



# **The Scottish Birth Record**

## *Clinical User Manual*

***June 2011***

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## **Section 1: Background & Introduction**

Welcome to the Scottish Birth Record (SBR) Clinical User Manual.

There are two separate yet dependent modules to the SBR system. There is the **clinical module**, which can be completed by midwifery, neonatal and paediatric staff as well as administrative staff where appropriate. This then feeds the relevant data items into the smaller **coding module**. The coding module is then amended and checked by trained coding staff. Amendments to clinical data items by coding staff do not change the entries made on the clinical side. The coding staff also add any diagnostic codes (ICD10) and procedural codes (OPCS4) where appropriate and submit the record to the national central database.

Until 1996 every baby was entered onto the SMR11 scheme. At that time it was decided that details of healthy babies should reside on SMR02 (maternity), and the SMR11 would be reserved for 'sick' babies and those with congenital anomalies. However, this did not prove successful and there was confusion over what constituted a 'sick' baby. There was also an unacceptably low level of reporting of congenital anomalies.

The SBR has replaced the SMR11 reporting scheme and every baby born in Scotland will have one (and only one) Scottish Birth Record. All 'sick' babies born from the 1<sup>st</sup> April 2003 have been entered onto the SBR system. In due course we aim to record all births in Scotland including homebirths and stillbirths. The SBR system provides the functionality to record **all** of a baby's neonatal care in Scotland, including readmissions and transfers in **one** record.

The growth of Internet technology has allowed us to devise a web-based reporting scheme. Although the SBR is a web-based system it does not reside on the public Internet, instead it is on the NHSNet, which is the NHS private version of the Internet. All interactions are password protected and the system has a full audit trail.

Further work is planned to build on the SBR's ability to share data. This will bring additional benefits to areas such as: direct patient care; service management; planning, and research. Already the SBR extracts data from clinical maternity systems and Patient Administration Systems and can be used to interface with the system which generates Community Health Index (CHI) numbers (62% of babies in Scotland already get their CHI number this way). We plan to build further interfaces so that data can be more effectively shared amongst all relevant systems – maternity, neonatal and child health surveillance. The end result shall be a clinical and coding system which will play a pivotal role as a 'key node aggregator' in the future sharing of data.

**Please note that a training database has been used in the development of this manual, therefore there are no real patient data displayed within the manual.**

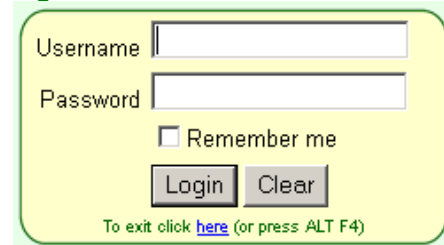
## Section 2: Log In

To allow users to practice on the system there are **two** Scottish Birth Record (SBR) systems – ‘**Live**’ and ‘**Training**’. To access these systems:

1. Double click on the relevant icon on the desktop
2. Enter a username and password



**Figure 1**

A login form with a yellow background and a green border. It contains two text input fields: 'Username' and 'Password'. Below the 'Password' field is a checkbox labeled 'Remember me'. At the bottom are two buttons: 'Login' and 'Clear'. Below the buttons is the text 'To exit click [here](#) (or press ALT F4)'.

Username

Password

Remember me

Login Clear

To exit click [here](#) (or press ALT F4)

2. Click on Login button

NB. If you tick the ‘remember me’ box, the system will automatically remember the last username entered so that you will not have to enter it again when logging back in.

### The Training System

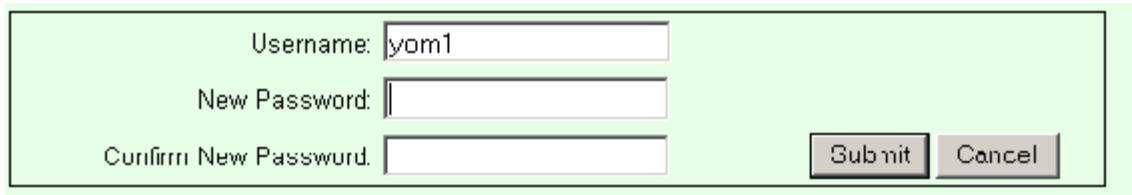
Generic user names and passwords are created for each site within the training system. Please contact your local SBR administrator or the SBR Team to confirm the username for your hospital (see Appendix D “Contacting us”). Your training system password is ‘**training1**’.

**PLEASE NOTE** - The training system does not reside on a secure website therefore it is very important that you **DO NOT** enter any **CONFIDENTIAL DATA**.

### The Live System

To access the live SBR you will require a unique username and password. You can obtain this from your local SBR Administrator or the SBR Team (see Appendix D “Contacting Us”).

**Figure 2**

A password reset form with a light green background and a black border. It contains three text input fields: 'Username:' with the value 'yom1', 'New Password:', and 'Confirm New Password:'. At the bottom right are two buttons: 'Submit' and 'Cancel'.

Username: yom1

New Password:

Confirm New Password:

Submit Cancel

For first time users, or if your password has been reset, the password is ‘**password**’. Once you have entered your login details you will be prompted to provide **your own secure personal password that must be at least 6 characters long with 1 number**.


**PLEASE NOTE** – you **must** only enter the system using your **own unique username and password**.

If you have any problems accessing the SBR, including forgetting your password, please contact your local SBR Administrator or the SBR team via the Atos helpdesk

### Section 3: The Dashboard

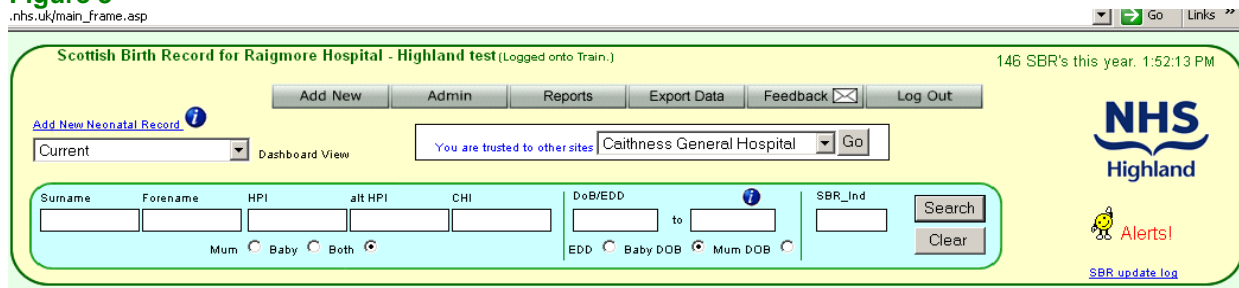
Once logged in you will be presented with the **dashboard**, a screen showing summary patient details that also gives you access to system administration and enhanced system functionality.

The top section (see Figure 3) identifies the user, site and relevant NHS Board. It also provides access to additional functions:

- Add new record
- Accessing alternative dashboard displays
- Searching for records
- System and password administration
- Reports
- Exporting Data
- Contact
- Logging out
-  Alerts! - User alerts where records require attention
- [SBR update log](#) is a link to SBR website providing information about version changes

These functions are described in detail later.

**Figure 3**



The lower section (see Figure 4) provides access to your patient records. It also:

- Provides access to the print room
- Provides ability to delete a record
- Provides ability to send a record to another location
- Indicates the transfer/sent status of a record
- Provides access to the CHI interface (where implemented)

If a record has a blue background, it is a boy, if it has a pink background it is a girl, and yellow backgrounds are when the sex of the baby is unknown. A grey background indicates a record over twelve months old. A dark blue dot next to the baby's forename indicates a stillbirth or a baby that died during care.

A count of records together with the number of pages is provided for information. Again these are described in detail later.

**Figure 4**

Baby Surname	Forename Baby (mum)	Baby DOB (if born)	Hospital Patient ID / CHI			
Tawrie SBR_Ind=3914	Toby	16/04/2009	not entered	Open		
Fruitella SBR_Ind=3900	Baby (Jane)	31/03/2009	not entered	Open		
Mccoys SBR_Ind=3896	Mark	31/03/2009	not entered 310309232	Open		
Pastilles SBR_Ind=3897	Fruity	31/03/2009	not entered	Open		
Peta SBR_Ind=3903	Baby (Petula)	31/03/2009	not entered	Open		
Smithy SBR_Ind=3902	Samual	31/03/2009	not entered	Open		
Twix SBR_Ind=3895	Teresa	31/03/2009	not entered 310309141	Open		
Woody SBR_Ind=3907	Morris	30/03/2009	not entered	Open		
Popcorn SBR_Ind=3892	Poppy	26/03/2009	not entered	Open		
Wotsit SBR_Ind=3857	Baby (Sally)	10/02/2009	not entered	Open		

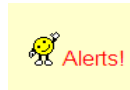
## Viewing Alternative Dashboard Displays

The option for dashboard displays are:

- **Current** - Records which have a baby's date of birth recorded but do not have a discharge entry, this excludes still births, home births and babies recorded as being 'born outwith scotland' unless they are subsequently admitted to your hospital. Note - All births pre 2004 are excluded from current views
- **All** - Every record which is stored within the system at your hospital
- **Booked (not yet delivered)** - Any mum which has been booked into your hospital on the SBR but is still to deliver
- **Four weeks after EDD** - Any Mum that has gone 4 weeks (or more) past their EDD
- **CHIs to be allocated** – SBR records which do not have a baby CHI entered on them
- **Invalid CHIs** – SBR records which have an invalid baby CHI entered e.g. only 4 digits
- **Invalid baby dates of birth** – SBR records where the baby date of birth is entered at that time to make the baby over 10 years old or a duff date of birth e.g. 40/07/07 or 21/13/06.
- **By ward** - Everyone recorded as being currently within the selected ward

When you first enter the system it defaults to display the current records. You can change to any of the views mentioned above by clicking on the drop down box on the "Dashboard View" box.

## User Alerts



This will warn users to the following:

- Identify any booked but not yet delivered records that are more than 4 weeks past the recorded Estimated Date of Delivery.
- CHIs to be allocated – SBR records which do not have a baby CHI entered on them
- Invalid CHIs – SBR records which have an invalid baby CHI entered e.g. only 4 digits

To open the alerts click in the logo above, and select the appropriate alert you wish to view.

## SBR Update Log

Clicking on the [SBR update log](#) will take you to the SBR website. Details of version updates as well as User Manuals and Quick Guides can be accessed here.

## Baby Death Indicator

A stillbirth or a baby death is indicated on the dashboard with a small dark blue circle next to the baby surname.

## Section 4: Finding Your Patient Record

The record you are looking for may already exist on the SBR either having been manually keyed by another user or imported from an existing hospital system. It is therefore always advisable to ensure the record does not already exist on the SBR before adding a new one. If the baby was born or has been treated at another hospital the record may still be with this site, please contact the relevant site or the Atos helpdesk for further assistance.

### Finding a Record

The search facility can be found on the top of the dashboard.

- Search for mother/baby or both using partial surname/forename, HPI, alternative HPI, Community Health Index (CHI) number, Expected Date of Delivery (EDD), Baby DOB, Mum DOD or SBR Indicator\*.
- Enter the data you are searching on i.e. surname, DOB, CHI
- Click on the 'Search' button
- Results will also include any alternative/previous surnames
- Remember to select mum, baby or both (it is recommended that you select both)
- There are two boxes in the section for searching on EDD, Baby DOB or Mum DOB. If you want to search just on a singular date you can enter this in either box. If you want to search on a range of dates put the start date in the left box and the end date in the right hand side box.
- Remember that if you want to search for certain records i.e. those with EDD dates you need to change to a dashboard view that shows them, i.e. 'All' or Booked but not yet delivered 'BBNYD'.

