SWSLHD Paediatric Behavioural Assessment and Observation Form and Increased Supervision and Specialling of At-Risk Children

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Outline

- To provide education and inform SWSLHD paediatric staff on the introduction of the Paediatric Behavioural Assessment and Observation Form (PBAOF)
- To inform staff on the:
  - Background
  - Definitions
  - Assessing for and mitigating Risk
  - Proactive measures
  - De-escalation techniques
  - Indications for Increased Supervision or Individual Patient Special

- *Please note the diagram examples of the PBAOF may change slightly once the official document is released however the content will remain the same*

Background

- Until the design of *the Behavioural Assessment and Observation Form* there was no means for how staff could identify, monitor and document behaviours in patients receiving care

- The *Behavioural Assessment and Observation Form* was developed as part of the Feeling Safe in the ED Project and was due to a gap analysis identifying that some basic needs for adult mental health consumers were not being met and therefore proactive measures were not being taken to prevent episodes of escalation and absconding.

- Staff were using subjective language such as “going off” and could not differentiate between a patient with some minor escalation to those who were having a major episode resulting in Code Black calls.

- This led to hit-or-miss care for mental health patients and didn’t treat the cause of the acute illness. Imagine if we didn’t give Ventolin to a patient in an asthmatic crisis or analgesia for a child with a broken arm!

- Staff were unable to effectively communicate escalation between each other. We all understand a systolic of 80 or a pulse above 160 is a MET call, however when describing and discussing patients with escalating or deteriorating behaviours, we couldn’t articulate this

- SWSLHD implemented the Increased Supervision and Specialling of at Risk Patients Procedure in November 2018. The procedure is inclusive of all behavioural presentations varying between delirium, dementia, confusion, drug and alcohol and mental health.

- The governing procedure is currently under revision also to include the changes to the document and also include paediatrics which was previously excluded

The Paediatric BAOF was designed due to the high number of paediatric patients presenting to hospital who require specialist mental health or behavioural care

Inclusion of Paediatrics

- Gap analysis and data has demonstrated that children were not being adequately monitored or risk assessed for behavioural management in key areas and were at risk of the same issues as adults, such as escalation

- An increase in incidents involving children with escalating behaviours, absconding and other potentially critical incidences within EDs and paediatric units

- The adult tool was insufficient as we know that children have very different needs physiologically to adults. *Children are not small adults!*

The Numbers

- Children and young adults accounted for almost 15% of all *mental health* presentations to SWSLHD in 2020.
- This was an almost 13% increase on 2019 presentation data
- This data was obtained from Triage presentation information on FirstNet and does not include those with a behavioural type diagnosis or those with intellectual disabilities etc
- Data collection for this cohort has been obtained from FirstNet presentation data in the ED over the last 2 calendar years as a baseline for the Paediatric Behavioural Assessment and Observation Form

There was a slight decrease in mental health presentations in April 2020, which may have been due to hospital avoidance due to the COVID shut down, however presentations increased significantly in the second half of the year and in total, there was 11% more mental health presentations in total to SWSLHD in 2020

Facility by Facility

	2019		2020		Yearly Comparison	
	C&A	Total	C&A	Total	C&A	Total
Bankstown	183	2292	195	2405	6.56%	4.93%
Bowral	132	633	104	519	-21.21%	-18.01%
Camden	17	67	16	75	-5.88%	11.94%
Campbelltown	864	4516	989	5101	14.47%	12.95%
Fairfield	28	202	24	228	-14.29%	12.87%
Liverpool	515	4374	633	5062	22.91%	15.73%
	1739	**12084**	**1961**	**13390**	**12.77%**	**10.81%**

- There was an overall 13% increase in paediatric Mental Health presentations in 2020 even with Bowral, Fairfield and Camden all experiencing reductions in Paediatric MH presentations
- Liverpool and Campbelltown had the most significant increase in paediatric presentations with 23% and 14.5% respectively

Assessing for Risk

- Identifying patients who may be at risk by using tools we have such as a Mental State Exam, Substance Use Screen, Glasgow Coma Score, Paediatric Falls Risk, Sepsis

- Utilising tools which we have to compliment behaviour monitoring, such as an individualised Behaviour Management Plan,

Definitions

Increased Patient Supervision:

Increased supervision refers to a higher level of care; this may be 1:2, 1:3 or 1:4. This type of supervision does not require additional staff members, but an adjustment to ward / department models of care.

Individual Patient Specialling (IPS):

IPS refers to a 1:1 allocation of a nurse to a patient

Indications for Increased Patient Supervision / IPS

1 - Patients at risk of harming themselves (not scheduled under *Mental Health Act, 2007*):

- Impaired cognition placing themselves or others at risk (i.e. aggression)

Some children may have intellectual disabilities or other cognitive delay and may not be aware of their own risk of self harm requiring increased supervision or specialling depending on the severity

- Severe hyperactive delirium
- Drug and/or alcohol intoxication
- Children who are a falls risk due to age

Indications for Increased Patient Supervision / IPS

2 - Scheduled under Mental Health Act:

- Admitted to non-mental health units with actual or possible suicidal behaviour. The Mental Health team on call must assess the patient and provide a treatment plan if indicated.

Not all children will be under the Mental Health Act who are also not allowed to leave the hospital, such as those who are living under Guardianship or other duty of care or those who are too young to make informed decisions about their well being.

Indications for Increased Patient Supervision / IPS

3 - Higher clinical level of observation and care required:

- Patient awaiting transfer to a critical care area or another facility.
- Drug desensitization / medications that require 1:1 nursing.
- Frequent clinical observations or complex care.

How to use the Paediatric BAOF

- Once identified as having a challenging behaviour, the child should be commenced on a PBAOF.
- The Registered or appropriately educated Enrolled Nurse (not an AIN) should select which is the most appropriate risk assessment (mental health or non-mental health) and attend to this at least once per shift.
- The recommended time for the risk assessment is handover, but as this is a trial, you should tell us how it has worked best in your unit.

