safer Nursing Care Tool – implementation

Applying the SNCT in practice
Context

How to ensure the right people, with the right skills, are in the right place at the right time
A guide to nursing, midwifery and care staffing capacity and capability

Review into the quality of care and treatment provided by 14 hospital trusts in England: overview report
Professor Sir Bruce Keogh KBE

The Mid Staffordshire NHS Foundation Trust Public Inquiry
Chaired by Robert Francis QC

A promise to learn — a commitment to act

Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry
Executive summary

Improving the Safety of Patients in England
National Advisory Group on the Safety of Patients in England
Setting The Right Establishment

- Using Evidence Based Tools
- Safer Nursing Care Tool
- Birthrate Plus for Midwifery
Safer Nursing Care Tool - Origins

- No basis for historical staff establishments
- Patients on the wards becoming sicker
- Need to determine critical care capacity
- No simple consistent tool that
  - nurses liked
  - general managers accepted
- No tool that linked input with outcomes
- Allows benchmarking
- Staffing requirements = quality outcomes
Acuity/Quality Method

**Strengths**
- Allows for most variables – discriminates between patients with differing needs
- Measures workload and patient acuity
- Measures throughput
- Quality measures included
- Easy to use and understand

**Weaknesses**
- Measures actual – not predictive
- Requires validation of data to prevent ‘gaming’
- Not suitable for use in small wards
Development

AUKUH Acuity/Dependency tool

- Based on Comprehensive Critical Care Classification DH 2000
- Added criteria for ‘Stable’ but highly dependent on nursing intervention (1b)
- Applied in practice in 10 UK NHS Trusts
- Required academic input
Development

Leeds University Acuity database (1000 wards)

- 3332 hours activity observed in 86 wards
- 119000 nursing interventions

- Multipliers developed by aligning 2 sets of data
Development

• Patient needs measured on 2 scales
  ➢ Leeds Dependency Acuity/Quality rating instrument contains data from 1000 wards
  ➢ AUKUH (SNCT) criteria (based on Comprehensive Critical Care Classification DH 2000)
• Significant level of correlation between 2 scales*
• Low nurse assessing error rate

Correlation between
  ▪ bank staff/drug related incidents/complaints
  ▪ levels of RNs/no. of falls
  ▪ bank staff/patient satisfaction/confidence in carers findings

Enough nurses but in wrong place
  ▪ *Hurst K. Developing & Validating AUKUH’s WP&D System (2005)
Field Testing/Validation

- Dual scoring/assessment across 3 sites
  - Low nursing assessment error rate
  - Strong correlation across 3 sites
  - Leeds acuity data recalibrated to create AUKUH/SNCT multipliers
Field testing the Tool

Development of Implementation Guide

9 pilot sites +
University and District General Hospitals
NHS Scotland

Findings
easy to use
acceptable time commitment
guidance sufficient

Critical success factors
systematic application
interrogate trends
consistency – data collection/validation/time period
Safer Nursing Care Tool (SNCT) 2013

- Updated criteria definitions & multipliers collection of data on over 40,000 patient care episodes
- Recommended tool by the Chief Nursing Officer for England
- NICE examination of evidence base
- Multipliers being developed that are more specific for certain care areas
  1. Care of the older person
  2. AMU
  3. Children/Young People
  4. A&E
## Safer Nursing Care Tool Classifications

<table>
<thead>
<tr>
<th>Level</th>
<th>Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Patient requires hospitalisation Needs met by provision of normal ward cares.</td>
</tr>
<tr>
<td>1(a)</td>
<td>Acutely ill patients requiring intervention or those who are UNSTABLE with a GREATER POTENTIAL to deteriorate.</td>
</tr>
<tr>
<td>1(b)</td>
<td>Patients who are in a STABLE condition but are dependant on nursing care to meet most or all of the activities of daily living.</td>
</tr>
<tr>
<td>2</td>
<td>May be managed within clearly identified, designated beds, resources with the required expertise and staffing level OR may require transfer to a dedicated Level 2 facility / unit</td>
</tr>
<tr>
<td>3</td>
<td>Patients needing advanced respiratory support and / or therapeutic support of multiple organs.</td>
</tr>
</tbody>
</table>
The multipliers 2013

Level 0 = 0.99
Level 1a = 1.39
Level 1b = 1.72
Level 2 = 1.97
Level 3 = 5.96

(includes 22% uplift for Annual leave etc)
Key considerations prior to introducing SNCT

• Ensure Executive Board, General Managers, Clinical Directors engaged & supportive

• Ensure data collection & analysis systems are in place & not labour intensive

• Gain co-operation of Ward Sisters/Charge Nurses & Matrons

• Ensure staff are trained and prepared for applying the tool in practice
Red Rules for practice - organisational level

• Identify a Lead for the project
• Nominate staff to quality control the data collection
• Data collection min 2 times per year
• No changes to establishment until minimum of 2 data sets
• Feedback to sisters/charge nurses
Red Rules for practice- ward level

