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The Behaviour Support Profile Evaluation Report

2025

Melbourne Children's Campus Mental Health Strategy

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Prepared by

Prepared by the Campus Mental Health Strategy, The Royal Children's Hospital, Murdoch Children's Research Institute, and The University of Melbourne, with support from The Royal Children's Hospital Foundation.

Authors

Alma Giborski, Maddie Cranney, Melissa McKinlay, Kelly Light.

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We extend our recognition to individuals and communities who face or have faced personal challenges and adversity. In our work implementing the Campus Mental Health Strategy, we strive to ensure that the lived experiences of young people, their families, friends, and support networks are central to the care we provide, and their voices continue to inform all aspects of our professional practice.

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Terminology

This evaluation report endeavours to use inclusive terminology and the best language for this point in time. The language is subject to change as this topic evolves. Each community may have their preferences regarding terminology. Individuals should take care to respect these preferences.

Artwork

The 'Sky Garden' illustration shown below and throughout this document is inspired by the sculptures that hang in Main Street (the main foyer) at the Melbourne Children's Campus.

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For more information, please visit mentalhealth.melbournechildrens.com or you can email CMHS@mcri.edu.au.

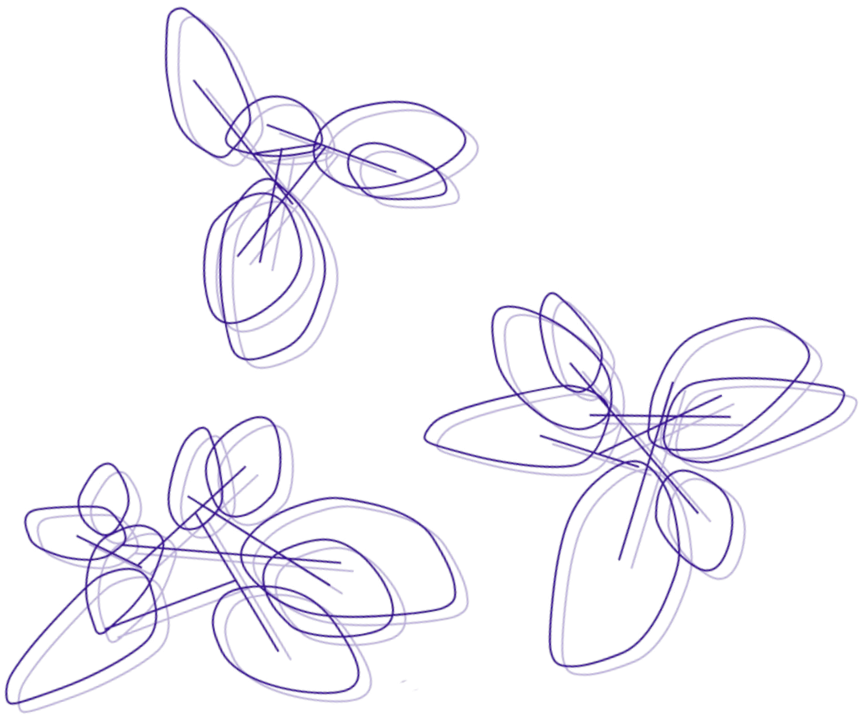

Illustration above: depicts the 'Sky Garden' sculptures that hang in Melbourne Children's Campus foyer.

The Campus Mental Health Strategy

The Campus Mental Health Strategy (CMHS) was developed to address the complex mental health requirements of children and young people within the paediatric healthcare system. The vision driving the CMHS is:

> **"That all infants, children, adolescents, and their families will be able to access high-quality, equitable, and consistent prevention and mental health care where and when they need it, to achieve sustained, optimised developmental, health, and wellbeing outcomes".**

The CMHS is the product of a collaborative effort that brings together the expertise and insights of those with lived experience, clinicians, researchers, educators, and healthcare professionals. This integrated strategy is designed to holistically strengthen research, education, and care in addressing mental health needs across the Melbourne Children's Campus (campus), which includes The Royal Children's Hospital (RCH), Murdoch Children's Research Institute (MCRI), and The University of Melbourne (UoM).