How to use the Paediatric BAOF

The child should have a set of behavioural observations attended to as follows:

- Mental Health Patients: *Emergency Department* only

  must be monitored as an OCL 3 unless specified otherwise by a Mental Health CNC or their condition is acute and they require more frequent monitoring (OCL 1 or 2). Only a Mental Health CNC or Registrar can step a patient down to an OCL 4

- Non-Mental Health Patients (in the ED and inpatient units. Also MH patients admitted to non-mental health units):

  may be monitored hourly or more frequently dictated by their condition. They should not wait more than one hour for behavioural observations

How to use the Paediatric BAOF

- Once you have determined the child's risk and their score, review the decision matrix.

- The child may need a high level of supervision due to their individual condition rather than the score they are identified as having. *A low SAT score doesn't necessarily mean they don't qualify for increased supervision*
  - Clinically unstable, risk to safety, abscond risk

The decision to increase supervision or provide an individual patient special must be discussed with the NUM / AHNM and the PBAOF used to inform this decision

How to organise increased supervision for your patient

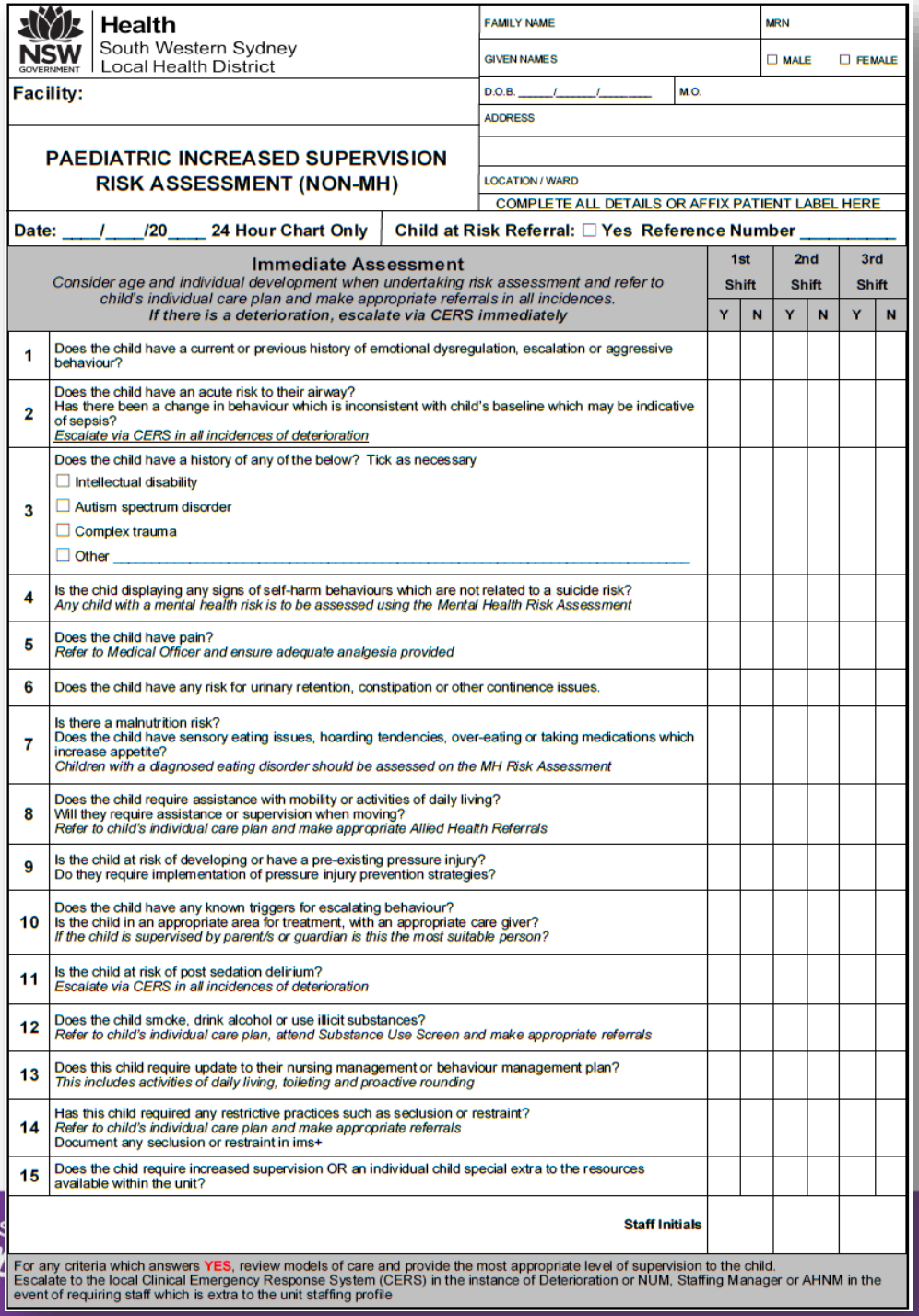
- Follow your hospital processes

- In the future there will be a standardised approach from the LHD

Risk Assessments

- *Emergency staff will already be familiar with the adult risk assessments, the paediatric ones are similar but have different more age appropriate content*

- The Risk Assessments align with National Standards requirements for Comprehensive Care (Standard 5) and the Recognition and Responding to Clinical Deterioration (Standard 8)
- Should be attended at minimum three times per day. Suggested time is change of shift to assist with Transfer of Care
- There is a Child at Risk Referral box for documentation of the reference number



Health
South Western Sydney
Local Health District

FAMILY NAME	MRN
GIVEN NAMES	☐ MALE ☐ FEMALE
D.O.B. ____/____/____	M.O.
ADDRESS	
LOCATION / WARD	
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE	

Facility:

PAEDIATRIC INCREASED SUPERVISION RISK ASSESSMENT (NON-MH)

