ACUTE SEVERE BEHAVIOURAL DISTURBANCE IN PICU - CHW

PRACTICE GUIDELINE ©

DOCUMENT SUMMARY/KEY POINTS

- This document is for use in PICU/COU to assist staff with planning and management of patients with Acute Severe Behavioural Disturbance (ASBD).
- The following policies have been reviewed and used in the development of this guideline.
  - Seclusion and Restraint in NSW Health Settings
  - Analgesia and Sedation PICU – CHW
  - Acute Severe Behavioural Disturbance in Emergency Departments
- ASBD definitions, admission and management strategies and resources for use in this group of patients are provided in this document.

CHANGE SUMMARY

- This is a new document.

READ ACKNOWLEDGEMENT

- All staff working in PICU

Approved by:	SCHN Policy, Procedure and Guideline Committee	
Date Effective:	1st July 2023	**Review Period**: 3 years
Team Leader:	Quality and Data Manager	**Area/Dept**: PICU CHW

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Acute Severe Behavioural Disturbance

Definition

"Behaviour that puts the patient or others at immediate risk of serious harm and may include threatening or aggressive behaviour, extreme distress, and serious self-harm which could cause major injury or death" [1]

Patients who are experiencing, or who may be at risk of experiencing, acute severe behaviour disturbance (ASBD) may be admitted electively or as an unplanned admission. Elective admissions will predominantly be post-operative patients.

Behavioural disturbances may be triggered or confounded by the unfamiliar and stimulating environment of the PICU. Pain or other factors relating to critical illness may compound the behavioural issues.

ASBD Folder

The ASBD folder should be kept at the PICU nurses' station.

It contains ' I Like/Dislike" communication boards, Picture exchange communication system (Picture boards) and Parent/ Carer questionnaires.

Elective Admissions

Once a patient has been identified as presenting a behavioural risk during/ after extubation, PICU care will be coordinated by the PICU CNC with the involvement of the PICU NUM and the PICU SMO on duty on expected day of admission. The PICU CNC should be made aware of the patient by the pre-admission clinic staff.

Pre-Admission roles

PICU complex care CNC:

- Coordinate with the clinic staff to ensure the family have the opportunity to complete and return the PICU questionnaire (appendix 1), and to consider a tour of the ICU.
- Plan MDT

PICU MDT:

- Include PICU medical and nursing team, the surgical team, the relevant anaesthetist (or the delegated anaesthetist) and the psychological medicine team.
- Goals of this meeting would include outlining the expected patient course through PICU, clarifying a **behavioural management and escalation plan**, thresholds for chemical and physical restraints and discussion of home medications.
- Team should consider the potential benefit of transferring the patient from theatre to PICU sedated and intubated to enable emergence from anaesthesia to occur in a less stimulating environment.

PICU NUM:

- Identify which bed spaces in PICU and/or COU are most appropriate.
- Consideration of appropriate nursing skills required and pre-allocation of bedside staff.
- The need for a Hi-Lo bed should also be considered.

Admission roles

PICU CNC:

- Coordinate the admission with the PICU NUM, bedside RN and the PICU medical team.
- Provide behavioural management and escalation plan.
- If admission is expected to occur out of normal working hours, coordination may have to be via the PICU team leader or access nurse.
- A pager should be provided to the parents so that they can be contacted once the first call is received from operating theatres. Parents should ideally be present for patient arrival and handover.

PICU NUM:

- Confirm an appropriate bedspace and patient requirements and endeavour to be present for patient handover.

PICU RN:

- Obtain handover from the PICU CNC and prepare the bedspace environment accordingly.
- Obtain the Hi-Lo bed if required.
- Complete "I Like/Dislike" board based on the parent/carer questionnaire.
- Communication picture board available if required.
- Ensure the behavioural management and escalation plan is present and followed at the bedspace.
- All resources to be obtained from ASBD folder located at the nurses station.