- Identify max 3 people to complete scoring on each ward
- MUST include ward Sr/C/N
- Patient scoring at 15.00 hrs approx each day
- Minimum of 20 days
- Weekly external validation by a Matron/Consultant Nurse

(Shelford 2013)
How it is used – In practice

- Ward sister or deputy assigns score to each patient each day
- Completed as part of a walk around beds
- Score for patient occupying bed for largest time in 24 hours
- Direct score entry to iPad at the bedside
How it is used - in practice

Assigned Matron/Consultant Nurse - weekly verification of scoring at the bedside ensures

- must be with the sister/deputy who regularly identifies the level of care
- consistency of application
- reduces risk of bias
- matrons/consultant nurses allocated to wards outside of own management
Feedback from staff

• I have been thinking a lot about the acuity scores since we walked round together and am concerned that where the audit was delegated (which it isn't anymore) it may not reflect our true acuity. (Ward Sister)

• I completely forgot to do the validation last week, a call from the ward would have prompted me (an external validator)

• charge nurse has everyone down as a 2, we had a nice chat about that (external validator)

• There are a number of 1b's this time - primarily for mobility issues: patients requiring log rolling, regular turns with 2+staff, etc. 1 patient new palliative diagnosis yesterday so have put them as 1b (has been referred for counselling so felt appropriate). (external validator)

• I now do the majority of the acuity scoring and only let my deputy do it in exceptional circumstances as I now understand how my staffing is set according to this. (ward sister)
Application in practice

Case studies to work on in groups to determine the levels of care of these patients.
Followed by presentation back to group
Case Study for practice

No. 1

- 41 year old gentleman Low grade Lymphoma,
- On S/C Cyclizine,
- 8hrly IV fluid regime,
- Food Chart
- Washing & dress, toileting independent

Level:
Case Study for practice

No. 2

• 87 year old gentleman,
• had a bladder tumour resection 3 days ago.
• It is 3pm,
• checking his clinical observations he appears to be stable, 6 hourly observations.
• He is asleep just now so not possible to talk with him

BUT
Case Study for practice

No. 2 cont.

Upon checking with Sister:
• He is very confused particularly at night when he gets very agitated,
• has fallen twice as he is very unsteady on his feet and gets out of bed without asking for help
Case Study for practice

No. 3

• 63 years old lady
• Type II diabetes
• 1st day post-op revision hip replacement
• EWS Breached
• 1/2 hourly observations discontinued at 10:00 today
• IV fluids
• Epidural Patient Controlled Analgesia
• Needs assistance with hygiene, toileting, taking fluids, moving
Case Study

No. 4

- 87 years old lady
- Pneumonia
- Clinical observations stable, 6 hourly
- Dementia
- Very confused and agitated – at risk of falling
- Needs assistance of 2 nurses to mobilise/transfer
- Needs assistance with all ADLs
Case Study for practice

No. 5

John a 28 year gentleman who had his bowel resection 2 weeks ago. He is a very nice man but his wife is so fussy. He can probably go home in next few days.
Calculating Ward Staffing Establishment

28-bedded ward has:
- 12 patients at Level 0
- 7 patients at Level 1a
- 8 patients at Level 1b
- 1 patient at Level 2

Sum
- 12 patients at Level 0 = 0.99 \times 12 = 11.88
- 7 patients at Level 1a = 1.39 \times 7 = 9.73
- 8 patients at Level 1b = 1.72 \times 8 = 13.76
- 1 patient at Level 2 = 1.97 \times 1 = 1.97