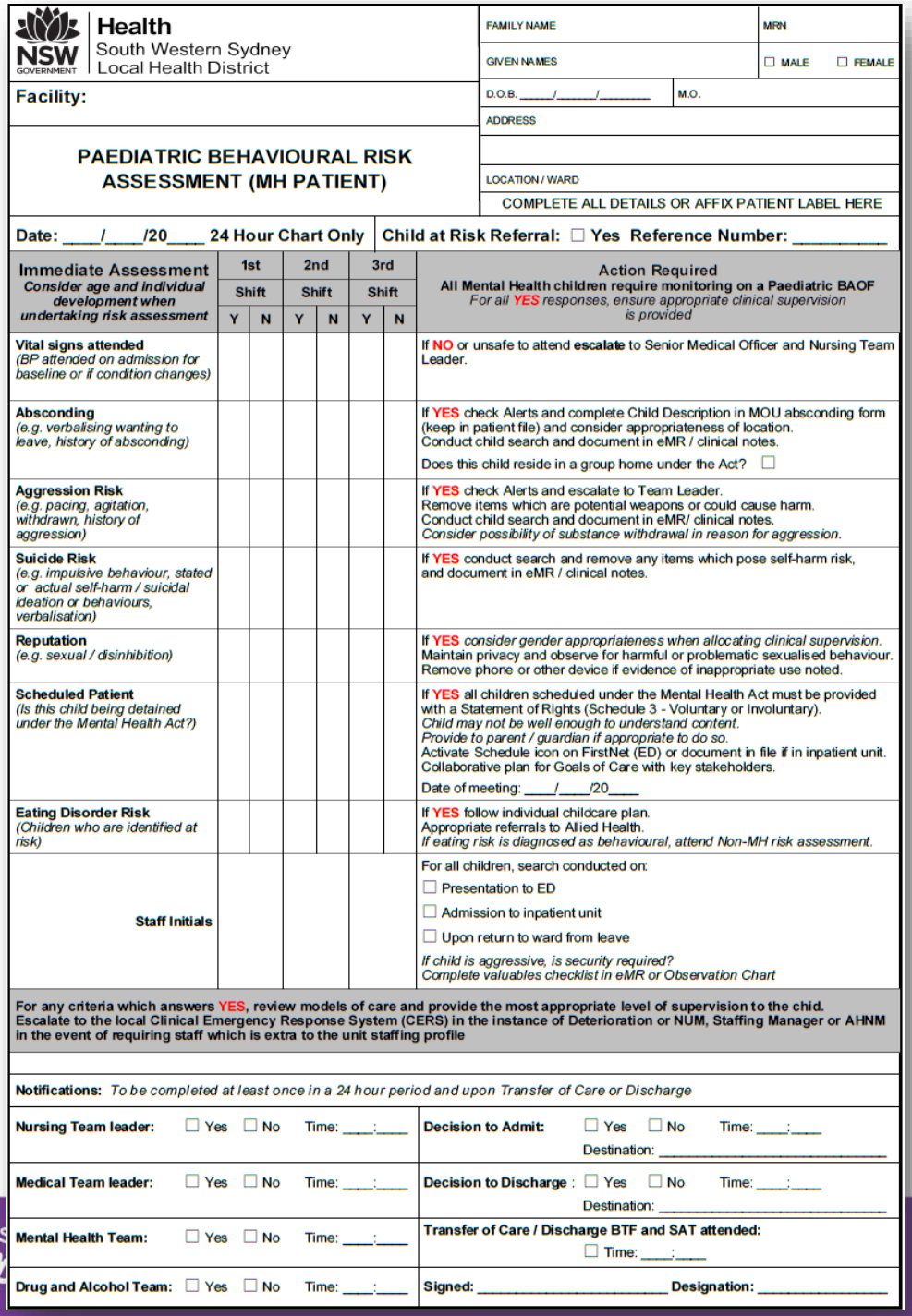
Date: ____/____/20____ 24 Hour Chart Only

Child at Risk Referral: ☐ Yes Reference Number _____

	Immediate Assessment *Consider age and individual development when undertaking risk assessment and refer to child's individual care plan and make appropriate referrals in all incidences.* ***If there is a deterioration, escalate via CERS immediately***	1st Shift Y	1st Shift N	2nd Shift Y	2nd Shift N	3rd Shift Y	3rd Shift N
1	Does the child have a current or previous history of emotional dysregulation, escalation or aggressive behaviour?						
2	Does the child have an acute risk to their airway? Has there been a change in behaviour which is inconsistent with child's baseline which may be indicative of sepsis? *Escalate via CERS in all incidences of deterioration*						
3	Does the child have a history of any of the below? Tick as necessary ☐ Intellectual disability ☐ Autism spectrum disorder ☐ Complex trauma ☐ Other _____						
4	Is the chid displaying any signs of self-harm behaviours which are not related to a suicide risk? *Any child with a mental health risk is to be assessed using the Mental Health Risk Assessment*						
5	Does the child have pain? *Refer to Medical Officer and ensure adequate analgesia provided*						
6	Does the child have any risk for urinary retention, constipation or other continence issues.						
7	Is there a malnutrition risk? Does the child have sensory eating issues, hoarding tendencies, over-eating or taking medications which increase appetite? *Children with a diagnosed eating disorder should be assessed on the MH Risk Assessment*						
8	Does the child require assistance with mobility or activities of daily living? Will they require assistance or supervision when moving? *Refer to child's individual care plan and make appropriate Allied Health Referrals*						
9	Is the child at risk of developing or have a pre-existing pressure injury? Do they require implementation of pressure injury prevention strategies?						
10	Does the child have any known triggers for escalating behaviour? Is the child in an appropriate area for treatment, with an appropriate care giver? *If the child is supervised by parent/s or guardian is this the most suitable person?*						
11	Is the child at risk of post sedation delirium? *Escalate via CERS in all incidences of deterioration*						
12	Does the child smoke, drink alcohol or use illicit substances? *Refer to child's individual care plan, attend Substance Use Screen and make appropriate referrals*						
13	Does this child require update to their nursing management or behaviour management plan? *This includes activities of daily living, toileting and proactive rounding*						
14	Has this child required any restrictive practices such as seclusion or restraint? *Refer to child's individual care plan and make appropriate referrals* Document any seclusion or restraint in ims+						
15	Does the chid require increased supervision OR an individual child special extra to the resources available within the unit?						
	Staff Initials						

For any criteria which answers YES, review models of care and provide the most appropriate level of supervision to the child.
Escalate to the local Clinical Emergency Response System (CERS) in the instance of Deterioration or NUM, Staffing Manager or AHNM in the event of requiring staff which is extra to the unit staffing profile

- **The Non-Mental Health risk assessment** :
  - Information on NHPPD for staff to refer to at the bedside
  - Check boxes for risk assessment labeled 1st, 2nd and 3rd shift
  - Form clearly states it is 24 hours only (then a new one must be commenced)
  - Space to document child at risk referral and number
  - Staff also directed to utilise other supportive and appropriate risk assessments where available
  - Staff directed to utilise CERS if necessary



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Local Health District

Facility:

PAEDIATRIC BEHAVIOURAL RISK ASSESSMENT (MH PATIENT)

FAMILY NAME | MRN

GIVEN NAMES | ☐ MALE ☐ FEMALE

D.O.B. ____/____/_____ | M.O.

