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24-hour behaviour monitoring record

A guide on how to use this clinical record

The new 24-hour behaviour monitoring record is available for use in NSW Health facilities. It aims to support standardising care and reducing the variation between clinical practice and documentation.

The record:

- provides an accurate picture of a patient's behaviours and behavioural changes over a 24-hour period
- guides clinical decisions, including non-pharmacological approaches and potential response according to the Clinical Emergency Response System (CERS)
- is simple to use and time efficient to complete.

Why have a 24-hour behaviour monitoring record?

- Previously, there was no template available for recording a 24-hour period of behaviour observations to provide an overview of a patient's behavioural fluctuations or changes.
- As a result, clinicians could only provide limited descriptive information about behaviours, triggers and intervention strategies and non-pharmacological interventions or strategies.

Why is a 24-hour monitoring record important?

Care of patients with challenging behaviours is a priority so an accurate record of those behaviours is essential. The record will be used to monitor changes in a patient's behaviour or mental state.

The record is used to:

- monitor sleep patterns and changes
- provide cues for non-pharmacological intervention strategies
- enable enhanced prompts for staff to document descriptions of behaviours and possible triggers
- enable staff to document effective intervention strategies to guide clinical practice.

When do I use the record?

The record can be used for a patient with:

- a new confusion or a change in behaviour
- dementia or delirium with behaviour change
- hyperactive and hypoactive (fluctuating) behaviours
- a need for increased supervision.

Note
Continue documenting Vital Sign Observations on BTF chart and escalate as per local CERS protocol.

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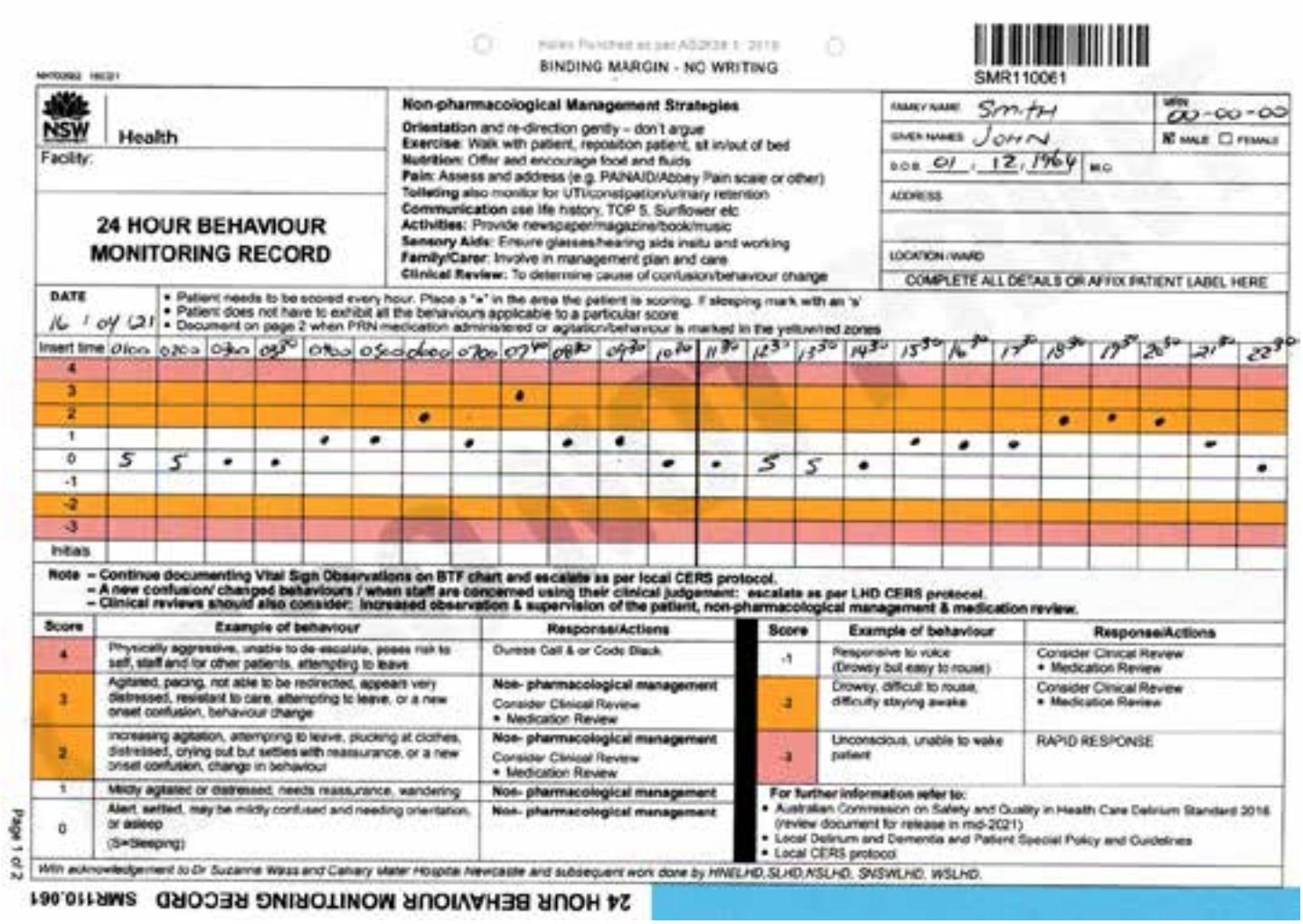
How to complete page 1