Figure 5

The search form contains the following fields and options:

- Surname: [ ]
- Forename: [ ]
- HPI: [ ]
- alt HPI: [ ]
- CHI: [ ]
- DoB/EDD: [ ] to [ ]
- SBR\_Ind: [ ]
- Search button
- Clear button
- Radio buttons: Mum , Baby , Both
- Radio buttons: EDD , Baby DOB , Mum DOB

- The \*SBR Indicator is a unique system identifier for each SBR record. It can be found below the surname on the dashboard.

Baby Surname	Forename Baby (mum)	Baby DOB (if born)	Hospital Patient ID / CHI	6 Records in total, Page 1 of 1	
Green SBR_Ind=3600	Baby	14/08/2008	not entered	Code [ ] Send [ ] CHI [ ]	Submit [ ]
Orange SBR_Ind=3598	Baby	14/08/2008	not entered	Code [ ] Send [ ] CHI [ ]	Submit [ ]

## Section 5: Creating a New Record

Before adding a new record it is advisable to search the database to ensure a record does not already exist - see "Section 4: Finding your Patient". There are 2 options for adding a new record, either by entering the Mother's details (with the ability to add Baby's details when required) by using "Add New" or entering only baby's details if appropriate via "Add new neonatal record" to create a new baby record without the mother information.

To add a new record for the Mother:

- Click on **Add New** from the main dashboard
- Complete all the mandatory fields (these are marked with \*)
- Click on Next, you will be presented with a screen listing possible matches for the mother.

### If the mother is not listed

- Click on **Add New Mum**
- Click on **OK** to add the mother

### If the mother is listed

- Click on [Confirm this Mum](#),
  - Confirm the data returned and update if necessary
  - If the data is correct, click on **Confirm**
  - If the data is incorrect click on **Back** and repeat steps above for confirming a mum or creating a new mum.
- Once the Mother has been added, search for the record (as explained in Section 4 – Finding your patient) to enter the data.

### If the mother has a multiple pregnancy

The screenshot shows a web form titled "New Scottish Birth Record - Mother Details Stage 2 : New Mother". The form is divided into several sections with input fields and buttons. The fields include: Surname (Leaves), First Forename (Autumn), Second Forename, Previous Surname, Date of Birth (Mother) (01/11/1985), Marital Status, Ethnic Group, GP Practice Code, GP G/MC No., Synchronise with Baby GP Details, CHI Number, Hospital Patient Identifier, Alternative Case Ref No., and Estimated Delivery Date (EDD). There are also fields for Address, Post Code (EH12 9EB), and Phone No. A checkbox "Use this Address for Baby Record." is checked. A note "\* Indicates a mandatory field" is present. At the bottom right, there is a dropdown menu for "Number of births expected" with "Singleton" selected. An arrow points to this dropdown menu. Buttons for "Add New Mum", "Back", and "Back to Dashboard" are at the bottom.


- To add another record automatically please refer to Mother details stage 2 of adding a new record
- In the bottom right hand corner there is a 'number of birth expected' drop down box. Enter the required option i.e. twins, triplets etc, then add new mum
- The system will then automatically create the number of records required automatically.

### Notes –

- If the mother has transferred to your hospital during this pregnancy, please **do not** add a new record, contact the appropriate site to send the record to you or call the Atos Helpdesk (Atos Helpdesk 0845 957 2700) and the SBR team will contact you for more details to transfer the record.
- Mum's surname, address, GP and GP practice will be assumed for the baby record. If you do not wish GP Practice and/or address to automatically populate the baby record then please deselect these by clicking on the relevant check box. If you wish to change any of the details this can be done later - see Entering Patient Information.




To add a new record for a baby (without mother's details):

- Click on [Add New Neonatal Record](#) from the main dashboard
- Complete all the mandatory fields (these are marked with \*)
- Click on 
- Once the baby has been added, search for the record (as explained in Section 4 – Finding your patient) to enter the data.

## **Section 6: Entering Patient Information**

### Access to Patient Records

Once you have created/found your patient click on the  button on the main dashboard next to the appropriate record to access it. The following tabs will be displayed:

- Mother
- Antenatal
- Birth
- Initial Exam
- Baby
- Episode
- Newborn
- Routine Exam
- Care
- Post Delivery
- VLBW (only when the baby's birth weight is 1500grams or under or gestation is 32 weeks or under)

To access the tabs, click on the appropriate header. These can be accessed in any order.

Some of the data items may already be recorded either as they were entered manually when adding a new record or the data was imported from an existing hospital system. If you require clarification on definitions and standards for the SBR data items please contact the SBR Team - see Appendix D Contacting Us.

## Mother Tab

This screen shows all the mothers details such as name, address, GP details etc. It also has the facility to record the partner/supporter details.

Figure 7

The screenshot displays the 'Mother' tab interface. At the top, there is a navigation bar with tabs: Mother (selected), Antenatal, Birth, Initial Exam, Baby, Episode, Newborn, Routine Exam, Care, and Post Delivery. The main content area is yellow and contains several input fields and sections:

- Personal Details:** Surname, Previous Surname, First Forename, Second Forename, Date of Birth (Mother), Marital Status (dropdown menu showing 'Not Known'), Mother's Occupation (optional), Ethnic Group (dropdown menu), GP Practice Code (with 'Find...' button), GP GMC No., Synchronise with Baby GP Details (checkbox with info icon), Mother CHI Number, Hospital Patient Identifier (with info icon), and Alternative Case Ref No.
- Address and Contact:** Address (with 'Find...' button), Post Code (with info icon), and Phone No. (with info icon). There is also a checkbox for 'Synchronise with Baby Address' with an info icon.
- Medical History:** A green box contains the text: 'Latest Recorded Past Medical and Obstetric History. Click [here](#) to see the details.'
- Partner / Supporter Details (optional):** A green-bordered box containing fields for Surname, Forename, Second Forename, Occupation, and Age.
- Buttons:** 'Update' and 'Close' buttons are located at the bottom right.

At the bottom left of the form, there is a small text note: 'Last updated By Christine Richardson (Borders\_Test) on Apr 1 2009 4:02PM'.

When a mother is transferred to you from another hospital please ensure that you overwrite the existing Hospital Patient Identifier (HPI) with the one from your hospital. The previous HPI can be recorded in the "Alternative Care Ref Number" field. New functionality will be written in the future to allow recording of multiple HPIs.

Latest Recorded Past Medical and Obstetric History can be visible on the mother tab if these fields have been completed on the Antenatal Tab, or you may wish to hide these details.

## Antenatal Tab

This screen shows all the mothers antenatal details. It contains past obstetric history, past medical history, family history etc.

Figure 8

The Mother's age is automatically calculated, at time of data entry of mum's date of birth on the mother screen.

If you do not know the exact day or month when entering dates please default to 01/01 and the year.

The BMI is automatically calculated once you have entered height (in metres and cms) and weight (in kilos).

### Past Obstetric History

Due to increased use of the SBR, many mothers have been through the SBR before and had their Past Obstetric History (POH) recorded. Therefore for mothers with subsequent pregnancies you will not have to enter the POH details again. They will be automatically populated for you; however you are able to edit these if required. It also allows for an unlimited number of entries.

Estimated Date of Delivery box – a nagging message will appear to remind you to fill this in, if this is not entered, before you try and click onto the next tab. It will not prohibit you from clicking onto the next tab, it is purely a reminder.

Smoking, alcohol and drugs are also recorded by clicking on this pop-up screen:

**Smoking / Alc / Drugs**

## Birth Tab

This screen covers all the details relating to the delivery of the baby. It is split into 3 sections, labour, delivery and baby.

**Figure 9**

The 'Delivery' box will give you the option of choosing the various different types of deliveries, including Caesarean Sections. If you need to add a reason for the CS this can be entered on the

Delivery Complications free text box. This can then be run off in a report from the Export tab (Clinical Maternity data).

Homebirths can also be recorded by selecting either 'Home Birth Plan N/K', 'Home Birth Planned', or 'Home Birth Unplanned' in the 'place of birth' field. The baby can also be admitted as a homebirth on the episode screen by selecting Level of Care 'Homecare' and then select Discharge Type as 'Homebirth'. The record will remain in the current view of records unless the baby is discharged from care.

If care is provided for a baby who was born outwith Scotland, please remember to record place of birth as 'Born outwith Scotland'.

Between the hours of midnight and 6am the 'Use today's date' link will be hidden, forcing you to manually enter the date. This has been introduced to reduce the number of incorrect dates of birth entered on the system for babies born during the night.

### Apgar Scorer:

Total scores can either be entered directly or individual scores can be recorded via the [Score](#) link. NR should be selected if the Apgar score has not been recorded. RR should be selected if the baby was receiving resuscitation and the Apgar score could not be calculated.

Figure 10

The screenshot shows a web page dialog box titled "SBR - Apgar Scorer -- Web Page Dialog" with the subtitle "Apgar Score Calculator at 1 Minute." The dialog contains a table for recording Apgar scores at 1 minute. The table has columns for "Score" (0, 1, 2) and rows for "Colour", "Heart Rate", "Response to Stimulation", "Respiratory Effort", and "Tone". Each cell contains radio button options. For example, under "Colour", the options are "Blue or pale", "Blue extremities", and "Pink". Under "Heart Rate", the options are "Absent", "Less than 100", and "More than 100". Below the table, there is a "Current Score: -" field and "OK" and "Cancel" buttons.

### Initial Examination Tab

Allowing you to record the results on the initial physical examination carried out on the baby such as Vitamin K given, cord check, chest examination etc.

Figure 11

The screenshot shows the "Initial Exam" tab in the SBR Clinical User Manual. The tab is highlighted in purple. The main area is divided into several sections. On the left, there are dropdown menus for "Midwife Examination Date", "Time", "Date Given", "Vitamin K (1st dose)", "Head Skin Colour", "Head Sutures and Fontanelle", "Eyes", "Ears", "Mouth and Palate", "Neck", "Trunk Skin Colour", "Chest", "Cord", "Genitalia", "Anus", "Spine", "Limbs Skin Colour", "Palmar and Plantar Creases", "Muscle Tone", "Digits", and "Axillae". There is a "Select ALL Normal" checkbox. Below these is a "Midwife Comments and Observations" text area with a "Reset" button. On the right, there are sections for "Special / Neonatal Care", "Exam Details (Initial)", and "Exam Details (Routine)", each with a "No Examination Carried Out" message and an "Add/Update" button. At the bottom right, there are "Update" and "Close" buttons.

For ease of data entry we have included a 'Select ALL Normal' tick box, as the majority of these examinations are normal. If required, the user has the ability to then select a different value for an individual data item.

If there has been any information entered onto the medical exam or the care screens it is seen in the summary boxes on the right hand side of the screen.



By clicking on the Print room you have direct access to the Initial Baby examination report, which can be printed off and filed in the case notes

## Baby Tab

This shows very similar data to the mother screen; however it refers to the baby.

Figure 12

Anderson, Catherine 03/07/196

Mother Antenatal Birth Initial Exam **Baby** Episode Newborn Routine Exam Care Post Delivery

Baby Surname: Anderson  
Alternative Surname:   
First Forename: Janice  
Second Forename:   
Date of Birth (Baby): 25/05/2011 [use today's Date](#)  
Time of Birth: 10:00 hh: mm (24 hr)  
Sex: Not Known  Boy  Girl  Not Specified   
Ethnic Group: White Scottish  
Find... GP Practice Code: 85244 46 - 62 Bank Street  
Alexandria  
G83 0LS  
GP GMC No.:   
Synchronise with Mother GP Details:   
CHI Number: 2505115044 CHI Number allocated by CHI/XML Interface: [Unlock](#)  
Hospital Patient Identifier:   
Alternative Case Ref No:   
Initial Outcome of this Baby: Livebirth

Find... Address: Main Street  
Howwood  
Johnstone  
Pentfrewshire  
Post Code: PA9 1AP  
Synchronise with Mother Address:

Update Close

Please note that the Address, GP and GP practice code entered for mum can automatically populate the baby screen from the Mother tab and vice versa (by clicking on Synchronise with Mother /Baby Address and GP Details) You can however change these details if necessary.