ADDRESS

LOCATION / WARD

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

Date: ____/____/20____ 24 Hour Chart Only | **Child at Risk Referral: ☐ Yes Reference Number: _____**

Immediate Assessment *Consider age and individual development when undertaking risk assessment*	1st Shift Y	1st Shift N	2nd Shift Y	2nd Shift N	3rd Shift Y	3rd Shift N	**Action Required** All Mental Health children require monitoring on a Paediatric BAOF *For all YES responses, ensure appropriate clinical supervision is provided*
Vital signs attended *(BP attended on admission for baseline or if condition changes)*							If NO or unsafe to attend **escalate** to Senior Medical Officer and Nursing Team Leader.
Absconding *(e.g. verbalising wanting to leave, history of absconding)*							If YES check Alerts and complete Child Description in MOU absconding form (keep in patient file) and consider appropriateness of location. Conduct child search and document in eMR / clinical notes. Does this child reside in a group home under the Act? ☐
Aggression Risk *(e.g. pacing, agitation, withdrawn, history of aggression)*							If YES check Alerts and escalate to Team Leader. Remove items which are potential weapons or could cause harm. Conduct child search and document in eMR/ clinical notes. *Consider possibility of substance withdrawal in reason for aggression.*
Suicide Risk *(e.g. impulsive behaviour, stated or actual self-harm / suicidal ideation or behaviours, verbalisation)*							If YES conduct search and remove any items which pose self-harm risk, and document in eMR / clinical notes.
Reputation *(e.g. sexual / disinhibition)*							If YES *consider gender appropriateness when allocating clinical supervision.* Maintain privacy and observe for harmful or problematic sexualised behaviour. Remove phone or other device if evidence of inappropriate use noted.
Scheduled Patient *(Is this child being detained under the Mental Health Act?)*							If YES all children scheduled under the Mental Health Act must be provided with a Statement of Rights (Schedule 3 - Voluntary or Involuntary). *Child may not be well enough to understand content. Provide to parent / guardian if appropriate to do so.* Activate Schedule icon on FirstNet (ED) or document in file if in inpatient unit. Collaborative plan for Goals of Care with key stakeholders. Date of meeting: ____/____/20____
Eating Disorder Risk *(Children who are identified at risk)*							If YES follow individual childcare plan. Appropriate referrals to Allied Health. *If eating risk is diagnosed as behavioural, attend Non-MH risk assessment.*
Staff Initials							For all children, search conducted on: ☐ Presentation to ED ☐ Admission to inpatient unit ☐ Upon return to ward from leave *If child is aggressive, is security required? Complete valuables checklist in eMR or Observation Chart*

For any criteria which answers YES, review models of care and provide the most appropriate level of supervision to the chid. Escalate to the local Clinical Emergency Response System (CERS) in the instance of Deterioration or NUM, Staffing Manager or AHNM in the event of requiring staff which is extra to the unit staffing profile

Notifications: *To be completed at least once in a 24 hour period and upon Transfer of Care or Discharge*

Nursing Team leader: ☐ Yes ☐ No Time: ____:____	**Decision to Admit:** ☐ Yes ☐ No Time: ____:____ Destination: _____
Medical Team leader: ☐ Yes ☐ No Time: ____:____	**Decision to Discharge :** ☐ Yes ☐ No Time: ____:____ Destination: _____
Mental Health Team: ☐ Yes ☐ No Time: ____:____	**Transfer of Care / Discharge BTF and SAT attended:** ☐ Time: ____:____
Drug and Alcohol Team: ☐ Yes ☐ No Time: ____:____	**Signed:** _____ **Designation:** _____

- **The Mental Health risk assessment:**
  - Inclusion of Eating Disorder Risk
  - Information on NHPPD for staff to refer to at the bedside
  - Check boxes for risk assessment now labeled 1st, 2nd and 3rd shift
  - Form clearly states it is 24 hours only (then a new one must be commenced)
  - Staff also directed to utilise other risk assessments such as Substance Use Screen
  - Staff directed to utilise CERS if necessary
  - Capacity to document referrals to the MDT
  - Updated clarity on Searching patients
  - **Discharge Vital Sign Observations reminder for patients leaving ED**

The Monitoring Section

- There was a comprehensive evaluation of the trial adult BAOF in 2019, which allowed us to review the content and also make a better design for the trial of the Paediatric BAOF:
  - Additional capability to describe legal status, this should assist with children who live in group homes or with a foster family etc
  - Language changes to Interventions section, Restrictive Practices Register replaces Restraint Register
  - More options for Personal Care and Toileting documentation to be more inclusive of non-mental health patients who have challenging behaviours and those admitted to non-mental health inpatient units and of course children with physical and intellectual disabilities
  - OCLs clearly marked as Emergency Department Use Only and colour coded in line with SAT scoring as a guide
  - Clearer alignment of SAT scores with the CERS process

Health
South Western Sydney
Local Health District

NSW GOVERNMENT

Facility:

PAEDIATRIC BEHAVIOURAL ASSESSMENT & OBSERVATION FORM

FAMILY NAME	MRN
GIVEN NAMES	☐ MALE ☐ FEMALE
D.O.B. _____/_____/_____	M.O.
ADDRESS	
LOCATION / WARD	

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

Sedation Assessment Tool

Score	Responsiveness	Speech
+3	Combative, violent, out of control	Continual loud outbursts
+2	Very anxious and agitated	Loud outburst
+1	Anxious and restless	Normal / Talkative
0	Respond easily to name	Speaks normally
-1	Asleep but rouses if name is called	Slurring or prominent slowing
-2	Physical stimulation	Few recognisable
-3	No response to stimulation	Nil