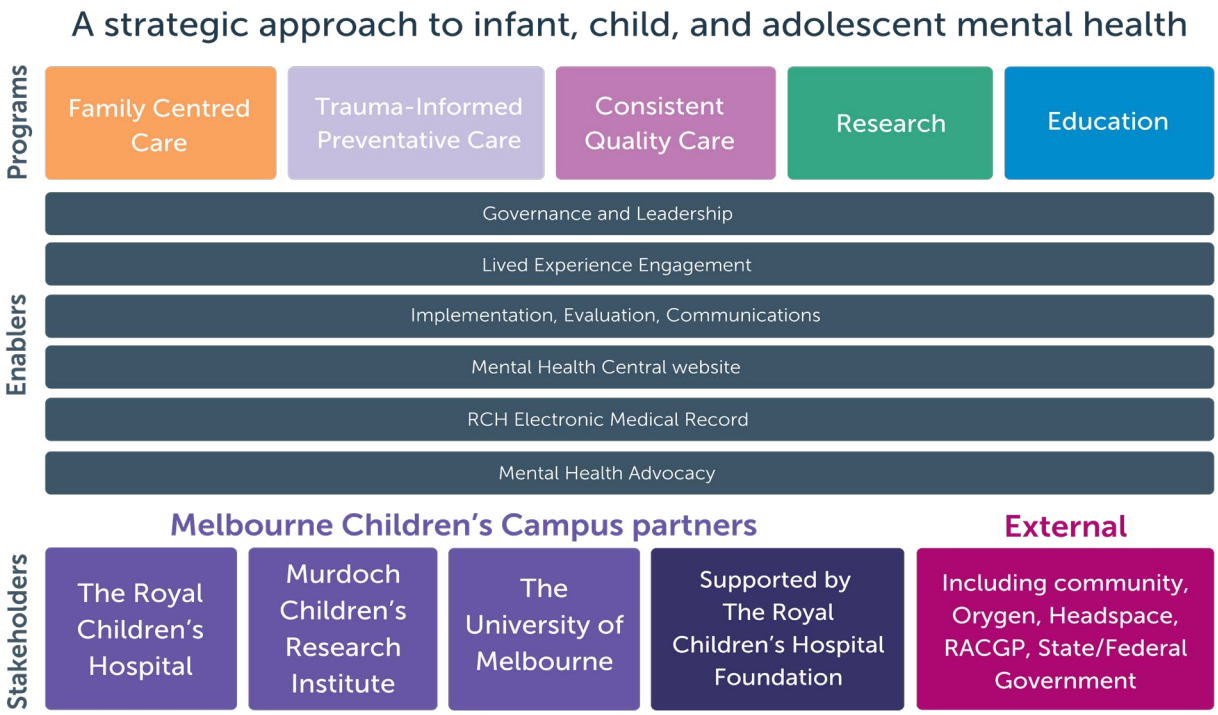

Photo above: Campus Mental Health Strategy

Trauma-Informed Preventative Care program at the CMHS

The Trauma-Informed Preventative Care (TIPC) program integrates the principles of trauma-informed care (TIC) with an emphasis on prevention. TIPC realises that trauma is prevalent and pervasive and has a profound impact on developing children (Olweny, Elliott, Giborski, Thiraviarajah, & Goldfeld, 2024).

Increased awareness enables empathetic responses when caring for children, young people, and their parents and carers while actively preventing re-traumatisation within healthcare settings (Olweny et al., 2024). By emphasising physical, psychological, psychosocial, emotional, and cultural safety, TIPC provides a comprehensive framework that underpins family-centred care and addresses staff wellbeing (Olweny et al., 2024).

TIPC within the CMHS aims to support campus staff in recognising and responding to trauma and adversity by raising awareness, strengthening trauma-informed practices, and developing resources to enhance care.

Our objectives are to:

- increase understanding and promote a shared language of trauma and TIC
- advocate for practices that prevent trauma and re-traumatisation in hospital settings
- develop trauma-informed resources to support children, young people, parents, carers, supporters and staff

TIPC acknowledges that illness and treatment can be distressing but a universal, proactive, and preventative psychosocial approach can minimise harm (Olweny et al., 2024). Childhood trauma is disproportionately experienced by vulnerable groups, including children in out-of-home care, those experiencing homelessness, Aboriginal and Torres Strait Islander communities, the LGBTQIA+ community, and youth under justice supervision (Bendall et al., 2018).