## Recording Stillbirths

All births should be recorded on the SBR. To record stillbirths change the Initial Outcome of the Baby on the baby screen to stillbirth. This field automatically defaults to livebirth.

Between the hours of midnight and 6am the 'Use today's date' link beside the DoB field will be hidden, forcing you to manually enter the date. This has been introduced to reduce the number of incorrect dates of birth entered on the system for babies born during the night.

## Episode Tab

This screen details the care given to the baby and by whom i.e. admissions to other wards such as special care, discharges from wards and the hospital, and any transfers from other hospitals etc. It also allows you to transfer the record to another hospital if the baby is going to receive ongoing care at the new hospital.

Figure 13

The screenshot shows a web interface with a top navigation bar containing tabs: Mother, Antenatal, Birth, Initial Exam, Baby, Episode (highlighted), Newborn, Routine Exam, Care, and Post Delivery. Below the tabs is a green header section titled "Admission / Internal transfers for this baby" with a help icon. It contains a form with fields for Date (20/02/2010), Ward, Level of Care (Normal), Obstetrician, Paediatrician, Midwife, and Nurse. Below this is a yellow section titled "History" containing a table with columns: Date, Ward, Level of Care, Consultant Obstetrician, Consultant Paediatrician, Midwife, and Nurse. The table has three rows of data. Below the history is a pink section titled "Discharge from hospital for this baby" with a help icon. It contains a form with fields for Date, Type, To, Place, Follow up Appointment Date, and Time. Below this are fields for Drugs on Discharge and Discharge Comments. At the bottom of the pink section is a "Transfer" button and a "Discharge Letters" section with links for "Immediate Discharge Letter", "Neonatal Discharge Letter", and "Handover to Health Visitor Letter". There are also "Update" and "Close" buttons at the bottom right.

Date	Ward	Level of Care	Consultant Obstetrician	Consultant Paediatrician	Midwife	Nurse
20/02/2010	This baby has been discharged. Discharge Type : Home					
18/02/2010	pink	Special Care		Caroline Clark		<a href="#">Edit</a>
18/02/2010	Patient transferred from Aberdeen Maternity Hospital to Raigmore Hospital by Notes:					
17/02/2010	Primrose ward	High Dependency	David Abramovich	Hilal Al-rafi	bootsie	

Data recorded here is for **baby activity only**.

### To add an episode:

- Complete the boxes within the "Admission/Internal Transfers for this baby" box, at the top of the screen (the green area).
- If you want to use today's date click on the "Use Today" link above the date field. (NB the admission date defaults to the baby's DOB)
- You must have either an obstetrician \ paediatrician or midwife selected to record an episode
- Click on **Update** to save the episode

The last episode added would always be populated in the "Admission/Internal Transfers for this baby" box, to add a new episode, overwrite the existing data and click on Update.

### To add a discharge:

- Complete the "Discharge from hospital for this baby" box at the bottom of the screen (the pink area).
- If you want to use today's date click on the "Use Today" link below the date field.
- Select the Type of discharge.
- Specify where they are discharged to in the free text box.
- Click on **Update** to save the discharge.

The discharge will be added to the top of the episode history box.

### To remove an episode:

If you have incorrectly entered an episode of care you can remove it by clicking on the [remove](#) link beside the relevant episode. Please note that you can only remove the top episode from the episode

history, therefore if you wish to remove an episode further down the list you must take a note of all the episodes above it and remove them, then once you have removed the relevant episode you are required to enter the other episodes back into the system.

*Note: You always read the episode history box from the bottom upwards as new episodes of care are added to the top of the list.*

## **Transferring a Patient**

**Figure 14**



This screen is used when either the baby or the expectant mother is being transferred from your hospital to another Scottish hospital for continued care. If they have not been admitted to your hospital use the **send** facility instead.

To transfer:

- Click on **Transfer** (on the Episode screen)
- Complete the date (click on the “Use Today” link to use today’s date)
- Select the hospital the patient is being transferred to. To select the hospital quicker type in first letter of hospital and the box will be populated with the full name. If there are several hospitals beginning with the same letter, continue to hit the relevant key (the first letter of the name) until the Hospital you are looking for appears
- Enter who carried out the transfer and add any appropriate notes
- To complete the transfer click on **Transfer**
- To cancel the transfer click on **Close**

By transferring the baby’s record on the SBR you are changing the access rights to this particular record. The new location will have full read and edit access. Note that if the baby is transferred to England this will be treated as a discharge (Discharge Type = ‘Facility / Hospital Outwith Scotland’) as the Scottish Birth Record system is not available outside Scotland. The discharge date in this instance is the date the baby leaves Scottish Hospital care.

### **Tips for Transferring:**

- Do not use the transfer screen when a baby is being moved between wards within the same hospital, this should be recorded as a new episode.
- If the baby is going directly from your hospital to another hospital, do not discharge the baby from your care on the SBR, just use the transfer facility.
- Once a record has been transferred you cannot access it unless the record is transferred or sent back to you.
- Ensure that you complete the record with as much information as possible **BEFORE** you transfer the record as once you have transferred it you will no longer have access to it.



- If you have transferred a record and have forgotten to add something please contact the designated SBR user at the receiving site.
- If you have transferred to the wrong hospital please contact the Atos Helpdesk (0845 957 2700) and someone from the SBR team will contact you to un-do the transfer.
- If you want to transfer a baby that has been born, to another hospital you must ensure that the baby has been admitted on the 'Episode' screen first, either an obstetrician, paediatrician or midwife has been entered and the level of care has been entered.
- If a baby has been transferred to you, you must admit the baby on the 'Episode' screen before it can be discharged or transferred back.
- A list of records that have been transferred from your hospital can be viewed on the Admin page.

## In Utero Transfers

Figure 15

This facility is used when a clinical decision has been made that a mother should immediately be transferred to another hospital for any reason. For example if a mother is attending a small community hospital and complications occur during labour, a decision may be made to transfer her to a city hospital with more facilities.

To transfer in utero follow the instructions detailed above for transferring a record, however also ensure that "In Utero" box is ticked.

### Tips for Transferring In Utero:

- See "Tips for Transferring" above
- As many women do not know if they will deliver at the hospital they have booked for, it is advisable only to forward a record when the destination is certain.

### Readmissions

When a baby has been readmitted to hospital after transfer or discharge this must be entered on the episode screen. To do this, follow the instructions previously detailing how to add an episode. If a baby dies after discharge or is readmitted and dies it should generate an SMR01 so it depends on how the site uses SBR as to whether this should be recorded.

### Home Births, Born Before Arrival & Born Outwith Scotland

Homebirths can also be recorded by selecting either 'Home Birth Plan N/K', 'Home Birth Planned', or 'Home Birth Unplanned' in the 'place of birth' field. The baby can also be admitted as a homebirth on the episode screen by selecting Level of Care 'Homecare' and then select Discharge Type as 'Homebirth'. The record will remain in the current view of records unless the baby is discharged from care.

### Discharge Letters:

Immediate Discharge Letter, Neonatal Discharge Letter and Handover to Health Visitor Letter can be selected at the bottom of the screen. These can also be found in the print room from the dashboard.

## Newborn Tab


This screen shows the baby details such as type of feed, congenital anomalies and screening.

Figure 16

The screenshot shows the 'Newborn' tab selected in a clinical software interface. The form is divided into several sections:

- Top Section:** Contains fields for 'First Feed', 'Birth Weight (grams)' (1400), 'Max Bilirubin', 'OFC (cm)', 'Cord at discharge' (On/Off), 'Feed on Discharge', 'Subsequent Weight (grams)', 'Birth Weight (grams)' (1400), 'Phototherapy', 'Lowest Glucose', 'Length Crown Heel (cm)', 'Estimated Gestation (Weeks)', and 'Feed at 10 days'.
- Vitamin K Section:** Includes fields for 'Initial 1st dose' (31/03/2009), 'Oral 2nd dose', and 'Oral 3rd dose', each with a 'Use today's Date' link.
- Congenital Anomaly Section:** Features a 'Congenital Anomaly' dropdown, 'Please specify all congenital anomalies' text area, and 'Other Physical Problems at Discharge' dropdown with 'Please specify' text area.
- Screening Section:** Includes 'Newborn Blood Spot Test' with a 'synchronize all\* with PKU' checkbox, fields for 'PKU', 'CH', and 'CF' with dates, 'Hearing Screen (Left)', 'Hearing Screen (Right)', 'Date of Screening', 'Repeat Test', and 'Reason for Repeat'. There is also a 'Comment' field.

Information icons (i) are present next to several fields, indicating additional information is available for those items.

Within this screen there are a number of information points . These icons give you additional information regarding the data item being recorded. To access the information point, use the mouse to hover over the icon and the message box will appear.

### Tips for the Newborn Tab

- 1) If a data item appears on more than one screen. For example '**OFC**' appears on the '**Delivery**' screen and again on the '**Newborn**' screen. When you enter data into one it automatically populates the other
- 2) The '**Max Bilirubin**' field is the highest recording within 28 days of birth. If you enter a recording of 121 on the second day of life and then the following day the '**Max Bilirubin**' is recorded as being 124 then this field should be over-written with the 124 recording.
- 3) The '**Lowest Glucose**' should also be over-written with the lowest glucose measured.
- 4) The birth weight should be entered in grams. Birth weight must be entered as 4 digits and preceding zeros should be entered if the weight is less than 1000 g
- 5) In addition the '**Subsequent Weight**' field also has the addition of a date field so that where possible the date of the latest weight should be entered
- 6) The Hearing screen comments box should be used to record any information on referral to audiologist, reason not done etc

## Routine Examination Tab

Allows the results of the routine examination to be recorded.

**Figure 17**

The screenshot shows a web-based medical examination form. At the top, there are navigation tabs: Mother, Antenatal, Birth, Initial Exam, Baby, Episode, Newborn, Routine Exam (highlighted), Care, Post Delivery, and V.L.B.W. The patient information section includes: DoB: 22/04/2009, Time: 12:45, Birth Weight (grams): 1220, Gestation (Wks):, OFC (cm): 12.5, Exam Date: (with a 'Use Today's Date' link), Age (hrs):, and Performed by:.


The main form area is divided into several sections:

- Select ALL Normal:** A checkbox with a 'Reset' button.
- Physical Examination:** A grid of dropdown menus for various body parts, all set to 'Normal'.
  - Head: Normal
  - Facies: Normal
  - Eyes: Normal
  - Ears: Normal
  - Nose: Normal
  - Mouth: Normal
  - Palate: Normal
  - Neck: Normal
  - Skin: Normal
  - Umbilicus: Normal
  - Heart Sounds: Normal
  - Murmurs: Normal
  - Chest auscultation: Normal
  - Abdomen: Normal
  - Spleen: Normal
  - Liver: Normal
  - Kidneys: Normal
  - Anus: Normal
  - Genitalia: Normal
  - Spine: Normal
  - Arms: Normal
  - Hands: Normal
  - Legs: Normal
  - Feet: Normal
  - Posture and Movement: Normal
  - Muscle Tone: Normal
  - Grasp: Normal
  - Moro: Normal
  - Cry: Normal
  - Red reflex: Normal (LEFT), Normal (RIGHT)
  - Femoral Pulses: Normal (LEFT), Normal (RIGHT)
  - Testes: Normal (LEFT), Normal (RIGHT)
  - Hips: Normal (LEFT), Normal (RIGHT)
- Family History / Risk Factors:** Includes dropdowns for Hip, Hearing Loss in Childhood, and Cardiac Disease, and a text area for 'Other'.
- Exam Details (Initial):** A box on the right with an 'Add/Update' link.
- Comments and Other Observations:** A large text area with a printer icon.