See examples of behaviours noted at bottom of the record. Note they may be in the white, yellow or red zone.

- Record the date
- Note the time over 24 hours
- A dot (•) is to be placed in the section relevant for the behaviour most consistently displayed over the time period
- Complete the record at least hourly and more frequently as required
- Place an 'S' to indicate when the patient is sleeping



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SMR110061

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Facility:

24 HOUR BEHAVIOUR MONITORING RECORD

Non-pharmacological Management Strategies

Orientation and re-direction gently – don't argue
Exercise: Walk with patient, reposition patient, sit in/out of bed
Nutrition: Offer and encourage food and fluids
Pain: Assess and address (e.g. PAINAID/Abbey Pain scale or other)
Toileting also monitor for UTI/constipation/urinary retention
Communication use life history, TOP 5, Sunflower etc
Activities: Provide newspaper/magazine/book/music
Sensory Aids: Ensure glasses/hearing aids insitu and working
Family/Carer: Involve in management plan and care
Clinical Review: To determine cause of confusion/behaviour change

FAMILY NAME: Smith
GIVEN NAMES: John
D.O.B. 01 / 12 / 1964 M/F
ADDRESS
LOCATION / WARD
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

DATE 16 / 04 / 21

- Patient needs to be scored every hour. Place a "•" in the area the patient is scoring. If sleeping mark with an 's'
- Patient does not have to exhibit all the behaviours applicable to a particular score
- Document on page 2 when PRN medication administered or agitation/behaviour is marked in the yellow/red zones

Insert time	01am	02am	03am	04am	05am	06am	07am	08am	09am	10am	11am	12pm	1pm	2pm	3pm	4pm	5pm	6pm	7pm	8pm	9pm	10pm	11pm	12am
4																								
3																								
2																								
1																								
0	S	S	•	•								•	•	S	S	•								•
-1											•													
-2																								
-3																								
Initials																								

Note – Continue documenting Vital Sign Observations on BTF chart and escalate as per local CERS protocol.
– A new confusion/ changed behaviours / when staff are concerned using their clinical judgement: escalate as per LHD CERS protocol.
– Clinical reviews should also consider: increased observation & supervision of the patient, non-pharmacological management & medication review.

Score	Example of behaviour	Response/Actions
4	Physically aggressive, unable to de-escalate, poses risk to self, staff and /or other patients, attempting to leave	Duress Call & or Code Black
3	Agitated, pacing, not able to be redirected, appears very distressed, resistant to care, attempting to leave, or a new onset confusion, behaviour change	Non- pharmacological management Consider Clinical Review • Medication Review
2	Increasing agitation, attempting to leave, plucking at clothes, distressed, crying out but settles with reassurance, or a new onset confusion, change in behaviour	Non- pharmacological management Consider Clinical Review • Medication Review
1	Mildly agitated or distressed, needs reassurance, wandering	Non- pharmacological management
0	Alert, settled, may be mildly confused and needing orientation, or asleep (S=Sleeping)	Non- pharmacological management