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Observation Care Level (OCL) As per Observation Care Level Policy	Date / Time / OCL / Supervision / Legal Status
Supervision RN / EN (N), AIN (A), Security (S), Police (P), Other (O), SERCO (SE)	
Legal Status Sections (s10), (s19), (s20), (s22), (s23), Voluntary (V), Guardianship (G), Duty of Care (DOC), Under 18 (P), Public Health (PH)	
Sedation Assessment Tool Score *Per OCL if in MHU or ED. Per Child's condition in all other areas* **Observations must be graphed by using X in score that matches child's behaviour and speech**	SAT Score +3 15 / +2 / +1 / 0 / -1 / -2 / -3 15 — OCL Prescribed or Matrix
Interventions for Care *Consider age and individual development* **Attended (✓), Unsafe (US), Not due (ND)**	
Vital Signs: (as per Frequency of Vital Signs Table page 3)	Vital Signs
Individual Therapeutic Strategies: *Refer to child's behaviour management plan, tick box and document intervention in file*	Individual Therapeutic Strategies
Sedation: Oral (O), Intramuscular (IM), Intravenous (IV)	Sedation
Restrictive Practice Register: Mechanical Restraint (MR), Physical Restraint (PR), Chemical Restraint (CR), Seclusion (SE)	Restrictive Practice Register
Ims+: Completed for all incidents +/- restraint (✓)	Ims+ (✓)
Personal Care: Shower (S), Wash (W), Repositioning (R) Skin Checks (SC), TEDS (T)	ADLs: Pers Care
Oral Hygiene: Attended (✓)	Oral Hyg
Oral Intake: Food (F), Drink (D), Nil by Mouth (NBM)	PO Intake
Toileting: Urine (U), Bowels open (B), Incontinent (I), Catheter (C), Aperients (A), Pad (P), Colostomy (CO)	Toileting
	Initials

OCL Definitions - ED and Inpatient MHU Use Only

OCL 1: Constant supervision by skilled RN
- 1:1, document 15/60 on Behavioural Obs Form
- De-escalate and manage behaviours
- Vital signs as per Frequency of Vital Signs (page 3)

OCL 2: 15 minutely visual observations
- 15 minutely documentation on Behavioural Obs Form
- Vital signs as per Frequency of Vital Signs (page 3)

OCL3: 30 minutely visual observations
- 30 minutely documentation on Behavioural Obs Form
- Vital signs as per Frequency of Vital Signs (page 3)

OCL4: Hourly visual observations
- Hourly documentation on Behavioural Obs Form
- Vital signs as per Frequency of Vital Signs (page 3)

SWSLHD HUMANITY HUDDLE
A Safety Culture Initiative

Hunger and Hygiene
- Consider environment and ADLs

Understand their Rights
- Voluntary and Involuntary Statement of Rights

Medications and Medical Clearance
- Medications Administered, regular and PRN for psych and chronic conditions. Are they safe for TOC?

Abscond and Aggression Risk
- Abscond risk assessment and suicide risk considerations

NRT and Substance Use Screening
- No smoking policy
- AWS and other substance use considerations

Seclusion and Restraint Considerations
- Register completed as necessary and Ims+ attended

Paediatric Sedation Assessment Tool

For Deterioration, follow facility CERS protocol. ***For detailed instructions refer to Supervision Matrix***

SAT +1	SAT +2	SAT +3
• Agitation / anxiety • Argumentative • Teary • Isolating / withdrawing / staring • Anger / pacing	• Arguing with others • Yelling and swearing at others • Panic attack • Making threats • Throwing things	• Physically attacking others • Risk of self harm • Posing a high risk of physical aggression to others
Interventions *Attempt for 20 minutes only then escalate to SAT +2*	**Interventions** *Attempt for 20 minutes only then escalate to SAT +3*	**Interventions**
• Verbal de-escalation • Refer to child's individual care plan • Encourage deep breathing • Offer food / fluid • Re-direct child with quiet activities	• PRN medications • Separating child from others • Time-out • Discuss options with staffing or AHNM for individual child special	• MET call to Red Zone • Sensory modulation • Medication • Requires additional supervision from an appropriate nurse. *Document all SAT +3 episodes and outcomes in eMR and Ims+*

Sedation Assessment Tool		
Score	**Responsiveness**	**Speech**
+3	Combative, violent, out of control	Continual loud outbursts
+2	Very anxious and agitated	Loud outburst
+1	Anxious and restless	Normal / Talkative
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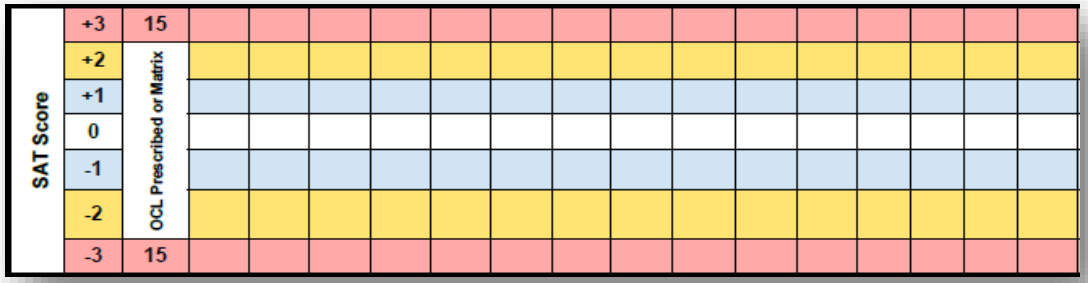