At the bottom, there is a status box showing 'Examination : ALL NORMAL' and a note: 'Please note that this baby is a Very Low Birth Weight'. There are 'Update' and 'Close' buttons at the bottom right.

For ease of data entry we have included a 'Select ALL Normal' tick box, as the majority of these examinations are normal. If required, the user has the ability to then select a different value for an individual data item.

There is a summary box on the right hand side of the screen where details of the Initial examination are recorded.


You are able to print the results of the medical examination by clicking on the printer icon  at the bottom of the page.


## Care Tab

This screen is used when you wish to record data for a baby who requires any **special, neonatal** or **intensive care**. This screen has been designed so that it can either be used at discharge, or, perhaps more effectively it can be updated on a daily basis so that if and when the care is handed over to another consultant they are able to see at a glance the latest status of a particular baby.

Figure 18

Once data items have been entered into either the 'Initial Exam' or 'Routine Exam' screens, a brief summary of this will appear in the boxes on the right hand side of the care screen. You can enter these sections by clicking on the 'add/update' buttons at the bottom of the individual box or by using the separate tabs across the top.

By clicking on the  printer icon at the bottom of the page you will be able to print off the Neonatal Immediate Discharge letter.

The respiratory screen can be accessed from the care screen to record any information about intubation, oxygen therapy, surfactant, ventilation and any other relevant respiratory information. The screen is accessed by clicking on the  button at the bottom of the care page.

## Respiratory Screen

Figure 19

The screenshot shows a web page dialog titled "Respiratory -- Web Page Dialog". The main heading is "Respiratory". The form is divided into several sections:

- Intubated:** Fields for Date (with a "use today's Date" link) and Time (with a "Use Now" link).
- Surfactant:** Fields for 1st Dose Surfactant Date and Time, 2nd Dose Surfactant Date and Time, and a dropdown for "How many additional doses?".
- Oxygen Therapy:** Radio buttons for "Oxygen therapy at 28 days of age" (Yes/No), "Oxygen therapy at 36 wks corrected age" (Yes/No), and "Sent home on Oxygen" (Yes/No). A field for "Date of Final Oxygen" with a "use today's Date" link.
- Other:** Radio buttons for "Pneumothorax requiring drainage", "Needled", "Chest drain", "Nitric Oxide", "ECMO", and "Postnatal systemic steroids for CLD" (Yes/No). A field for "Maximum base excess" and a "How many?" field for "Chest drain".
- Ventilation:** Radio buttons for "Ventilated" (Yes/No). Fields for "IPPV no. of days", "HFV no. of days", and "CPAP no. of days".

Buttons for "Update" and "Close" are located at the bottom right.

## Post Delivery Tab

This screen is for the addition of **Postnatal Mother details only**. Please note that all of the data items on this screen appear in the Immediate Discharge Letter.

Figure 20

The screenshot shows a tabbed interface with the "Post Delivery" tab selected. A message at the top states: "Please note that all fields on this screen relate to the Mum and not the Baby." The form includes:

- Fields for "Anti D" (dropdown), "Date" (with "use today's Date" link), "Rubella Vaccine" (dropdown), "Date" (with "use today's Date" link"), "Postnatal Hb" (dropdown), "Result" (text), "g/dl" (text), and "Treatment" (dropdown).
- Discharge:** Fields for "Discharge Date" (with "use today's Date" link) and "Discharge Type" (dropdown). A "Contraception" dropdown. A "Discharged to" field with a help icon. A "Discharge Comments" text area. A "Drugs on Discharge" text area.
- Follow Up Appointment:** Fields for "Place" (dropdown), "Date" (text), and "Time" (text).

A note at the bottom of the Discharge section reads: "NB. Please note information stored in these boxes will automatically populate the Immediate Discharge Letter". Buttons for "Update" and "Close" are at the bottom right.

## VLBW Tab

The Very Low Birth Weight (VLBW) screen is where information on Clinical Risk Index for Babies (CRIB) and Morbidity data are recorded.

**Figure 21**

The screenshot displays the VLBW tab interface. At the top, a navigation bar includes tabs for Mother, Antenatal, Birth, Initial Exam, Baby, Episode, Newborn, Routine Exam, Care, Post Delivery, and VLBW (which is highlighted). Below the navigation bar, there is a 'Post Mortem' dropdown menu and a question: 'If the baby died was there/will there be a post mortem?'. The main content is divided into two sections: 'CRIB Data' and 'Morbidity Data'. Each section contains several data entry fields, including dropdown menus and text boxes, with corresponding instructions or notes. At the bottom right, there are 'Update' and 'Close' buttons.

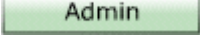
Field	Instruction/Note
Lowest appropriate FIO2 <12 hours	Please refer to blood gas charts and nursing charts to determine what was lowest appropriate FIO2
Highest appropriate FIO2 <12 hours	Please refer to blood gas charts and nursing charts to determine what was highest appropriate FIO2
Baby too well to be monitored	Baby's oxygenation not monitored in first 12 hours
Worst base deficit < 12 hours	Largest negative value. Please refer to blood gas chart: include capillary and arterial samples, but exclude cord blood gas
Intraventricular haemorrhage (3)	On USS definite and persistent increase in echogenic are within brain parenchyma surrounding lateral ventricles consistent with intracerebral extension of intraventricular haemorrhage
Intraventricular haemorrhage (4)	On USS definite and persistent increase in echogenic are within brain parenchyma surrounding lateral ventricles consistent with intracerebral extension of intraventricular haemorrhage
Parenchymal cysts	On USS cystic changes in one or more areas of brain parenchyma
Posthaemorrhagic hydrocephalus	Following intraventricular haemorrhage lateral ventricles >4mm larger than 97th centile
Retinopathy date first screened	date of first examination by ophthalmologist
Retinopathy required treatment	treatment with laser/cryotherapy needed
Necrotising enterocolitis clinical diag	Please make an assessment from notes, xray reports and surgical/PM reports> Clinically clear NEC. Symptoms and signs (one or more of poor feed toleration/vomiting, abdo distension, blood in stools, abdo tenderness) with diagnostic radiological signs (intramural/intrahepatic air, perforation, 'fixed' loop)
Necrotising enterocolitis proven at surgery	self explanatory
Positive blood culture	Please refer to bacteriology reports. Any positive blood culture after 48 hours of age. Please quote all positive blood cultures, whether thought to be true bacteraemia or a contaminated sample
Need for supplemental oxygen 36 weeks	Receiving supplemental oxygen at 36 weeks

This tab will only be visible if the baby meets the VLBW criteria - birth weight of the baby is less than 1500 grams or the baby is less than 32 weeks gestation. Completion of this screen is not mandatory for the Information Services return.

### Using the SBR in the Community

Community Midwives can also access the SBR system. In some areas this is only to record information on homebirths. Other areas permit access to enable further data collection and sharing of patient information.

## **Section 7: System and Password Administration**

To access the Admin screen, click on  from the main dashboard.

This screen allows you access to the following functions: -

- User administration
- Automated imports
- Record movement
- Tools

### User Administration

Your view of this section will vary depending on the type of user you are.

- Standard User – This is where you can change your password.
- Admin User - This is where you can change passwords, introduce new users, change or update user details, reset passwords and administer nurses/midwives on the episode screen and also add any new wards. Only users with administrator rights to SBR can access this part of the system. There is a separate manual that explains how to work the functionality. It is available to administrators.

### Link to the SBR User Manuals and Quick Guides

Click the link to open a new browser window and view the up-to-date SBR User Documentation. This lists all the current manuals and guides which can be downloaded.

### Automated Imports

If you are automatically sending files to the SBR database then you can access your own Automated Import Log. This enables you to view a log of the files you have sent in, how many records were in each file and if it was successfully imported into the SBR.

### Record Movement

This allows you to view records, which have been:

- Transferred Records
- In Utero Transfers
- Sent Records

## Section 8: Reports


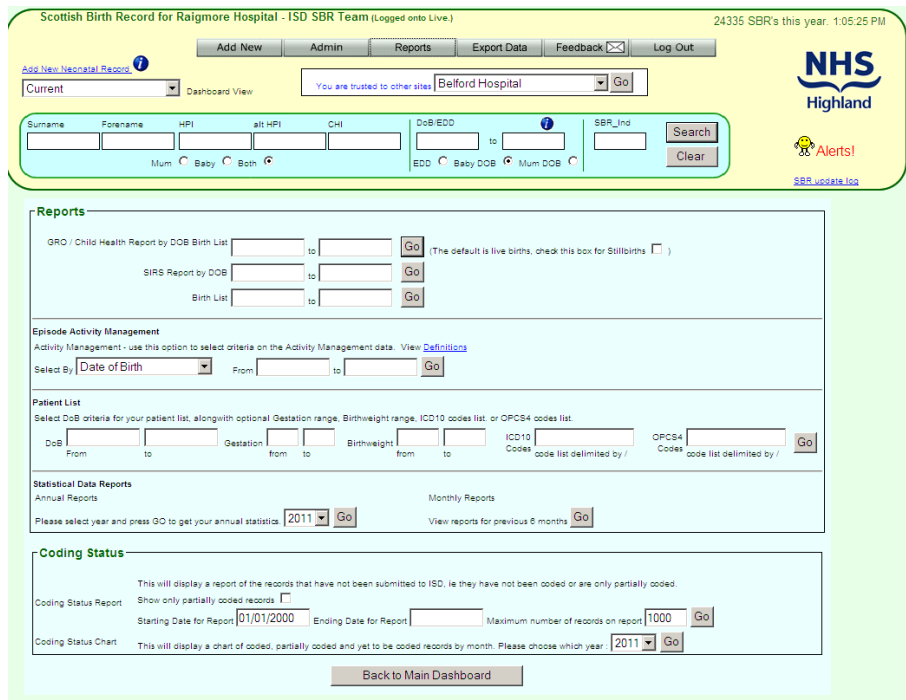
Clicking on  from the main dashboard allows access to reports and graphical analyses of the data entered into the system.

Figure 22



The screenshot displays the 'Scottish Birth Record for Raigmore Hospital - ISD SBR Team' interface. At the top, there's a navigation bar with 'Reports' highlighted. Below it, a search bar and a 'Go' button are visible. The main content area is divided into several sections: 'Reports' (with options for GRO/Child Health Report, SIRS Report, and Birth List), 'Episode Activity Management', 'Patient List', 'Statistical Data Reports' (including Annual and Monthly Reports), and 'Coding Status'. A 'Back to Main Dashboard' button is located at the bottom of the interface.

The following reports are available:

- **GRO/Child Health Report** – This report gives a list of all the babies born within the hospital (can include still births if requested) for a specified period of time. (N.B The initial outcome field must be set for baby to appear in this report).
- **SIRS Report** – A more detailed list of all the babies born within the hospital for a specified time period.
- **Birth List** - Lists Mum and Baby demographics, GP details, birthplace and outcome.
- **Episode Activity Management** – This is a report required primarily for finance. The user can choose to limit this report by specifying a date range for the following dates:
  - Date of birth
  - Date of admission
  - Internal transfer date
  - Date of discharge
  - External transfer date
- **Patient List** – reports on patients by either dates of birth, gestation, birth weight, ICD or OPCS codes
- **Annual Report** – shows full birth details including; gestation, birthweight, feed on discharge, discharge type, multiples, top 10 diagnosis – 4 digits, top 10 diagnosis – 3 digits, ITU days, ITU ALOS, HDU days, HDU ALOS, SCBU days, SCBU ALOS, Vent days, VENT ALOS, HFO days, HFO ALOS, CPAP days, CPAP ALOS as a number and percentage of total by selected year. (ALOS = average length of stay).
- **Monthly Report** - cover the previous six months and they display the following: Birth Number, Outcome, Place of Birth, Birthweight, Gestation, Feed on Discharge, Parity, Onset of Labour, Induction, Augmentation, General Anaesthetic, Epidural Anaesthetic, Local Anaesthetic, Spinal Anaesthetic, Blood Loss, Placenta Delivery, Tears, Episiotomy, Type of Delivery.
- **Coding Status Report** – This report will show all the records that have not been submitted to ISD i.e. they have not been coded or are only partly coded.
- **Coding Status Chart** – This will display a chart of coded, partially coded and yet to be coded records by month for a specified year.