PICU Medical team:

- Discuss the likely course of the patient through PICU including likely timing of extubation and removal of any hardware.
- Confirm the behavioural management and escalation plan and the general medical plan. Consideration should be given to any home medications and whether these should be continued.
- The admitting JMO should notify the SMO prior to the patient handover with the anaesthetic team.

Emergency and Unplanned Admissions

Even with emergency or unplanned admissions, there may be ample time for team members to complete some of the tasks as per elective pre-admission roles.

PICU Medical team:

- If the patient is being admitted postoperatively, they should liaise with the anaesthetic team prior to transfer and discuss the value of transferring the patient from theatre to PICU sedated and intubated to enable emergence from anaesthesia to occur in a less stimulating environment.
- There may be an opportunity to discuss patient's behaviour and likes/dislikes with the parents in advance and ask them to complete the ASBD questionnaire. If not completed pre-admission, this should be done promptly once the patient is admitted. If time permits, hospital care plans/community care plans may provide useful information (check Management plans tab in PowerChart). Early contact with the psychological medicine team may be warranted, especially if the patient is known to them.
- Post-handover, the medical team must ensure a behavioural management and escalation plan has been formulated. Planning for duration and securing of invasive hardware (IDC, arterial lines etc.) and monitoring should be discussed. Where feasible and safe to do so, invasive hardware should be removed prior to waking the patient.

PICU NUM:

- Confirm an appropriate bedspace and endeavour to be present for patient handover.
- Ensuring level of nursing experience at the bedside is appropriate.

PICU RN:

- A "I Like/Dislike" board to be completed based on the parent/carer questionnaire.
- Ensure a behavioural management and escalation plan has been formulated post-handover.
- Communication picture board available if required.
- Obtain and arrange transfer to a Hi-Lo bed if required.
- All resources to be obtained from ASBD folder located at the nurses station.

During PICU Admission

Bedspace considerations

Minimise stimuli such as bright lights, loud noise, and excess staff members where possible. A single room should be considered and may be crucial in some circumstances.

Communication

Where possible, staff should communicate through the patient's preferred method of communication. If a patient is verbal, use simple language and short phrases, speak slowly

and allow time to respond. Some patients communicate with sign language so staff knowledge of some simple hand signs may be very useful and could be ascertained from the parents or guardians. Consider the use of a Picture Exchange Communication System (PECS). Parental input should be sought at all times. Aim to familiarise oneself with the child's pattern of escalation or triggers for challenging behaviours e.g., rocking, stimming (repetitive or unusual body movements or noises) or distressed noises.

Non-pharmacological management

Use the patient's identified interests and routines in management strategies and minimise routine interruptions. Consider use of devices such as tablets or smartphones.

Avoid triggers of behavioural disturbance, employ any identified comfort strategies, and use other measures of de-escalation that may have been included in the formalised behavioural care plan.

Consider child life therapy and music therapy.

Physical restraints are last-line therapy as this may worsen anxiety and unwanted behaviours.

Pharmacological management and assessment

Pharmacological management should be considered in close consultation with the psychological medicine team. A medication history should be obtained for the patient, and consideration should be given to whether agents will be continued during admission, when these have last been administered, and whether a switch to an alternative route is possible as required.

Alpha-2 agonists (such as dexmedetomidine and clonidine) are often useful adjuncts. However, these agents may cause bradycardia and/or hypotension – especially when used in conjunction with other agents (see PICU sedation guideline). Consider the patient's medical history and current medication regime when initiating an alpha agonist.

Atypical antipsychotics, such as olanzapine, are being used more frequently in the treatment of delirium in children. Although these entities can also overlap, it should be clearly documented whether such agents are being prescribed for the management of delirium or behavioural disturbance. Atypical antipsychotics are rarely required for management of behavioural disturbances **without** delirium in younger children. Consider any home medications such as anticonvulsants which may induce the metabolism of other agents.

Many medications used for behavioural disturbances, such as atypical antipsychotics, can cause QT prolongation. A baseline 12 lead ECG prior to initiation of treatment is useful with the frequency of repeat 12 lead ECGs dictated by clinical concern and the likelihood of QT prolongation from pharmacological treatments. However, application of ECG dots and leads may not be well tolerated.