Score	Example of behaviour	Response/Actions
-1	Responsive to voice (Drowsy but easy to rouse)	Consider Clinical Review • Medication Review
-2	Drowsy, difficult to rouse, difficulty staying awake	Consider Clinical Review • Medication Review
-3	Unconscious, unable to wake patient	RAPID RESPONSE

For further information refer to:
- Australian Commission on Safety and Quality in Health Care Delirium Standard 2016 (review document for release in mid-2021)
- Local Delirium and Dementia and Patient Special Policy and Guidelines
- Local CERS protocol

With acknowledgement to Dr Suzanne Wass and Calvary Mater Hospital Newcastle and subsequent work done by HNELHD, SLHD, NSLHD, SNSWLHD, WSLHD.

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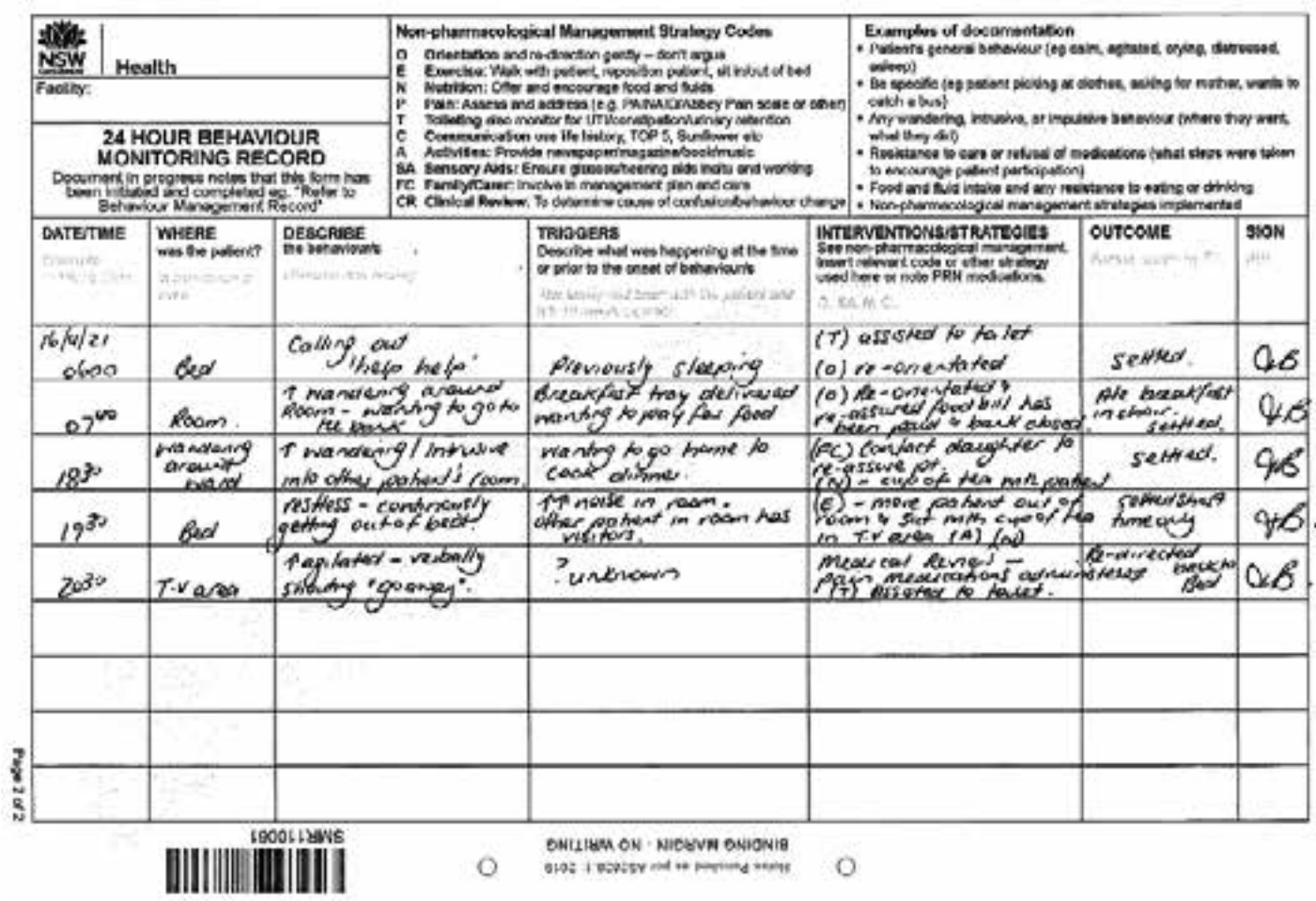
On page 2 you can document when PRN medications are administered and describe agitation or behaviour which you have marked in the yellow or red zone.