Total = 37.34 WTE
## Nursing Inpatient Staffing Report

<table>
<thead>
<tr>
<th>Beds</th>
<th>Current FTE for 2013</th>
<th>FTE establishment recommended in 2013</th>
<th>Acuity / Dependency Variance 2013</th>
<th>Number of RN:NA achievable Day Shift</th>
<th>Number of RN:NA achievable Night Shift</th>
<th>RN:Pt Ratio achievable Day Shift(not incl NIC)</th>
<th>RN:Pt Ratio achievable Night Shift (incl NIC)</th>
<th>Considerations</th>
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<tbody>
<tr>
<td>28</td>
<td>36</td>
<td>36.7</td>
<td>-0.70</td>
<td>6+2</td>
<td>4+2</td>
<td>1:5.6</td>
<td>1:7</td>
<td><img src="commentary" alt="2 sets of data used only. June data unreliable. On one day per week can have 6+2 therefore achieving 1:5RN:Pt ratio" /></td>
</tr>
<tr>
<td>26</td>
<td>31.4</td>
<td>33.5</td>
<td>-2.10</td>
<td>5+2</td>
<td>4+2 M-F; 4+1 S &amp; S</td>
<td>1:6.5</td>
<td>1:6.5</td>
<td><img src="commentary" alt="2 sets of data used only. June data unreliable. On one day per week can have 6+2 therefore achieving 1:5RN:Pt ratio" /></td>
</tr>
<tr>
<td>12</td>
<td>18</td>
<td>14.4</td>
<td>3.60</td>
<td>3+1</td>
<td>2+1</td>
<td>1:6</td>
<td>1:6</td>
<td><img src="commentary" alt="Small ward therefore the recommended would not provide adequate 24 hour rota cover. 18.3FTE provides the ratios/numbers here with a 71:29 skill mix." /></td>
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<td>2+1</td>
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<td>Small ward therefore the recommended would not provide adequate 24 hour rota cover. 18.3FTE provides the ratios/numbers here with a 71:29 skill mix.</td>
</tr>
<tr>
<td>10</td>
<td>14.5</td>
<td>12.7</td>
<td>1.80</td>
<td>3</td>
<td>2+1 M-F; 2 S&amp;S</td>
<td>1:5</td>
<td>1:5</td>
<td>Small ward therefore the recommended would not provide adequate 24 hour rota cover. 14.9 FTE will provide this cover with a skill mix of 88:12. The use of other therapy staff during day shift should be taken into consideration.</td>
</tr>
<tr>
<td>15</td>
<td>27.3</td>
<td>20.2</td>
<td>7.10</td>
<td>4+1</td>
<td>3+1 M-F; 3 S&amp;S</td>
<td>1:5</td>
<td>1:5</td>
<td>To achieve the ratios/numbers here would require 22.8 and provides a skill mix of 80:20</td>
</tr>
<tr>
<td>24</td>
<td>40.6</td>
<td>30.8</td>
<td>9.80</td>
<td>6+1/5+2</td>
<td>4+1</td>
<td>1:4.8/1:6</td>
<td>1:6</td>
<td>8 single rooms therefore add 0.6FTE to recommended = 31.4FTE. Using 31.4FTE can provide the ratios/numbers recommended with a skill mix of 75:25/83:17.</td>
</tr>
</tbody>
</table>
Ward report

INPUTS
• FTE actual V recommended
• Actual Skill mix
• Acuity levels of care ratios
• Nurse:Bed ratios per day available V actual required

Mapped to:
OUTCOMES
• Processes of Care
• Incidence of harm
• Patient Experience
• Staff Experience
The Safer Nursing Care tool (SNCT) demonstrates that 30% of the patients cared for during June 2013 were Level 0. Level 0 patients may be those awaiting discharge to home, post operative patients and those who require assistance of one person for some daily activities such as mobilising. 9% of the patients were level 1a and there were no level 1b in June 2013. This compares to 50% of the patients being level 0, 8% level 1a and 4% were level 1b in April 2013.

Overall the SNCT recommends a nursing establishment of 26.5FTE for June 2013 however the budgeted establishment is 29.6FTE. Datas compliance on this ward was 83%. The current skill mix is 75RN:26NA and the Trust recommends that the skill mix should be 70RN:30NA as a baseline.

It is recommended that staffing changes should only be made following 2 or more rounds of data collection. 

HoN comment: The ward sister has been away on Maternity leave from September 2012. She has now submitted her resignation and the recruitment process for a replacement is in place. 2 RN to commence on 1st September.
## Divisional/Trust Level report

<table>
<thead>
<tr>
<th>Input-Staffing</th>
<th>Input-Process of Care</th>
<th>Outcome - Incidence of harm</th>
<th>Outcome - Patient &amp; Staff Experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>% Data compli ance</td>
<td>Acuity</td>
<td>Help with feeding</td>
<td>Percentage of Complete Vital Signs Observations</td>
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<td>Acuity</td>
<td>Help with feeding</td>
<td>Percentage of Complete Vital Signs Observations</td>
</tr>
<tr>
<td>100</td>
<td>4</td>
<td>100</td>
<td>98%</td>
</tr>
<tr>
<td>73</td>
<td>1</td>
<td>71.4</td>
<td>81%</td>
</tr>
<tr>
<td>83</td>
<td>1</td>
<td>100</td>
<td>90.0%</td>
</tr>
<tr>
<td>94</td>
<td>1</td>
<td>91.67</td>
<td>100%</td>
</tr>
<tr>
<td>98</td>
<td>-2</td>
<td>No data</td>
<td>No data</td>
</tr>
<tr>
<td>98</td>
<td>-2</td>
<td>No data</td>
<td>No data</td>
</tr>
<tr>
<td>90</td>
<td>5</td>
<td>66.67</td>
<td>100%</td>
</tr>
<tr>
<td>98</td>
<td>-4</td>
<td>90%</td>
<td>10%</td>
</tr>
</tbody>
</table>
Reports

• Report of ratios of levels of care, recommended staffing establishment, patient outcomes, care processes, patient experience & staff experience (Care Thermometer)
  - Per ward,
  - Per division,
  - Trust level

• Sent to Chief Nurse, DCN, NMB, all wards
Q&A

Thank you for listening.
If you have any questions at any time email

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Rachel.finn@nuh.nhs.uk
Or phone 0115 969 1169