## Section 9: Export Data

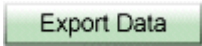
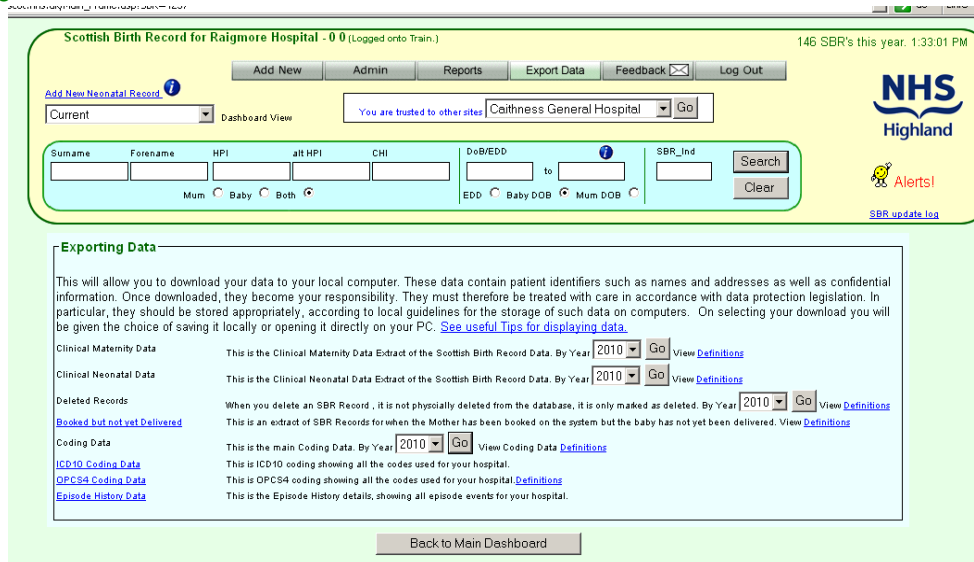

Clicking on  from the main dashboard allows information to be taken from the SBR and printed out or analysed locally.

Figure 23



These SBR data extracts contain up to the minute information which has been entered into the SBR (or transferred automatically) at your hospital. The download is in a pure text format enabling you to import it into any programme for analyses. Please note that you require Office 2000 to be able to view the data from this page.

To download the information:

- Click on  from the main dashboard
- Select the year beside the appropriate dataset you wish to extract i.e. Clinical Neonatal Data
- Click on 'Go'
- If no year is shown, click on the name of the dataset you want to download
- Select if you wish to "Open" the data from its current location or want to "Save" it to a secure location.

*Note: once downloaded the data becomes your responsibility. This data must be treated with care in accordance with data protection legislation. Please remember that the data will remain on the hard disk of your computer after you close the SBR and that data may still be retrievable even after deletion.*

The following downloads are available:

- Clinical Maternity Data – All maternity data extracts based on a particular year for current hospital.
- Clinical Neonatal Data – All neonatal data extracts based on a particular year for current hospital.
- Deleted Records – A list of all records that have been marked as deleted for the current hospital.
- Booked but not yet delivered – Records where mum has been booked on the system but baby has not yet been born.
- Coding Data – All coding data based on a particular year for the current hospital.
- ICD10 Coding Data – A record of all the ICD10 codes assigned to each SBR for the current hospital.
- OPCS4 Coding Data – A record of all the OPCS4 codes assigned to each SBR for the current hospital.
- Episode History Data – A list of all episode events for the current hospital.

Alongside each data extract is a Data Definitions document detailing the content of each extract. In addition there is a section on 'Useful Tips for displaying data' that may be helpful to you. In order to view these definition documents you will need to have Adobe Acrobat Reader on your computer.

**If you experience any problems opening up these Reports please try the following –**

- **Open up Windows Explorer,**
- **Go to Tools**
- **Select Folder Options**
- **Select File Types –**
- **Scroll down to CSV and**
- **Click on the 'Change' button and change it so that the association is with Excel.**

**You should now be able to open up the SBR file and either save it as an Excel or CSV file. If not please contact the SBR Team.**

### Statistics from the SBR

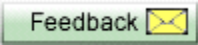
As the data entered into the SBR is up to date this will give you more accurate, timely analysis of different types of data.

Each Scottish Birth Record has its own unique number which is generated by the SBR system. This is called the SBR Indicator. You should use this field to link data with and to eliminate any duplicate episodes.

If there is any specific analyses you require or you just need help getting the data out of the excel spreadsheets then contact the SBR Team. See appendix D

### Section 10: Contact

The SBR helpdesk is maintained by Atos Origin and is available 24/7. You can contact them in a number of ways:

- Use the  link on the dashboard and complete the form.
- Email: [itservicedesk.nhss-ns@atos.net](mailto:itservicedesk.nhss-ns@atos.net)
- Telephone: 0845 957 2700

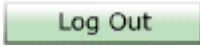
Atos Origin is the first point of contact if you require assistance. They can help immediately with the following:

- Find an SBR User
- Reset passwords
- Provide details of who you should contact to get a record transferred
- Add new postcodes to the system
- Unlock the baby CHI

Any other problems or queries will be passed to the SBR team who will get in touch with you during normal office hours.

**It is important that you do not use any confidential data in emails.** The SBR Identifier should be used to identify records that are being queried; see Section 4 Finding Your Patient Record.

## Section 11: Logging Out

Always click on  from the main dashboard to exit the system.


To close down the system click on Exit or press **Alt + F4**

If you have any problems closing the system down please contact us.

If the system freezes you can use the 'Alt' and 'F4' buttons together. Remember that if you have not pressed the 'Update' button on your current screen then any data items you have entered will be lost and not saved.

The SBR system will automatically log you out of the system if it has not been used for 20 minutes. However any unsaved data will be lost.

## Section 12: Send Function

If a mother/baby has NOT been admitted / reviewed by you click on  from the main dashboard **to send the record** to another SBR site.

*If a baby is **admitted** to your hospital and then moved to a different hospital in Scotland then this is classed as a **transfer** and you should use the transfer screen – refer to the Episode Screen section for further information. The **in-utero** transfer function should only be used when mum is admitted or reviewed and transferred to another hospital for continuing care/delivery. If however the mum or baby has NOT been admitted but is going to receive treatment in a different hospital/area then this is when you would use the **send** function.*

Note that once you have sent a record you will no longer be able to access it so please ensure that you complete the record as much as possible before sending it to another site.

To send a record:



- Click on the 
- Click on confirm once you are sure the correct record is selected.
- Select the correct hospital to send the record to
- Enter any comments relating to the sending of the record
- Click on 

Figure 24



Send this Record -- Web Page Dialog

Sending Record ....

Surname : Barlow  
Forename : Baby  
Date of Birth : 14/07/2006  
Baby HPI : L222569000

To: Ayr County Hospital

Comment

Send Cancel

If a record has been **sent to you** from another site you will see this icon



on the main dashboard.

If a record has been **transferred to you** from another site you will see this icon



on the main dashboard.

### **Section 13: CHI Interface**

The Scottish Birth Record system has the facility to obtain a Community Health Index (CHI) number for babies within minutes after birth. If your hospital is participating in this functionality a **CHI** button will be visible on the main dashboard to the right of the 'send' button. The CHI button will also appear on the Baby tab.

**Figure 25**

Start SBR_Inid=3641	Baby	24/12/2008	not entered	Open Code   Send  Submit
Bacon SBR_Inid=3688	Burt	29/09/2008	not entered	Open Code   Send  Submit
Door SBR_Inid=3682	Baby (Green)	29/09/2008	not entered 2909085031	Open Code   Send  Submit
Door SBR_Inid=3690	Baby (Green)	29/09/2008	not entered	Open Code   Send  Submit

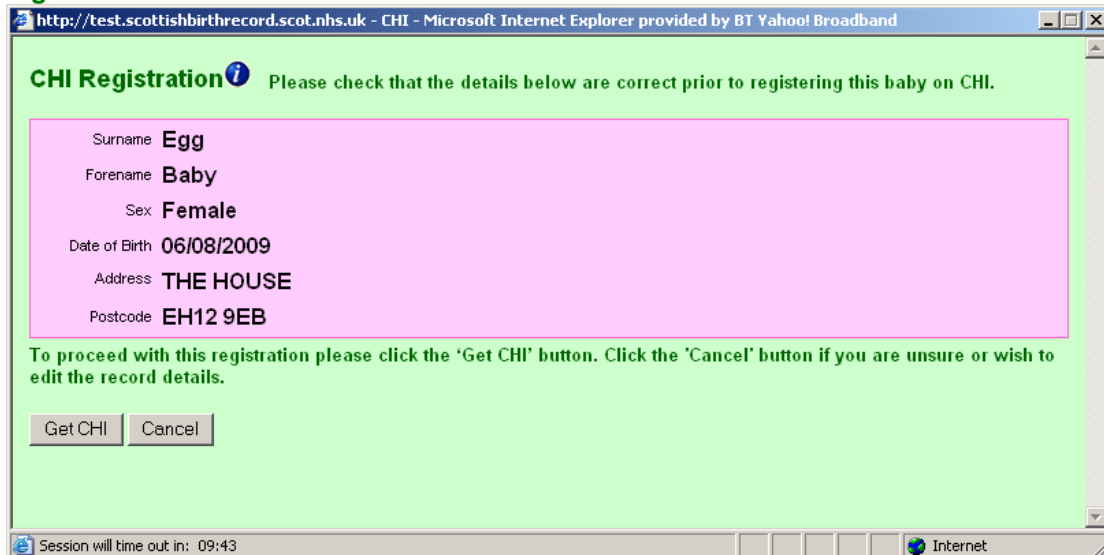
In order to obtain a CHI number the record you are sending **must** have:

- **baby surname**
- **baby forename** (default "Baby" is valid)
- **valid postcode** (it must include a space)
- **sex**
- **baby date of birth**
- **first line of address.**

To obtain a CHI:

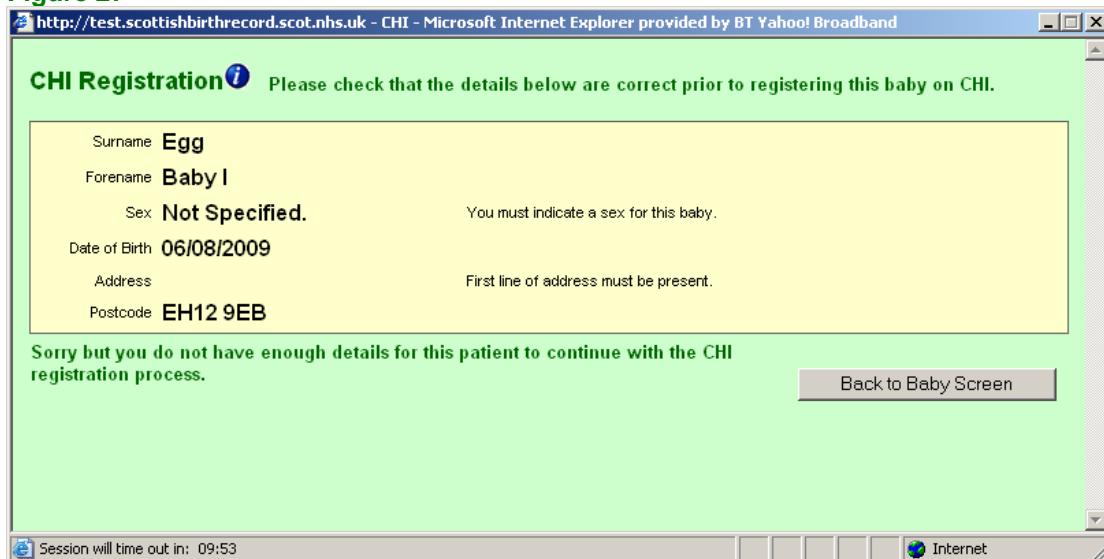
- Click on the button either on the main dashboard next to the record you want to get a CHI number for or on the baby tab of the particular record. Note: that if a CHI number for this baby has already been obtained via the SBR, or has been entered manually into the relevant field on the Baby screen, then this CHI button will not be shown.
- You will be presented with a screen that will show you the details you are sending to CHI to register this baby in order to get a CHI number back. Please ensure that these details are correct – if not please cancel, go back to the record and amend where necessary. When allocating a CHI number, the background colour of the pop up box to clarify the baby's details, corresponds to the gender of the baby. Blue =Boy, Pink =Girl.