Intubated ASBD patient

Refer to Analgesia and Sedation PICU – CHW guideline.

A pharmacological escalation plan should be clearly communicated and documented.

Consideration should be given to the anticipated route of administration of analgesics and sedatives once the child is extubated.

Peri – Extubation Phase

Parent/carer input

- Enable parental presence at bedside where possible.
- Discuss plan with parent/carer and ask for input around non-pharmacological strategies. This may include music, blankets, toys, devices, etc.
- Aim to avoid physical restraint.

Location/Personnel

- Consider moving the bed space if the current space is not ideal, e.g. single room, end of the unit, COU, or any need for security presence.
- Consider the number of medical/nursing staff needed for safety vs excess stimulation.
- Consider safe level of lighting vs overstimulation.
- Consider bedrail cushioning, height of bed, etc.
- Consider what equipment needs to be in the room or could be moved outside.

Monitoring/Lines

- The degree of monitoring depends on the clinical scenario and risks of extubation failure or organ dysfunction. Consider silencing alarms if appropriate. Monitors can also be relayed to a remote device.
- Consider risk/benefit of all hardware (such as IDC, art lines, NGT, additional PIVCs) and remove any non-essential invasive hardware. IV lines that are to be left in situ could be wrapped or concealed as appropriate.

Pharmaceutical

- For post-extubation sedation or analgesia, long-acting agents may be of benefit – especially when IV infusions are not tolerated or oral administration of medications is difficult. Options may include:
    - pre-extubation nasogastric tube in/out technique to facilitate enteral SR meds
    - sedation patches placed in hard to access areas, such as between scapulae. For example, clonidine patches may be of benefit. If a patch is used, it should be signed on the medication administration record (MAR) at time of application and then again when removed. See Meds4Kids for details on patch availability or contact Pharmacy.

Extubation

- Ensure there are no required procedures which would be preferentially performed pre-extubation. These may include blood sampling, swabs or dressing removals.
- Careful planning in case of need for reintubation, such as the required method of induction, etc.
- Consider deep extubation if safe to do so - a guedel airway could be considered. Input from the anaesthetic team may be useful.

Non-Intubated ASBD patient

If increased sedation required, the choice of agent/s will depend on the availability of IV access and the reason for presentation. The SCHN ED guideline may be helpful, particularly during the initial presentation. Intramuscular administration of a medication (such as ketamine, olanzapine or haloperidol), although not usually first-line, may be required and should be considered especially when there is an acute safety concern for the child or staff. Check Meds4Kids for dosing and administration advice.

As with all patients, potential need for airway management should be considered when administering any sedating medication.

Medical Causes of Agitation

Consider other potential causes of agitation in the hospital setting. Review of recent investigations and medical assessment may be required to rule out causes of agitation apart from an underlying ASD/behavioural disorder. Causes to consider include:

- Pain
- Delirium
- Hypoxia
- Withdrawal – from home medications or newly initiated medications
- Medication side effects or interactions
- Metabolic derangement (e.g. hyponatraemia, hypocalcaemia, hypoglycemia)
- Encephalopathy (e.g. liver or renal failure)
- Infection (e.g. encephalitis/meningitis)
- Seizure or post-ictal state
- Head trauma

Expectations of behaviour

Understanding the patients underlying behavioural strategies for self-soothing is important to managing their response to a stressful situation. These behaviours may involve those that are self-injurious. Interrupting these behaviours at times of high stress may lead to an escalation of behaviour for the child. Early conversations about acceptable behaviours that are not to be interrupted in the PICU setting empower staff to understand and support the patient through these difficult moments. This behaviour needs to be balanced against the risk of serious self-harm and should be defined at the morning and evening ward rounds with SMO input and documented in the behaviour plan.