For TIPC to be effective, it must be embedded into policies and procedures, requiring senior leadership's commitment to champion a proven TIPC framework across campus partner organisations.

The strategy's vision and TIPC objectives advocate for a trauma-informed approach across all areas of care. Recognising that compassionate care starts with well-equipped staff, TIPC aims to provide staff with the tools, resources, and training to deliver TIC. Foundational training, developed and piloted by the CMHS, fosters a shared understanding of trauma, a common language, and validation of staff experiences (Olweny et al., 2024). By prioritising staff wellbeing, TIPC builds a compassionate, trauma-informed workforce, better preparing staff to understand and meet the unique needs of children, young people, parents, carers, and supporters.

Central to this approach is recognising the varied ways individuals may respond under stress or in unfamiliar environments. These responses, often rooted in past experiences, can sometimes be misunderstood or misinterpreted (SAMHSA, 2014).

A key tool in facilitating this shift is the Behaviour Support Profile (BSP), developed to document and address the non-medical needs of patients, including their communication preferences, sensory needs, and coping strategies. The BSP tailors care to the individual needs of each patient, thereby enhancing their sense of safety and wellbeing within the hospital setting. This tool exemplifies the practical application of TIPC, supporting the broader objective of transforming how we understand and address the needs of children and young people in paediatric healthcare (Olweny et al., 2024).

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Glossary

AIWH	Australian Institute of Health and Welfare
BOC	Behaviours of concern
BSP	Behaviour Support Profile
Campus	Melbourne Children's Campus
CMHS	Campus Mental Health Strategy
CHA	The Centre for Health Analytics
CLT	Child life therapist
CK	Comfort Kids
EMR	Electronic Medical Record
Epic	The computer system the RCH uses as the basis for their EMR
FYI	"For your information" flag on Epic
MCRI	Murdoch Children's Research Institute
NHMRC	National Health and Medical Research Council
NSQHS	National Safety and Quality Health Service
Peter Mac	Peter MacCallum Cancer Centre
RN	Registered nurse
REDCap	Research Electronic Data Capture
RCH	The Royal Children's Hospital
RMH	The Royal Melbourne Hospital
RWH	The Royal Women's Hospital
SPSS	Statistical Package for the Social Sciences
TIC	Trauma-informed care
TIPC	Trauma-informed preventative care
UoM	The University of Melbourne

Background

Mental health challenges amongst children and young people have become increasingly prevalent. The Australian Institute of Health and Welfare (2022) indicates approximately 14% of Australian children and adolescents aged 4-17 experience a mental health disorder each year.

Conditions such as anxiety, depression, and ADHD are among the most common and nearly half of all Australians will face a mental health disorder at some point in their lives (AIHW, 2022). This signifies the need for early intervention and comprehensive mental health support from a young age. As the prevalence and impact of poor mental health during childhood are increasingly recognised, shifting focus towards early intervention and prevention strategies in healthcare settings is essential. Trauma-informed care (TIC) has a role in this, by taking action to minimise distress and re-traumatisation (SAMHSA, 2014).

The key principles of TIC are safety, respect, trust, choice, collaboration and empowerment (SAMHSA, 2014). In the paediatric healthcare context, upholding these principles can present unique challenges, especially when care requirements seem to contradict a patient's wishes. Distinctly, paediatric healthcare contexts include both the child and their parents or carers, and both need to be considered. Such situations can be distressing to patients, create moral uncertainty for staff, and risk damaging patient-clinician relationships. Additionally, miscommunication and lack of TIC can lead to elevated behavioural responses in the patient (SAMHSA, 2014), and sometimes their distressed parents or carers.

The term "Behaviour of Concern" (BOC) has been applied in healthcare settings to describe certain patient behaviours that challenge those providing care (AIFS, 2024). However, labelling patients' behaviours as "concerns" rather than responses to significant discomfort or expressions of unmet needs may perpetuate miscommunication and exacerbate distress (Graham et al., 2023). It is understood that children often use behaviours to communicate and having information about an individual's unique behavioural language can improve understanding (Early Childhood Australia, 2017). There is a pressing need for comprehensive behavioural information to be included in paediatric clinical documentation, in addition to patients' medical and physical health concerns.