Figure 26



If any of the required data for obtaining a CHI is incorrect or missing you will be shown an error message indicating what is required to be amended prior to obtaining a CHI number (see Figure 3).

Figure 27



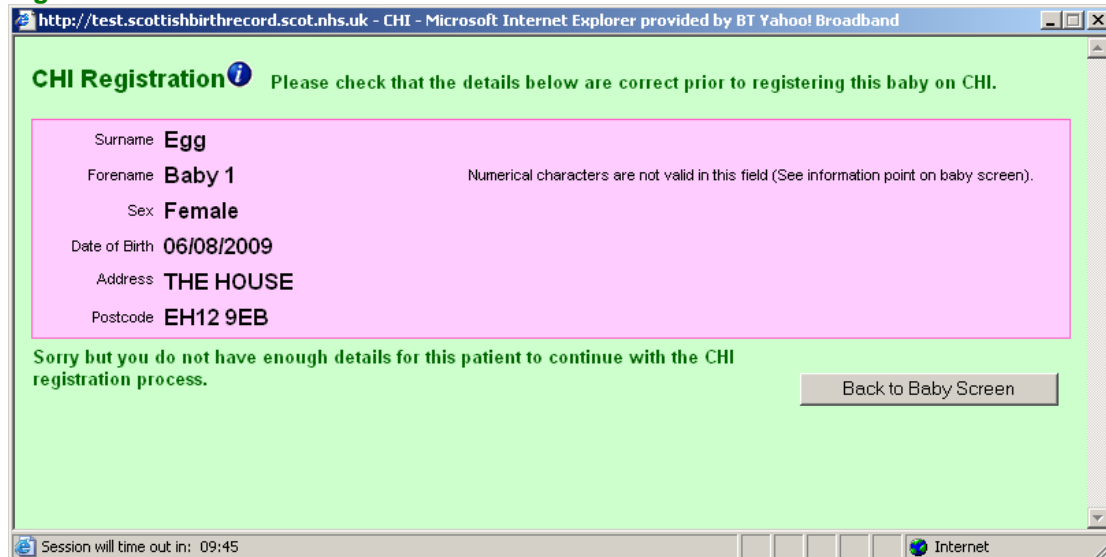
Click on 'Back to Baby Screen' and add the required details

- Once you have obtained a CHI number via the SBR it will automatically populate the CHI field on the Baby screen and you will not be able to edit this field unless you contact the Atos helpdesk or your local administrator who have the functionality to unlock the CHI. When contacting the ATOS helpdesk you need to make it clear that you require them to unlock the CHI. They do not need to know the reason why this is being requested.

**If the CHI is unlocked and another CHI allocated please ensure that the Child Health department are made aware of the CHI change so they can stop using the old one.**

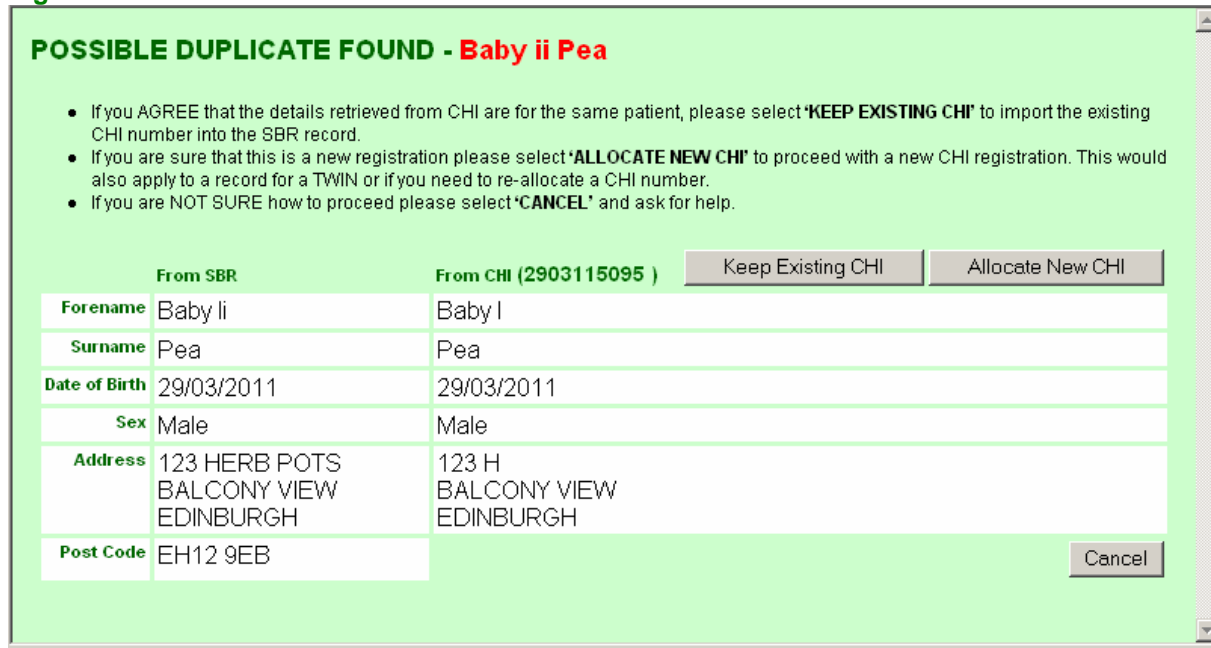
It is important that when you are registering multiple births, where the baby has no forename (and the default "Baby" is being used), that you use Baby I, Baby II, Baby III etc, as the CHI interface will not accept numeric characters (see Figure 4).

Figure 28



When the data you are sending to the CHI system closely matches an existing record (as will happen in the case of multiple births) it will be flagged up as a possible duplicate (see Figure 29 ) and will offer you the following options;

Figure 29



**'Keep Existing CHI' button**

- Click on this button if the details are for the same patient and you are **not** trying to re-allocate the CHI number. You will then retrieve the CHI number previously allocated to that baby.

**'Allocate New CHI' button**

- If, after checking the details, you are confident that the details that already exist on CHI belong to a different baby then you can go ahead and get a CHI number by clicking on this button. **This option would be used for a multiple birth.**
- If you are reallocating a CHI number to a baby and this message is displayed, click on the 'Allocate New CHI' button to get a new CHI number. **This option would be used where the wrong details had been entered (e.g. wrong sex) the first time that the CHI was allocated.**

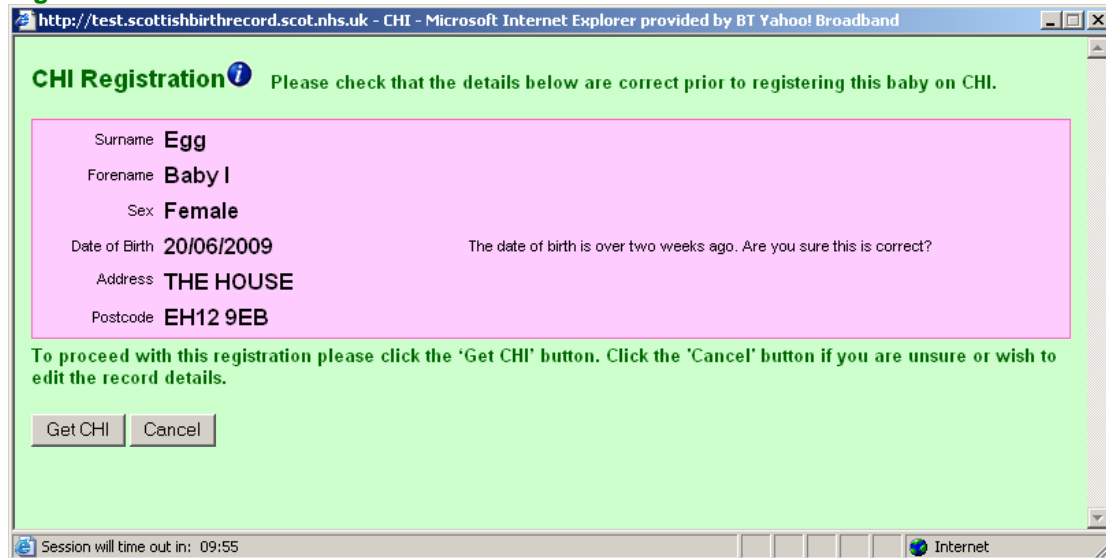
### 'Cancel' button

- If however you are unsure, you think this baby may already be registered on CHI or you want to go back into the record to check it then please click on the 'Cancel' button. **It is very important that the same baby is not allocated two CHI numbers unless the CHI number needs to be re-allocated because it was based on the wrong details (and therefore invalid).**

### When NOT to Allocate a CHI on the SBR

A warning will be displayed if the baby's DOB is **over 2 weeks old** (see Figure 6). A baby of this age should already have been registered on CHI. If the DOB is correct please contact your Child Health Department who will advise you of the correct CHI. The number can then be manually keyed in to the SBR.

**Figure 30**

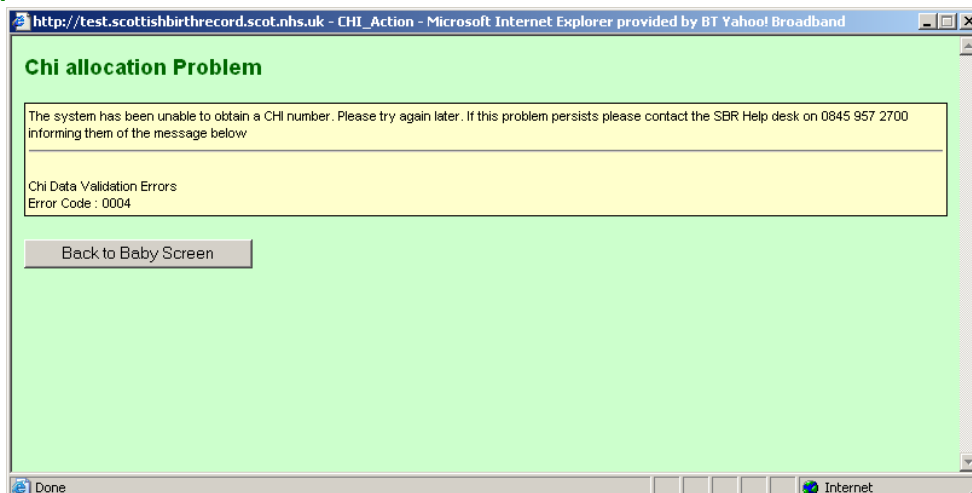


**Stillborns** are not allocated CHIs on the SBR. If your Child Health Department require one then they must allocate it.

### Error Messages when obtaining a CHI Number

On occasions you may be presented with an error message. Most of these errors will have to be reported to the ATOS helpdesk. However there is one error message that can be dealt locally and that is Error Code 0004 (see Figure 7) this error is generated when an invalid character has been entered in one of the essential data item fields.

