NH700562 160222

SMR110061

NSW GOVERNMENT Health

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

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

DATE / /

- 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																							
4																							
3																							
2																							
1																							
0																							
-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 and/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 Clinical Care Standard. Sydney: ACSQHC; 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.

24 HOUR BEHAVIOUR MONITORING RECORD SMR110.061

NSW GOVERNMENT Health

Facility:

24 HOUR BEHAVIOUR MONITORING RECORD

Document in progress notes that this form has been initiated and completed e.g. "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 insitu and working
- **FC** **Family/Carer:** Involve in management plan and care
- **CR** **Clinical Review:** To determine cause of confusion/behaviour change

FAMILY NAME | MRN

GIVEN NAMES | ☐ MALE ☐ FEMALE

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

ADDRESS

LOCATION / WARD

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

DATE/TIME	WHERE was the patient?	DESCRIBE the behaviour/s	TRIGGERS Describe what was happening at the time or prior to the onset of behaviour/s	INTERVENTIONS/STRATEGIES See non-pharmacological management. Insert relevant code or other strategy used here or note PRN medications.	OUTCOME	SIGN
Example 11/06/19 1105	*In bed space in ward*	*Shouting and pacing*	*The family had been with the patient and left 10 minutes earlier*	*O, SA, N, C,*	*Settled, watching TV*	*AW*

Examples of documentation

- Patient's general behaviour (e.g. calm, agitated, crying, distressed, asleep)
- Be specific (e.g. 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

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BINDING MARGIN - NO WRITING

Holes Punched as per AS2828.1: 2019