While many staff document aspects of psychosocial wellbeing, it is not typical for information about communication preferences, sensory sensitivities, coping strategies, and behavioural responses to be collected in a systemised, readily accessible manner (Strömberg et al., 2022).

Because of this, key information about needs, preferences and feelings can be missed, lost or inadequately communicated between staff. Consequently, staff rely on generalised beliefs and assumptions about patients' needs and preferences, which can alienate those who require differentiated or personalised care and cause distress (Australian Commission on Safety and Quality in Health Care, 2021).

Those with neurodivergence often experience significant differences in healthcare access and equity, due to variations in the communication and recognition of their needs (Call, Bernstein, Bottini, Kalia, Pattishall, & Muething, 2022). Current inequities highlight the need for a patient and family-centred approach (Iannuzzi, Kopecky, Broder-Fingert, & Connors, 2015). Evidence shows that hospital care must be individually tailored to each child's self-identified needs to ensure they receive the most effective care (Bray, Appleton, & Sharpe, 2019).

Additionally, unaddressed hospital trauma can lead to long-term impacts, resulting in both personal and broader societal costs, further highlighting the importance of tailored TIC within hospital settings.

In 2017, the RCH launched the project 'Do you know me? Caring for children with autism spectrum disorders or intellectual disabilities in hospital'. This project developed and piloted a paper-based tool called the Behaviour and Communication Profile designed to capture a patient's communication needs, sensory preferences, behaviours of concern, and routines.

Feedback from staff and parents/carers was overwhelmingly positive:

- 9 out of 10 parents/carers stated the tool improved staff's understanding of their child's needs
- 100% of parents/carers reported enhanced communication between staff and their child

By the end of the pilot:

- 92% of staff were aware of the profile
- 75% were using it in practice
- 95% of those using it reported finding it helpful.

A key suggestion for the profile was to integrate the tool into the Electronic Medical Record (EMR) system, as the RCH was transitioning from paper-based forms.

Building on this success, a follow-up project titled 'Do you know me? Caring for children with additional needs at the RCH' was conducted in 2018. This project focused on developing an electronic version of the tool, resulting in the creation of the Behaviour Support Profile (BSP).

The BSP, integrated into the EMR, is designed to document non-medical needs such as communication preferences, sensory sensitivities, patient likes and dislikes, and calming strategies, particularly for those with communication difficulties, behaviours of concern, or severe anxiety. Since its implementation into the EMR in 2019, the BSP has not been formally evaluated.

Method

1. Aims and objectives

The evaluation aimed to assess the acceptability, usability, and effectiveness of the BSP to guide its optimisation. The primary objective was to gather and analyse engagement data and user feedback from RCH staff and parents/carers to identify necessary changes and improve the BSP tool. A secondary objective was to explore ways to increase the number of staff using the BSP in routine care and overall user satisfaction with the tool.

2. Project design

This quality improvement project design involved a mixed methods evaluation, including an audit of BSP engagement data and analysis of user feedback.

Methods:

1. Staff user feedback was obtained via an online survey and in-person focus groups.
2. Feedback was obtained from parents/carers of children and young people with current BSPs via survey questions integrated into routine phone calls from clinical staff.
3. Existing BSP data within the hospital's EMR was audited to provide insights regarding patterns of use and operation.

3. Recruitment

Participants for the survey and focus groups were recruited using purposeful and convenience sampling to ensure broad representation across hospital disciplines. Invitations were distributed through internal email lists and facilitated by area managers and the research team.

For nursing: managers, advanced practice nurses, and nurse educators were engaged to share invitations within their teams. In the medical field, heads of departments were contacted to distribute invitations and efforts were made to access distribution lists for residents, registrars, and fellows. For allied health, outreach efforts targeted child life therapists (CLT), psychologists, occupational therapists, speech pathologists, social workers, and physiotherapists. These strategies ensured extensive engagement across all disciplines.