**Figure 31**



## Section 14: Print Room

Figure 32

### The Print Room

This page allows you to print reports and letters from the Scottish Birth Record system. To do this open up the required report and use File / Print to print.

Mother Details		Baby Details	
Surname	Biscuit	Surname	Biscuit
Forename	Choccy	Forename(s)	Baby I
Date of Birth	10/10/1964	Date of Birth	03/12/2010
Address	8 Croall Place, Kelty, Fife, KY4 0DY		
		Sex	Boy

**GPR Report**

This is an application form to register with a General Medical Practitioner.

- [Open GPR Report](#)

**Registration of Birth**

This is the Registration of Birth form.

- [Open Registration of Birth Form](#)

**Newborn Record**

This is the Newborn Record that you may wish to keep as your "hard copy". This report is split into three pages.

- [Open Antenatal and Birth History \(Page 1\)](#)
- [Open Initial Baby Examination \(Page 2\)](#)
- [Open Routine Baby Examination \(Page 3\)](#)

**Notification of Birth**

This is the Notification of Birth form.

- [Open Notification of Birth Form](#)

**Immediate Discharge Letter**

This is the immediate discharge letter.

- [Immediate Discharge Letter](#)
- [Neonatal Discharge Letter](#)
- [Handover to Health Visitor letter.](#)

**Newborn Hearing Screening Form**

This is the Newborn Hearing Screen form.

- [Newborn Hearing Screening](#)

This is the Newborn Hearing Screen form with mother and GP Details.

- [Populated Newborn Hearing Screening](#)

**Coding Output**

This is output for coders.

- [Coding Output](#)
- [Blank Coding Output](#)

The Print Room allows you to print reports and letters relating to a particular record from the SBR system. To open the Print Room:

1. Click on beside the appropriate record on the main dashboard
2. Click on the document you wish to open (it will appear in blue and underlined)
3. Once the document is open, go to "File"
4. Select "Page set-up" and ensure the header and footer boxes are blank
5. Click on "OK"

To print the document:

1. Go to "File"
2. Select "Print"

The following reports can be generated from The Print Room:

- General Practitioner Reports (GPR) Report – An application form to register with a GP
- New Born Record – A printable version of the data relevant to a new born split into antenatal birth history, physical baby examination and medical baby examination.
- Immediate Discharge Letter – A pre-populated discharge letter for mother and baby. Note – if a mother has had no previous pregnancies then it will display on this letter as being para 0+0.
- Neonatal Discharge Letter - A pre-populated discharge letter for babies who were admitted for further neonatal care.
- Handover to Heath Visitor Letter - A pre-populated letter containing information for the Health Visitor.
- Coding Output – A pre-populated report containing a summary of all the coded data together with the OPCS4 and ICD10 codes for the baby.
- Blank Coding Output - A blank report for recording the coded data items including OPCS4 and ICD10 codes for the baby where the notes are housed elsewhere.
- Registration of Birth – A pre-populated Registration of Birth form.
- Notification of Birth – A pre-populated Notification of Birth form.
- Newborn Hearing Screening Form – A blank screening form with only the patient information pre-populated.
- Pre-populated Newborn Hearing Screening form – This form is pre-populated with GP and Mother details (taken direct from Mother tab)




## Section 15: Delete Record

### Only Administrators are able to delete records

There are a number of reasons why you may want to delete a record from the SBR. Before you delete a record you should contact the SBR Project Team to ensure that the most appropriate action is to delete the record. You should also contact the SBR Project Team if you identify that there is a duplicate record for either the mother or the baby, or if you accidentally delete a record and you wish it to be retrieved. Note that the deleted record will remain on the main database with a note of who has deleted the record and why.

To delete a record:

- Click on  beside the appropriate record
- Select the reason for the record to be deleted from the following options:
  - **Error** (*duplicate record entered by mistake*)
  - **Miscarriage** (*loss of pregnancy prior to 24 weeks gestation*)
  - **Intra-uterine death** (*any fetal death after 24 weeks gestation but before onset of labour*)
  - **Moved outwith the area** (*either no forwarding address for transfer of care or moved out with Scotland prior to delivery*)
  - **Termination** (*therapeutic abortion*)
- Click on

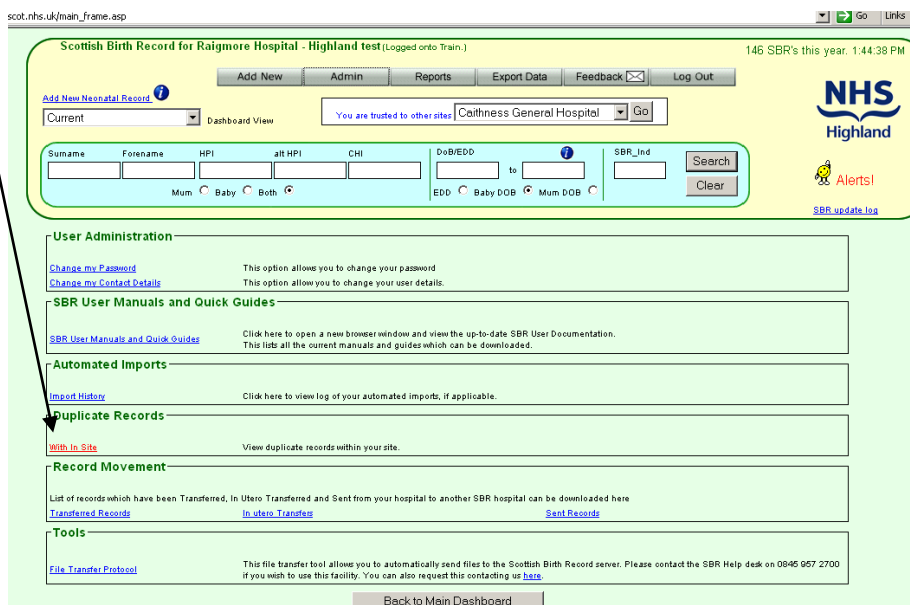
If you accidentally delete a record contact the SBR team (via the Atos Helpdesk) who can retrieve the record.

## Section 16: Duplicate Records

It is important that every baby has only **ONE** record. This avoids having spilt records i.e. a mother's record with no baby details or a baby record with no mother details. To avoid duplicate records it is important you search for an existing record before adding a new one, especially if they have been transferred from another hospital.

If you create/find a duplicate record it is important that all the data is merged into one record. If one of the records has a CHI number for the baby, this record must be used to avoid a duplicate CHI being created.

To find duplicated records within your site please go to Admin tab, Duplicate Record section and click on [Within site](#) link. See below



The screenshot shows the 'Scottish Birth Record for Raigmore Hospital - Highland test' interface. At the top, there are navigation tabs: 'Add New', 'Admin', 'Reports', 'Export Data', 'Feedback', and 'Log Out'. Below these is a search form with fields for 'Surname', 'Forename', 'HPI', 'alt HPI', 'CHI', 'DoB/EDD', and 'SBR\_Ind'. There are also radio buttons for 'Mum', 'Baby', and 'Both'. A 'Search' button is present. Below the search form, there are several sections: 'User Administration' with links for 'Change my Password' and 'Change my Contact Details'; 'SBR User Manuals and Quick Guides' with a link for 'SBR User Manuals and Quick Guides'; 'Automated Imports' with a link for 'Import History'; 'Duplicate Records' with a link for 'Within Site' (highlighted by a red arrow); 'Record Movement' with links for 'Transferred Records', 'In-use Transfers', and 'Sent Records'; and 'Tools' with a link for 'File Transfer Protocol'. At the bottom, there is a 'Back to Main Dashboard' button.

This report will open in an excel spreadsheet.

## **Section 17: Audit Trail**

There is an activity log incorporated into the system at data item and username level. Whenever a record is accessed or any data item is added / amended, the date, time and username are recorded on the audit log.

## Section 18: Fault Finding


Problem	Possible Cause	Action
Unable to submit a new record	The mandatory fields have not been completed	Complete all necessary fields – refer to page 7
The system has closed down and returned to the initial log-in screen	The system has automatically closed as it has not been used for 20 minutes – any unsaved data will be lost	Log back in to the system if you want to continue inputting data
The system continually crashes	There appears to be a problem with the hardware (the PC itself)	Inform your IT department
The data you have just added is no longer there	The update button has not been clicked and so the data has not been saved to the database	The lost data will have to be added again ensuring that the 'update' button is used.
You are unable to view the entire screen	The screen resolution on your pc is incorrect for this application	Please refer to the system pre-requisites in Appendix A.
A message appears saying that this 'record is locked for editing'	Another member of staff in your Hospital has this record open	Once they have closed this record you will be able to access it yourself
You are unable to access the excel file in the 'Reports' section		Please report the fault to the Project Team at Information Services.
A dialogue box appears asking you if you need help completing the form	Your pc has the incorrect AutoComplete setting	Please refer to the pre-requisites in Appendix A.
The background colour on the forms in the Print Room is being printed	The Print settings for Internet Explorer are set to print background	Follow the steps in Appendix A.
'Page cannot be found' error displays	The NHSNet is currently down or there is a fault with the SBR.	Report the problem to your IT helpdesk.
You have forgotten your password		Please contact your local Password Administrator.

If the SBR seems to be going slow here is a tip that you can try to improve performance.

### Empty your browser's temp files.

After constant use of the browser, this is the program you use to actually access the SBR system; your pc becomes blocked up with temporary files, stored in a temporary files folder. It is wise to empty (i.e. delete) these files from time to time.

To delete the Temporary Files:

1. Click on  Internet Explorer
2. Go to TOOLS
3. Go to INTERNET OPTIONS
4. Select the GENERAL tab
5. Under the section "Temporary Internet Files", click on the button DELETE FILES
6. Check the box "Delete all offline content"
7. Click OK
8. It may take a minute or two, depending on the amount of TEMP files
9. Once it is completed, click OK

## **Section 19: Frequently Asked Questions**

**Q. Baby has been transferred to a hospital outwith Scotland, what should I do with the record?**

**A.** The baby should be discharged on the episode screen to 'Facility/Hospital Outwith Scotland'. It may be useful to say in the discharge comments where the baby went. **You should not use the Transfer screen for these babies.**

**Q. A baby has been transferred from another Scottish Hospital but there is no SBR. What do we do?**

**A.** Before adding a new record either contact the relevant hospital to transfer the record to you or log a call with the Atos Helpdesk and someone from the SBR Team will contact you to transfer the record to you. The SBR team can check the whole database in Scotland to search for records.

**Q. I have been into the system previously but today I am told that I do not have access. What can I do?**

**A.** Firstly try re-entering username and password. If this doesn't work you can try resetting your password via your administrator. If this still doesn't work please contact the SBR team.

**Q. Can babies born outwith Scotland be recorded on the SBR?**

**A.** Yes they can. Simply start a new record adding as much information as you can. On the Delivery screen simply select 'Born outwith Scotland' in the Place of Birth field.

**Q. How can I forward a record to another site for postnatal care if the baby has been discharged home from our hospital?**

**A.** In this instance the record can be SENT to another site using the new send facility on the dashboard. This will enable the receiving site to access and add any additional information such as hearing screening results. Remember that once you have sent a record you will no longer be able to access it.

**Q. What do I do if I have accidentally transferred a record to the wrong hospital?**

**A.** Contact the Atos Helpdesk and the SBR Team can rectify it for you.

**Q. Where can I record who delivered a baby for a homebirth?**

**A.** On the Delivery screen fill in the 'Delivered by' box with the persons name.

## Appendix A – Technical Pre-Requisites


### **Internet Explorer Pre-Requisites for the Scottish Birth Record Web Based System**

#### Version

For the Scottish Birth Record to work, version 5.5 or later (128 bit) of Internet Explorer must be installed.