Restraint

PICU uses soft Velcro restraints attached to arm boards to restrict limb movement and protect accidental removal of lines, tubes and drains. The use of any restraint should be carefully considered, particularly in this patient group where restraints may trigger agitation and aggressive behaviour. Removing any lines/tubes/drains prior to removing an ETT so the physical restraints can also be removed should be considered. Restraints have to be documented in the patient record and consent by a caregiver must be obtained.

Discharge Planning

The PICU CNC should be involved in coordinating discharge, commencing at the time of admission or prior.

Early engagement of the “home team” is essential (such as the patient’s general paediatrician). Engagement with the psychological medicine team should continue.

Consider early the likely discharge destination from PICU, including the possibility of discharging directly home.

Feedback (from family and staff) and documentation for future admissions may be very useful. The PICU CNC should coordinate this, and document appropriately in the electronic medical record.

Appendix 1

Parent/Carer Questionnaire

MEDICATIONS (if any)

SCHOOL

What type of school does your child go to?

- ☐ Assisted mainstream
- ☐ Special school
- ☐ Respite/residential care
- ☐ Not schooled/home bound

COMMUNICATION

Expression

How does your child communicate?

- ☐ Speech
- ☐ Gestures
- ☐ Visual cues
- ☐ Augmented communication – PECS, iPad

How does your child express their wants and needs?

How does your child say yes? No?

How does your child express pain?

Does your child avoid eye contact or being in close proximity to others?

Understanding

How should we communicate with your child?

- Verbal/non-verbal
- Gestures
- Pictures

How does your child understand instructions?

- One/two step?

INTERESTS AND ROUTINES

Does your child have special interests? Foods?

What type of toys or activities does your child prefer?

Does your child have a strong need for routine?

What happens if these routines or interests are interrupted? What helps?

Does your child have difficulty with transitions? If so, what helps?

What strategies do you use when transitioning to different and unfamiliar environments?

SENSORY SENTITIVITIES

Does your child have specific sensory sensitivities?

- Eg: loud noises, light, colours, textures, unexpected noises, touch, smells

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What happens when they encounter distressing sensory experiences?

Does your child have sensory supports (e.g. blankets, headphones) available to help manage distressing moments/environments?

BEHAVIOUR

Does your child have a past history of:

- ☐ Anxiety
- ☐ Agitation
- ☐ Aggression
- ☐ Self-injury
- ☐ Disruptive behaviour
  - Eg: Head banging, screaming, rocking, flapping, hand wringing, repetitive self-stimulating vocalisations

What are triggers for this type of behaviour?

What is the best way to comfort your child/manage this behaviour?

Does your child have a behavioural care plan in place? (obtain copy if yes)

How can we make this admission easier for your child?

Appendix 2

I LIKE/DISLIKE BOARD

MY NAME IS:

I LIKE TO BE CALLED:

I LIKE:

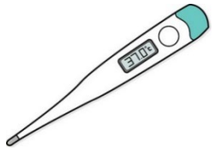
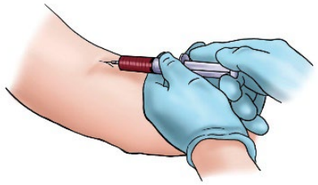
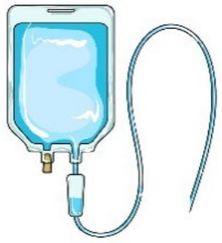
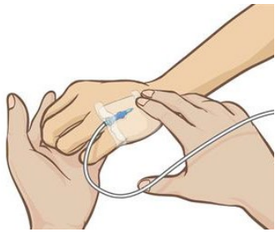
I DISLIKE:

SIGNS THAT I AM CONTENT:

SIGNS THAT I AM DISTRESSED:

Appendix 3

PICU Picture Chart

 Nurse	 Doctor	 Doctor Visit	 X-ray	 Operation
 Suction	 Oxygen Monitor	 Temperature	 Blood Pressure	 Taking Blood
 Pain	 Sleep	 Water	 Brush Teeth	 Bedpan/ Toilet
 Medication	 Drip	 IV Line	 Weight	 Sit in Chair

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