How to record behaviours on page 2

- Note the date and time
- Note where the behaviour occurred and what was happening at the time
- Briefly describe the behaviour – shouting, pacing, verbally aggressive
- Think about what happened at the time, or prior to the onset of the behaviour
- Note what could have been a trigger for the behaviour, such as:
  - the family has just left
  - needs to go to the toilet
  - too much noise in the room.
- Note interventions or strategies:
  - refer to the non-pharmacological management strategy codes at the top of form
  - note the strategies put in place, using letter code of interventions
  - note when PRN medication was administered.
- Record the outcome of the interventions or strategies, for example, 'called a family member to come' or 'patient settled'
- Sign your initials on the record

A written explanation of the behaviour may be required in the patient medical record progress notes to complement the 24-hour behaviour monitoring record.



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24 HOUR BEHAVIOUR MONITORING RECORD

Document in progress notes that this form has been initiated and completed eg. "Refer to Behaviour Management Record"

Non-pharmacological Management Strategy Codes

O Orientation and re-direction gently – don't argue
E Exercise: Walk with patient, reposition patient, sit in/out of bed
N Nutrition: Offer and encourage food and fluids
P Pain: Assess and address (e.g. PAINAID/Abbey Pain scale or other)
T Toileting also monitor for UTI/constipation/urinary retention
C Communication use life history, TOP 5, Sunflower etc
A Activities: Provide newspaper/magazine/book/music
SA Sensory Aids: Ensure glasses/hearing aids in situ and working
FC Family/Carer: Involve in management plan and care
CR Clinical Review: To determine cause of confusion/behaviour change

Examples of documentation

- Patient's general behaviour (eg calm, agitated, crying, distressed, asleep)
- Be specific (eg patient picking at clothes, asking for mother, wants to catch a bus)
- Any wandering, intrusive, or impulsive behaviour (where they went, what they did)
- Resistance to care or refusal of medications (what steps were taken to encourage patient participation)
- Food and fluid intake and any resistance to eating or drinking
- Non-pharmacological management strategies implemented

DATE/TIME	WHERE was the patient?	DESCRIBE the behaviours	TRIGGERS Describe what was happening at the time or prior to the onset of behaviours	INTERVENTIONS/STRATEGIES See non-pharmacological management. Insert relevant code or other strategy used here or note PRN medications.	OUTCOME	SIGN
16/4/21 0600	Bed	Calling out 'Help help'	Previously sleeping	(T) assisted to toilet (O) re-orientated	Settled	QB
07[00]	Room.	T wandering around room - wanting to go to the toilet	Breakfast tray delivered wanting to eat food	(O) Re-orientated & re-assured food will has been given & bed closed	Ate breakfast in chair. Settled.	QB
18[30]	wandering around unit	T wandering / intrusive into other patient's room	wanting to go home to cook dinner.	(FC) Contact daughter to re-assure pt (O) - cup of tea with patient	Settled.	QB
19[30]	Bed	restless - continually getting out of bed.	?? noise in room. other patient in room has visitors.	(E) - move patient out of room to sit with cup of tea in T.V area (A) (O)	Settled for short time only	QB.
20[30]	T.V area	Agitated - verbally shouting "go away".	? unknown	Medical review - pain medications administered (T) assisted to toilet.	Re-directed back to bed	QB

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The 24-hour behaviour monitoring record can be ordered by NSW Health staff via Stream Solutions (a division of Toll). **Product code: NH700562.**

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