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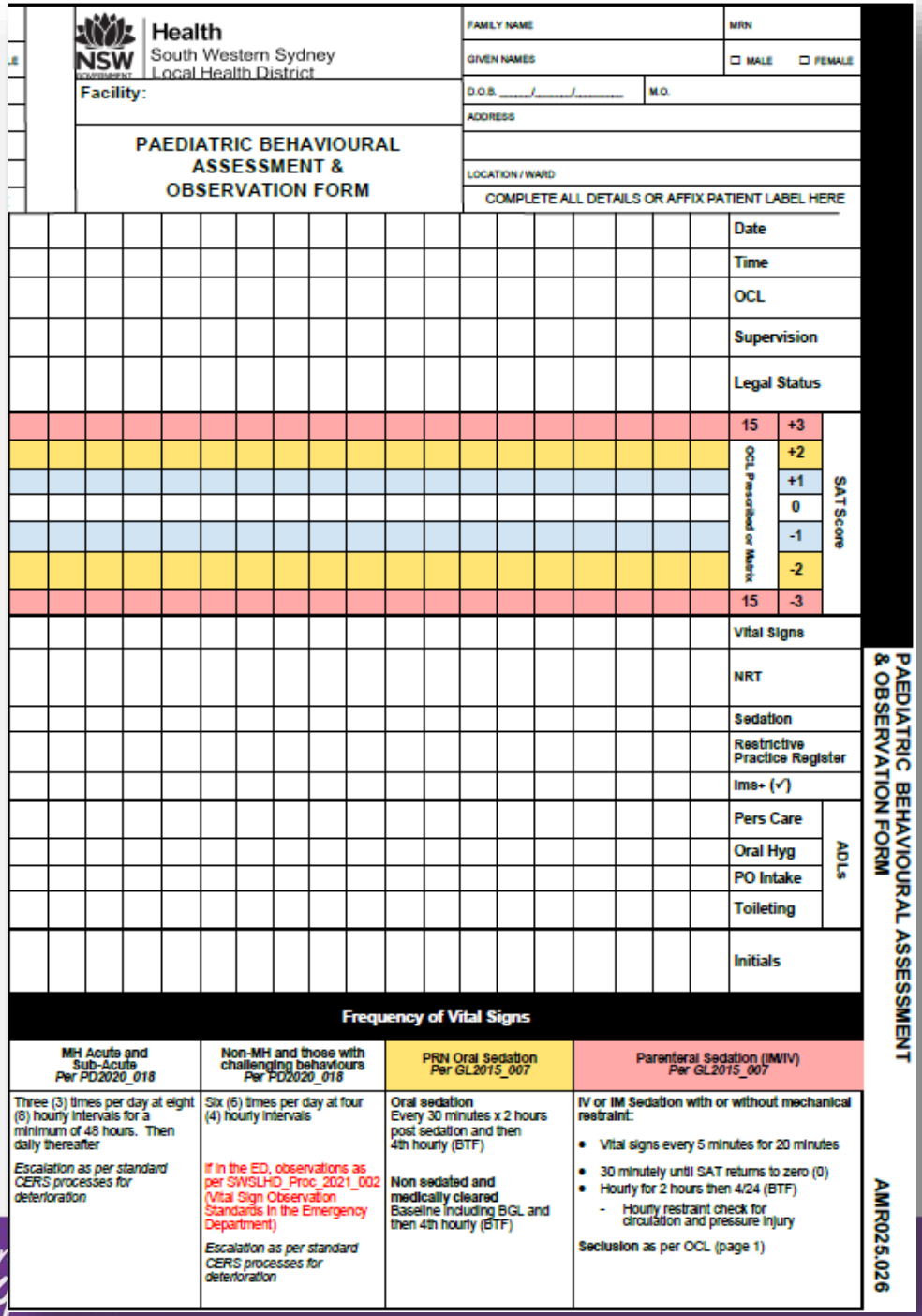
SAT +1	SAT + 2	SAT +3
• Agitation / anxiety • Argumentative • Teary • Isolating / withdrawing / staring • Anger / pacing	• Arguing with others • Yelling and swearing at others • Panic attack • Making threats • Throwing things	• Physically attacking others • Risk of self harm • Posing a high risk of physical aggression to others
Interventions ***Attempt for 20 minutes only then escalate to SAT +2***	**Interventions** ***Attempt for 20 minutes only then escalate to SAT +3***	**Interventions**
• Verbal de-escalation • Refer to child's individual care plan • Encourage deep breathing • Offer food / fluid • Re-direct child with quiet activities	• PRN medications • Separating child from others • Time-out • Discuss options with staffing or AHNM for individual child special	• MET call to Red Zone • Sensory modulation • Medication • Requires additional supervision from an appropriate nurse. *Document all SAT +3 episodes and outcomes in eMR and ims+*

Personal Care: Shower (S), Wash (W), Repositioning (R) Skin Checks (SC), TEDS (T)	ADLs	**Pers Care**			
Oral Hygiene: Attended (✓)		**Oral Hyg**			
Oral Intake: Food (F), Drink (D), Nil by Mouth (NBM)		**PO Intake**			
Toileting: Urine (U), Bowels open (B), Incontinent (I), Catheter (C), Aperients (A), Pad (P), Colostomy (CO)		**Toileting**			
	Initials				



Health
South Western Sydney
Local Health District

Facility:

PAEDIATRIC BEHAVIOURAL ASSESSMENT & OBSERVATION FORM

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Date
Time
OCL
Supervision
Legal Status

SAT Score (OCL Prescribed or Matrix): 15 +3; +2; +1; 0; -1; -2; 15 -3

Vital Signs
NRT
Sedation
Restrictive Practice Register
Ims+ (✓)

