Using the Baseline Emergency Staffing Tool (BEST)

IMPORTANT NOTICE: PRODUCT UNDER EVALUATION

Between April and Nov 2013 the BEST will be available for use but is under continuous evaluation. The aim of the evaluation period is to refine the calculations performed by the tool. During this period if you have questions about the tool or the results generated contact us via eca@rcn.org.uk it is important we receive your feedback to help us edit the final version for issue in Nov 2013.

The BEST has been designed to estimate Emergency Department (ED) nursing staffing requirements based on a combination of the number of patients attending the department, and a measure of the patients’ nursing dependency – not their acuity. A patient may be very sick, but not actually require much nursing input. Their acuity would be high, but their nursing dependency low. There may be another patient who is not actually very ill, but because of other factors, (perhaps incontinence, coupled with confusion), will have a low acuity, but very high dependency. They require significant nursing input, despite not being critically ill.

After using the tool, you will only be able to see your own data and will not be able to benchmark against other departments – benchmarking is not a function of the tool. The RCN accepts no responsibility for governance of the data inputted. The RCN will not share data with third parties without your express permission. After analysing the data we may anonymise your output graphs and use this in future presentations about the tool.

To ensure optimal output from the tool, seven days of data need to be collected. Ideally this should be consecutive days. Each patient attending the ED must be assigned a dependency score. The only validated tool, for measuring patient dependency in the emergency department is the Jones Dependency Tool (JDT).

Dependency Scoring

The JDT is constructed in 2 parts: Section A and Section B.

Section A (Appendix A) gives a range of indicators against which each patient is scored. A low score indicates that the patient does not have a high dependency in that indicator – for example in the category of communication, a person who is able to communicate without
difficulty and has pain at the lower level of the scale will score 1 for that indicator, whereas someone who has complete impairment in communication and pain at the higher end of the scale will score 3.

There are indicators for Communication, ABC factors, Mobility, Eating drinking elimination and personal care, Environmental safety, health and social needs and Triage scores.

Additional indicators have been written and discussed with an expert paediatric reference group for children. Where a child is being assessed it will be appropriate to use the adapted JDT for children - Appendix C.

Section B (Appendix B) of the JDT is very helpful in indicating what type of nursing input patients in the various levels of dependency will require, though does not contribute to the score. Where there is uncertainty whether the patient should score a 2 or a 3, it is often useful to look at the narrative in section B.

The total from the JDT part A, (appendix A or C) gives a score ranging from 6 to 18.

- 6-7 represents Low dependency
- 8-12 represents Moderate dependency
- 13-15 represents High dependency
- 16-18 represents Total dependency

Data Collection

Each hour all new patients attending the department are counted for each dependency category. In addition, all Moderate, High and Total dependency patients still in the department from the previous hour are added to the count. This includes those out of the department but with nursing escort (e.g. in CT scan etc). If patients change dependency during the hour (e.g. patient from Road Traffic Collision goes from Total to Moderate after they have been initially assessed and stabilised) they are added to the count for their new category.

Note- Low dependency patients are scored only once for the hour during which they arrive. Experience suggests these patients require very little nursing attention from when they are initially assessed at triage until they need treatment following diagnosis. If there are adequate resources, these patients can often been seen and treated within the hour.
A further category of patients that needs to be counted are those waiting for admission beds. Patients who have been fully assessed in the ED, have a recorded treatment plan and for whom a decision to admit has been made, should be placed in this category. **This does not apply to patients with complex conditions who are awaiting an ITU, HDU or CCU bed, or who require high levels of nursing care while in the ED - these patients should continue to be scored using the total, high or moderate scores as appropriate.**

**Please exclude CDU and observation ward patients from data collection.** There is separate RCN guidance on calculation of staffing for these areas.

The simplest method of data collection is to use one separate sheet for each hour, with sections for low, moderate, high and total dependencies and patients with a decision to admit. These can be developed in your own unit, or you can use or adapt the very simple model - Appendix D. If you are collecting data in separate areas, these will need to be collated into a cumulative data document, such as that at - Appendix E.