#### Printing

To print the reports, standard letters and forms your computer will have to be connected to a colour printer. You need to ensure that you have “print Background Colours” enabled – This can be found by:

- Right clicking on  Internet Explorer
- Go to Properties
- Go to Advanced
- Scroll down to PRINT OPTIONS
- Tick the box “Print Background Colours”

#### Internet Explorer Toolbars

The Scottish Birth Record runs in Kiosk mode, which means the application opens up Internet Explorer without any toolbars visible. However, to print reports, we utilise the Internet Explorer window, which automatically has toolbars present.


#### AutoComplete to be turned off

One feature of Autocomplete is that a dialogue box will appear asking if you require assistance completing the form. To switch this mode off:

- Open **Internet explorer**
- Go to the **Tools** menu
- Click **Internet Options**
- Click on the **Content** tab
- Under **Personal Information**, click Autocomplete
- Deselect the 'Forms' check box and the 'usernames & password on forms' box
- Click ok.

#### Screen resolution to be set at 1024 x 768

##### **To change your screen resolution**

1. Click on  at the bottom of your screen
2. Select **Settings**
3. Click on **Control Panel**
4. Double-click on **Display**
5. Go to the **Settings** tab
6. Under **Screen** area, click on and drag the slider to 1024 x 768
7. Click **Apply**

#### **Notes**

- A higher resolution reduces the size of items on your desktop
- A lower resolution increases the size of your desktop
- Your monitor and display adapter determine whether you can change your settings or not. (Any doubts, please contact your IT department)

## Appendix B – Setting Up Icons on Your Desktop

### Setting up a Training SBR logo on your desktop

- Firstly ensure that your PC is linked to the NHSNet
- Right click on the desktop
- Select **New**
- Select **Shortcut**
- 'Create shortcut' dialogue box appears – browse to where you have your Internet Explorer (usually on your local disk C / D – Programme Files or Plus or Internet Explorer) – look for the

lexplore.exe 

- Double click or OK
- At end of address put  `space-kspacehttp://test.scottishbirthrecord.scot.nhs.uk`
- Click on **Next**
- Type in 'Training - Scottish Birth Record'
- Click on **Finish**

### Setting up a Live SBR logo on a desktop which is linked to the NHSNet.

- Firstly ensure that your PC is linked to the NHSNet
- Right click on the desktop
- Select **New**
- Select **Shortcut**
- 'Create shortcut' dialogue box appears – browse to where you have your Internet explorer (usually on their local disk C / D – Programme Files or Plus or Internet Explorer) – look for the


lexplore.exe 

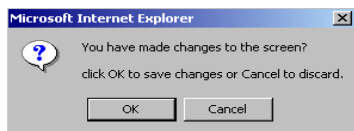
- At end of address put  `space-kspacehttps://www.scottishbirthrecord.scot.nhs.uk` (note this has to be EXACT or it will not work)
- Click on **Next**
- Type in 'Live Scottish Birth Record'
- Click on **Finish**


## Appendix C – Data Entry Guidance/Tips

### General

- For security reasons, if there has been no activity with the SBR for 20 minutes the system will log you out losing any data that has been keyed and not updated

- When you enter any information you **must** click on the  button to save the data. Don't worry if you forget and change screen. A warning message will appear notifying you that data you have entered has not been saved. Click 'OK' to save or 'Cancel' to close the screen without saving



- Information Points  appear throughout the system (hover your mouse over them to view)
- **DO NOT** use **BACKSPACE** on the keyboard if you are not clicked within a field, data may be lost as this moves you back a screen
- Where possible, data items shaded in blue should be completed. These are required for the National reporting

- It is important to fill out all fields using correct grammar and spelling as the information recorded can be used within the discharge letters and other documents.

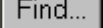
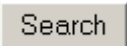
- When creating a new record, those fields, which are accompanied by an asterisk, are mandatory and must be completed before the new record can be added to the SBR. If a mandatory field is missing a warning box will appear providing details of the missing data item(s) which is needed to be completed before the record can be submitted.



- To find a GP and/or GP Practice please use the find button located to the left of the GP Practice Code field - see GP and Practice Finder below for further details
- It is advisable to use the 'find' button when entering addresses as this automatically populates the fields in a standard format. When entering a postcode you must include a space – e.g. FK104QB should be recorded as FK10 4QB – see Postcode and Address Finder below for more details
- If the connection is slow, please do not continually click on the 'Add Record' button when creating a new record, as this will create multiple records

### GP Practice Finder

If you know the GP Practice Code and the GP's GMC number you can type these into the relevant data fields. The built in search allows you to find any GP in Scotland and any GP Practice throughout the UK. The more specific your search, the quicker it will run. To use the built in search:

- Click on  to the left of the GP Practice Code field
- Search on either the GP's surname and/or the Practice address
- Click on 
- Highlight (click on) the relevant entry from the list presented of possible GPs and Practices
- Click select
- The GP Practice Code and GP's GMC number are now automatically completed

### Hints & Tips for Searching: -

- For surnames beginning with O', just search using O and include some other GP or Practice detail such as forename or partial practice address
- For patients in the Armed Forces who are not registered with a GP in the UK please use GP practice Code 99976
- When searching on the practice address enter details in the first line only – see below
- If you do not find the GP/practice you are looking for, you can widen the search by removing the address, or the GP forename. Be careful if you are looking for a common name such as Dr Smith, it is advisable to put in the first initial to avoid a large set of results being returned.

Figure 33

GP Practice Finder NB. This will search on all GP Practices in the UK, but will only return GMC Numbers for GPs practising in Scotland.

GP Surname:

GP Forename:

Address:  (Use this field to search on address details)

Postcode:

Search Results

70516,3303995,Jones,Colin,..24 Gracemount Drive,Edinburgh,..EH16 6PN,0131 664 2377,..  
76137,3205499,Jones,Neil,..North Berwick Health Centre,St. Beldred's Road,North Berwick,..EH394PU,01620 892169,..  
77036,4746391,Jones,Valerie,..Eastfield Medical Practice,Eastfield Farm Road,Penicuik,..EH268EZ,01968 675576,..  
78109,2983390,Jones,Ian,..Fauldhouse Health Centre,Blackfaulds Place,Fauldhouse,..EH479AS,01501 770282,..  
78255,4612867,Jones,Lucy,..Howden Health Centre,Howden Road West,Livingston,West Lothian,..EH546TP,01506 423800,..

### Postcode & Address Finder

It is recommended that you use the built in search facility to enter the address and postcode.

- Click on  to the left of the address field
- Search on either the postcode or part of the address
- Click on
- Highlight (click on) the relevant address from the list presented
- Click select
- The address and postcode are now automatically completed

### Hints & Tips for Searching: -

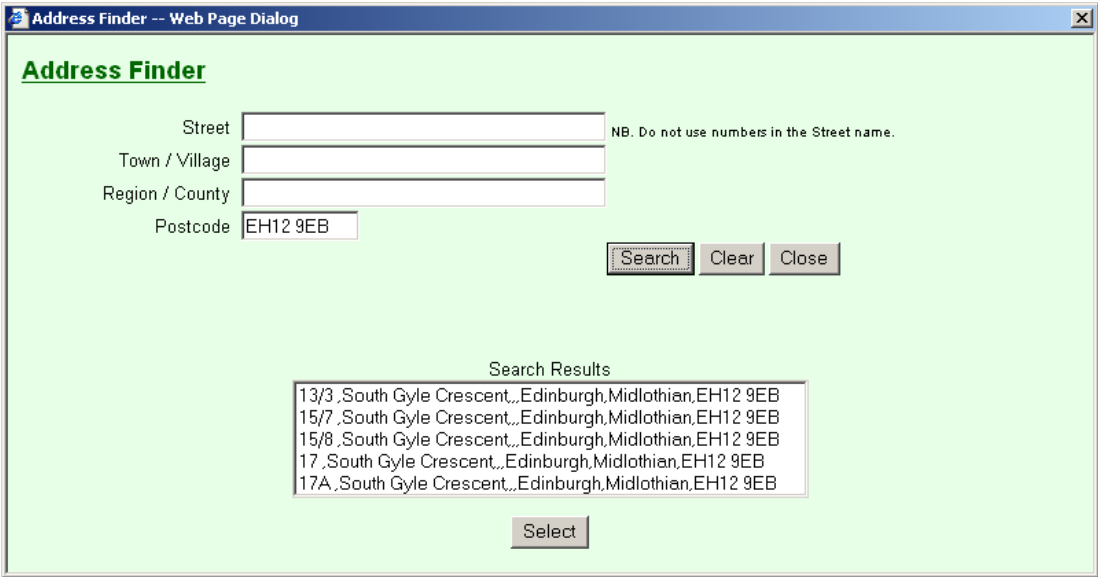
- The more specific your search is the quicker it will run. For example, if you are searching for a common street name such as 'High Street' you should also include the town / village
- Do not enter a house name or number in the address search
- When searching on a postcode you **must** include a space in the postcode e.g. EH3 9AW instead of EH39AW

If an invalid postcode is manually entered a warning will appear on screen. Where possible try to find the correct postcode.

However, if you know the address and postcode you can type them in to the relevant fields.

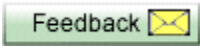


Figure 34



## **Appendix D - Contacting Us**

The SBR helpdesk is maintained by Atos Origin and is available 24/7. You can contact them in a number of ways:

- Use the  link on the dashboard and complete the form.
- Email: [itservicedesk.nhss-ns@atosorigin.com](mailto:itservicedesk.nhss-ns@atosorigin.com)
- Telephone: 0845 957 2700

Atos Origin is the first point of contact if you require assistance. They can help immediately with the following:

- Find an SBR User
- Reset passwords
- Provide details of who you should contact to get a record transferred
- Add new postcodes to the system
- Unlock the baby CHI

Any other problems or queries will be passed to the SBR team who will get in touch with you during normal office hours.

**It is important that you do not use any confidential data in emails.** The SBR Identifier should be used to identify records that are being queried; see Section 4 Finding Your Patient Record.

## **Appendix E - Glossary**

Discharge = when a baby is discharged from inpatient care to the community, transferred to specialist non-neonatal care, e.g. cardiology, or transferred to a hospital outwith Scotland.

Transfer = when a baby is transferred to another Scottish hospital for neonatal care. **Note** before a record is transferred it should be completed with all available information – a transfer should be the last thing you do with the record as currently once you transfer it you no longer have access to it. It is important to remember that the transfer facility should only be used if the mother / baby has been admitted to you first. If not then you must use the **send** facility.

Admission = when a baby is admitted or re-admitted to any ward within a hospital that provides any neonatal care – this includes 'normal' care.

### Categories of care definitions (based on BAPM 2001)

#### Intensive Care (ICU1)

- Needing 1:1 nursing care by 405/equivalent
- Intubated
- 24 hours post extubation
- NCPAP + <5 days old for any part of the day
- NCPAP + <1000g for any part of the day
- NCPAP + <1000g 24 hours after stopping NCPAP
- <29 weeks + <48 hours of age
- Pre-operative and 24 hours post operative
- Requiring complex clinical procedures (Exchange, peritoneal dialysis) or treatment with Inotropes, pulmonary vasodilator or prostaglandin
- 24 hours after stopping treatment with inotropes, pulmonary vasodilator or prostaglandin
- On day of death
- Transported by a team including medical/ANNP and nursing staff

#### High Dependency Care (previously ICU2)

- NCPAP for any part of the day and not fulfilling criteria for intensive care
- <1000g and not fulfilling criteria for intensive care
- Receiving TPN
- Convulsions
- Oxygen + <1500g
- Neonatal Abstinence Syndrome
- UAC / UVC / IA / chest drain / tracheotomy / partial exchange transfusion
- Severe apnoeas
- Needing 2:1 nursing care
- Transported by a trained nurse alone

#### Special Care

In the SBR this relates to babies who are receiving any special care, regardless of which ward they are in.

#### Normal Care

In the SBR this relates to babies who are receiving normal care usually on the post natal ward with Mum.