ADLs: Pers Care; Oral Hyg; PO Intake; Toileting

Initials

PAEDIATRIC BEHAVIOURAL ASSESSMENT & OBSERVATION FORM

AMR025.026

Frequency of Vital Signs

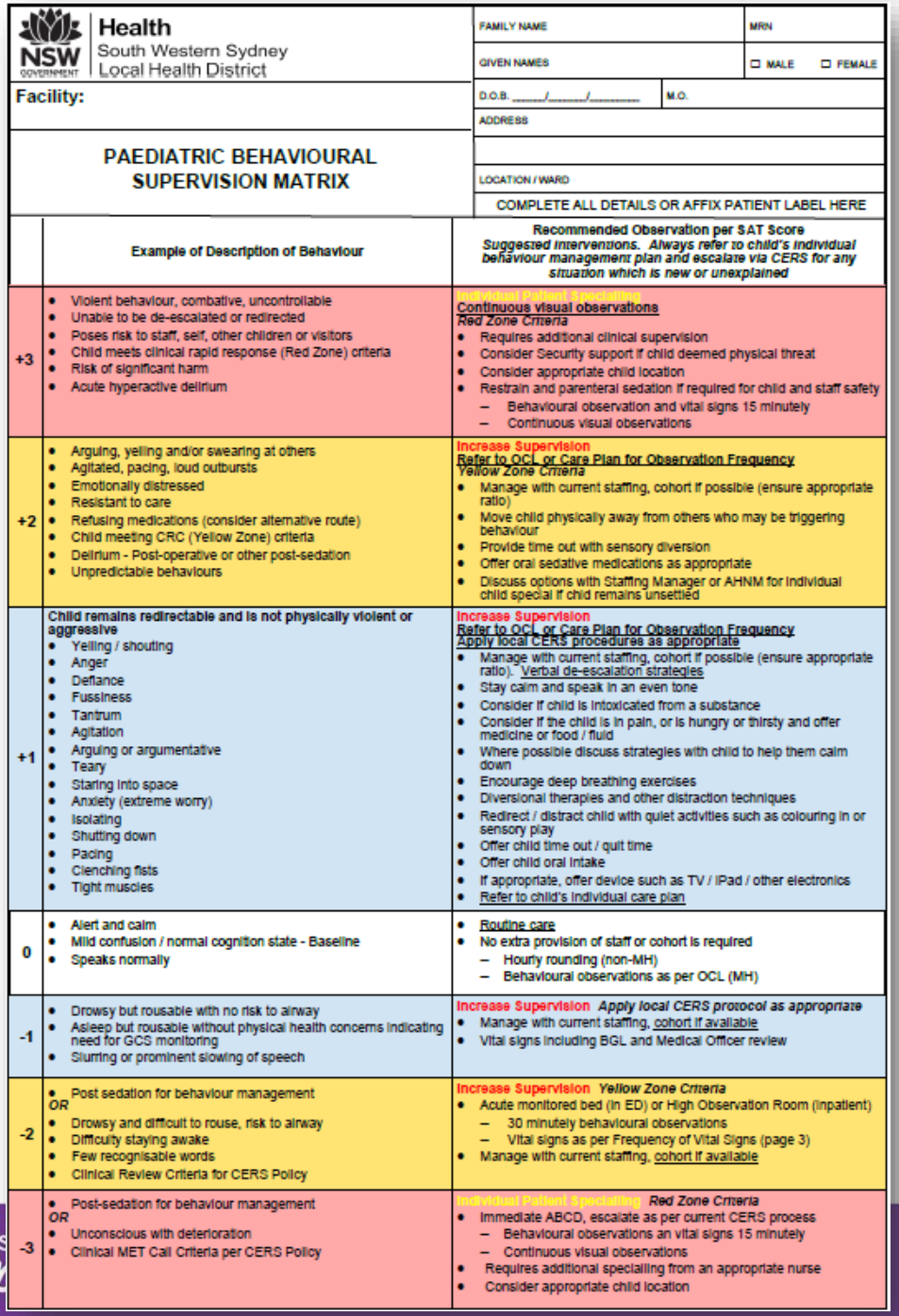
MH Acute and Sub-Acute *Per PD2020_018*	Non-MH and those with challenging behaviours *Per PD2020_018*	PRN Oral Sedation *Per GL2015_007*	Parenteral Sedation (IM/IV) *Per GL2015_007*
Three (3) times per day at eight (8) hourly intervals for a minimum of 48 hours. Then daily thereafter *Escalation as per standard CERS processes for deterioration*	Six (6) times per day at four (4) hourly intervals If in the ED, observations as per SWSLHD_Proc_2021_002 (Vital Sign Observation Standards in the Emergency Department) *Escalation as per standard CERS processes for deterioration*	Oral sedation Every 30 minutes x 2 hours post sedation and then 4th hourly (BTF) **Non sedated and medically cleared** Baseline including BGL and then 4th hourly (BTF)	**IV or IM Sedation with or without mechanical restraint:** • Vital signs every 5 minutes for 20 minutes • 30 minutely until SAT returns to zero (0) • Hourly for 2 hours then 4/24 (BTF) - Hourly restraint check for circulation and pressure injury **Seclusion** as per OCL (page 1)

- **Monitoring Section continued:**
  - Frequency of Vital Signs information updated with most recent changes to MOH Policy
  - Staff directed to utilise CERS if patient's clinical health deteriorates
  - Oral and Parenteral sedation boxes remain colour coded for staff to correlate to CERS criteria also

The Behavioural Decision Matrix

- The Sedation Assessment Tool Score is based on the *Management of Patients with Acute Severe Behavioural Disturbance in the Emergency Department* policy and also the *Continuum of Aggression Management for Consumers* tool developed by staff from Gna Ka Lun at Campbelltown Hospital.

- Recommended Observations and Interventions are in line with CERS and some wording changed to ensure staff more sure of what to do in the event of escalation or deterioration



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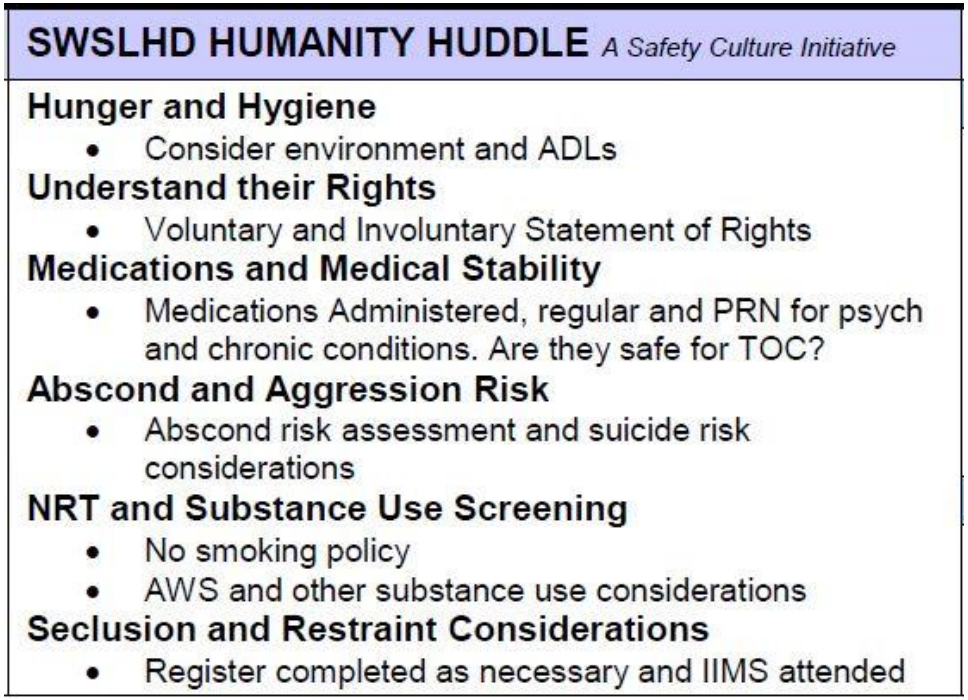
PAEDIATRIC BEHAVIOURAL SUPERVISION MATRIX