The most valid method of assigning patient dependency is to capture the data real time, on the hour every hour. This requires extra resources for data collection during the data collection week to ensure every patient in all areas are scored every hour. Invariably some data is lost. If you omit to record data for an hour, record it as soon as possible. If you fail to record the data then leave the cell blank. Do not enter a zero figure if the data is not collected. It is important to leave the cell blank if no data is collected.

Experience has shown that the data can be collected retrospectively if the nursing documentation is adequate to establish patient dependency. The advantage of this method is that it requires less on-the-ground resources to capture the data (it can all be done by one person) and data is rarely lost, thus 100% capture can be made.

In addition to patient data the tool also needs staff data. The tool required the number of staff rostered to be entered hour by hour. This number should **include** the shift co-ordinator and all registered nurses and support workers who have clinical duties (i.e. patient care) but **exclude** CDU and Observation ward nurses, Housekeepers with non-clinical duties, reception staff, Emergency Nurse Practitioners and Advanced Nurse Practitioners. The time to provide the diagnostic function of these latter two groups of staff is not captured within this version of BEST. Likewise, Nurse Consultants, Matrons, Professional Development Nurses, should not be included in the staffing unless they are rostered to have patients that hour. You will be able to acknowledge their presence when you are considering the suggested skill mix breakdown in the recommended whole time equivalence workforce.
BEST Output

For each day of data entry you will receive a graph which illustrates the number of staff rostered per hour and the calculated staffing per hour. The calculated staffing is a measure of the nursing workload per hour – not a recommended minimum staffing number.

When seven days’ worth of data have been entered there will be an eighth summary graph available depicting the same two data sets as above for the entire audit period at the 80th percentile. The rationale for this is that staffing to 100% for peak demand will mean that most of the time there will be an excess of nurses but staffing for 50% would mean that you will not have enough nurses to provide care for at least half of the time.

Whole Time Equivalent (WTE) Workforce

In addition to the graphs, you will be advised of the whole time equivalent (WTE) workforce you would need to provide the numbers of staff per hour as depicted in the summary hourly graph. This represents what the WTE would be if the disparity between the current roster and the nursing workload was addressed solely by rostering extra staff. In fact this is only one of many ways to address a disparity between workload and workforce and its use is in process and pathway planning as well as workforce planning.

This calculation uses a 25% uplift as recommended in previous RCN staffing levels publications.

Skill Mix

The skill mix breakdown is based on expert opinion from the RCN Emergency Care Association (ECA) and the Faculty of Emergency Nursing (FEN) and is applied to the WTE calculated. Rather than recommend agenda for change bandings we recommend competency levels. The competency levels are described in more detail on the Faculty of Emergency Nursing website: www.fen.uk.com The three levels referred to in the BEST are below - 80% of the WTE should be registered nurses in one of the following categories:

Fellow - Expert emergency nurse who draws on a large knowledge base and contributes to the development of new evidence base of emergency nursing practice, working without supervision in any care setting.

Member - Proficient emergency nurse who delivers evidence based care under minimal guidance with peer support. Competent to fulfil role of shift leader.

Associate - Competent emergency nurse who delivers evidence based practice to patients presenting with complaints, working under the direct guidance of a proficient emergency nurse.
In summary:

- You need to establish a dependency score for every patient coming through the department over a 7 day period using the Jones Dependency Tool.
- Patients of low dependency are scored once and counted in the hour in which they arrive. They are only counted again if their dependency increases during their time in the department.
- Patients of moderate, high or total dependency are counted for each hour they are in the department, their category may change up or down over time in the department.
- If patients are for admission, and are simply waiting for a bed, they should be moved to a ‘wait for bed’ category and counted for each hour they wait.
- Rostered staffing should reflect the numbers of staff you have on at each hour. Include all health care assistants, clinical support staff and nurses providing clinical nursing care including the nurse co-ordinator or nurse in-charge. Exclude ENPs, ANPs. Also exclude Matrons, Nurse Consultants and Practice Development Nurses, Specialist Practitioners (e.g. Mental Health Liaison, Alcohol workers or Physiotherapists) if they would not be counted in the nursing numbers at the time. Also exclude nurses staffing observation units or CDUs – as the patients here are not counted.
- The outputs from the tool are for use at local level for workforce planning, they will highlight any disparity between workforce and workload. The RCN do not recommend minimum staffing levels.

For support contact eca@rcn.org.uk