	Example of Description of Behaviour	Recommended Observation per SAT Score *Suggested interventions. Always refer to child's individual behaviour management plan and escalate via CERS for any situation which is new or unexplained*
+3	• Violent behaviour, combative, uncontrollable • Unable to be de-escalated or redirected • Poses risk to staff, self, other children or visitors • Child meets clinical rapid response (Red Zone) criteria • Risk of significant harm • Acute hyperactive delirium	Individual Patient Specialling Continuous visual observations *Red Zone Criteria* • Requires additional clinical supervision • Consider Security support if child deemed physical threat • Consider appropriate child location • Restrain and parenteral sedation if required for child and staff safety – Behavioural observation and vital signs 15 minutely – Continuous visual observations
+2	• Arguing, yelling and/or swearing at others • Agitated, pacing, loud outbursts • Emotionally distressed • Resistant to care • Refusing medications (consider alternative route) • Child meeting CRC (Yellow Zone) criteria • Delirium - Post-operative or other post-sedation • Unpredictable behaviours	Increase Supervision Refer to OCL or Care Plan for Observation Frequency *Yellow Zone Criteria* • Manage with current staffing, cohort if possible (ensure appropriate ratio) • Move child physically away from others who may be triggering behaviour • Provide time out with sensory diversion • Offer oral sedative medications as appropriate • Discuss options with Staffing Manager or AHNM for individual child special if child remains unsettled
+1	**Child remains redirectable and is not physically violent or aggressive** • Yelling / shouting • Anger • Defiance • Fussiness • Tantrum • Agitation • Arguing or argumentative • Teary • Staring into space • Anxiety (extreme worry) • Isolating • Shutting down • Pacing • Clenching fists • Tight muscles	Increase Supervision Refer to OCL or Care Plan for Observation Frequency Apply local CERS procedures as appropriate • Manage with current staffing, cohort if possible (ensure appropriate ratio). Verbal de-escalation strategies • Stay calm and speak in an even tone • Consider if child is intoxicated from a substance • Consider if the child is in pain, or is hungry or thirsty and offer medicine or food / fluid • Where possible discuss strategies with child to help them calm down • Encourage deep breathing exercises • Diversional therapies and other distraction techniques • Redirect / distract child with quiet activities such as colouring in or sensory play • Offer child time out / quit time • Offer child oral intake • If appropriate, offer device such as TV / iPad / other electronics • Refer to child's individual care plan
0	• Alert and calm • Mild confusion / normal cognition state - Baseline • Speaks normally	• Routine care • No extra provision of staff or cohort is required – Hourly rounding (non-MH) – Behavioural observations as per OCL (MH)
-1	• Drowsy but rousable with no risk to airway • Asleep but rousable without physical health concerns indicating need for GCS monitoring • Slurring or prominent slowing of speech	Increase Supervision *Apply local CERS protocol as appropriate* • Manage with current staffing, cohort if available • Vital signs including BGL and Medical Officer review
-2	• Post sedation for behaviour management *OR* • Drowsy and difficult to rouse, risk to airway • Difficulty staying awake • Few recognisable words • Clinical Review Criteria for CERS Policy	Increase Supervision *Yellow Zone Criteria* • Acute monitored bed (in ED) or High Observation Room (inpatient) – 30 minutely behavioural observations – Vital signs as per Frequency of Vital Signs (page 3) • Manage with current staffing, cohort if available
-3	• Post-sedation for behaviour management *OR* • Unconscious with deterioration • Clinical MET Call Criteria per CERS Policy	Individual Patient Specialling *Red Zone Criteria* • Immediate ABCD, escalate as per current CERS process – Behavioural observations an vital signs 15 minutely – Continuous visual observations • Requires additional specialling from an appropriate nurse • Consider appropriate child location

- **Paediatric Behavioural Supervision Matrix:**
  - Aligning behaviours with CERS protocols for ease of decision making in the event of deterioration or escalation
  - Simple language for descriptions of behaviour
  - Aligning the Levels of monitoring from the *Continuum of Aggression Management* into the +1, +2 and +3 interventions

Humanity Huddle

- A tool designed by the Safety Culture Coordinators to assist with handover and documentation
- Uses the HUMANS acronym to cover the basic cares a patient with any challenging behaviour may require



SWSLHD HUMANITY HUDDLE *A Safety Culture Initiative*

Hunger and Hygiene
- Consider environment and ADLs

Understand their Rights
- Voluntary and Involuntary Statement of Rights

Medications and Medical Stability
- Medications Administered, regular and PRN for psych and chronic conditions. Are they safe for TOC?

Abscond and Aggression Risk
- Abscond risk assessment and suicide risk considerations

NRT and Substance Use Screening
- No smoking policy
- AWS and other substance use considerations

Seclusion and Restraint Considerations
- Register completed as necessary and IIMS attended

Important Points to Note

- This is a 24 hour chart, if your patient requires more than 24 hours of monitoring Or more than three risk assessments are required in a 24 hour period, please start a new chart
- Risk assessments must be attended at a minimum of 3 times in a 24 hour period. Change of shift is a good time to attend. If the patient has an incident such as Code Black or MET call, the risk assessment should also be repeated

Moving Forward

- The SWSLHD Paediatric Behavioural Assessment and Observation Form is not available for managers to order. Should you require more copies, contact Clair McEntee or Karien Thomson

- There are two versions, an Adult version for people over the age of 17 and a Paediatric version. The adult tool will be available for managers to order however should not be used in paediatric units. No paediatric tool should be used in an adult unit.

- The project leaders can always be contacted for support and extra education

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