The online survey was accessible to staff through an invitation email, with recruitment open from 17 August to 5 October 2023. The survey, created in Research Electronic Data Capture (REDCap) required approximately 2–10 minutes to complete, depending on the participant's familiarity with the BSP (Harris et al., 2009). Participants familiar with the BSP were prompted to answer demographic questions and quantitative and qualitative items regarding their familiarity, engagement, and perceptions of its usability. Those unfamiliar with the BSP were asked how they documented non-medical patient needs in the EMR (eg communication preferences). The survey concluded with a link to further information about the BSP.

Focus group participants were recruited during the same period and registered for sessions held on 13, 15, 20 and 21 September 2023. Each session lasted 45 minutes to one hour and explored staff experiences with the BSP, including barriers and enablers to engagement, suggestions for improvement, and whether the BSP improved patient outcomes.

For parent/carer feedback, recruitment involved purposeful sampling of parents/carers contacted during routine clinical care for BSP updates or reviews. Staff from teams with high BSP engagement, such as Comfort Kids (CK), CLT, and the Disability Liaison Office were tasked with inviting parents/carers to participate. Participation was voluntary, with parents/carers informed that declining would not affect their care.

3.1 Inclusion and exclusion criteria

The survey included all clinical staff at the RCH with access to the BSP tool in the EMR, while staff from external organisations such as the Royal Women's Hospital (RWH), the Royal Melbourne Hospital (RMH), and Peter MacCallum Cancer Centre (Peter Mac) were excluded. Focus group participation was open to RCH staff familiar with the BSP, while those unfamiliar with the tool were excluded to ensure discussions remained relevant. Parent/carer feedback was limited to those contacted as part of routine care for BSP updates.

3.2 Consent

For staff, implied consent was obtained through survey completion and focus group participation. Families provided implied consent by choosing to participate in routine phone surveys. All data was de-identified to ensure participant privacy and confidentiality, adhering to the conditions of ethics committee approval and the National Health and Medical Research Council (NHMRC) for Ethical Considerations in Quality Assurance and Evaluation Activities (Project Number: QA/9747).

4. Data collection

4.1 Staff feedback data

Staff feedback was collected through an online survey and in-person focus groups. The survey included questions assessing demographic details, engagement with the BSP, and perceptions of its usability. Focus group discussions were recorded, transcribed, and de-identified to ensure confidentiality. The discussion questions are displayed in Table 1.

Table 1: Focus group questions

1.	What is your understanding of the purpose of the BSP and who to use it for?
2.	How do you use the BSP in your day-to-day role?
3.	What are the barriers that stop you from using the BSP?
4.	What would help you to use the BSP in your daily practice?
5.	What are families' or young peoples' responses when you complete the BSP with them?
6.	Have you felt the use of the BSP improved outcomes for your patients? If so, please give examples.
7.	What is missing/what would you add to improve the BSP?
8.	Have we missed anything during our session today that you would like to discuss?

A total of 220 staff completed the survey, with years of experience ranging from 0 to 40 years (mean = 10.45 years, median = 8 years, SD = 9.37), representing 69 unique departments (see Appendix C for department breakdown). The top five departments that completed the survey were Anaesthetics (22, 10.0%), Emergency Department (19, 8.6%), Mental Health/Banksia Ward (18, 8.2%), CLT (11, 5.0%), and General Medicine (9, 4.1%). Additionally, clinical staff (*n=17*) from the RCH participated in the focus groups. Refer to Table 2 for a breakdown of roles for both survey and focus group participants.

Table 2: Number of staff and departments represented per discipline

Role	Focus group participants		Survey participants	
	n (%)	Departments represented (*N=17*) *n*	*n (%)*	Departments represented (*N=69*) *n*
Nursing	10 (58.8)	12	100 (45.5)	39
Allied Health	5 (29.5)	3	59 (26.8)	24
Medical	2 (11.8)	2	51 (23.2)	19
Administration	-	-	5 (2.3)	3
Other	-	-	5 (2.3)	5
Total	17 (100)	17 (100)	220 (100)	69*

*Percentages may not add up to 100% due to rounding. *The department types listed in the "Survey department types" column are not unique. Some departments may overlap across roles or categories.*

4.2 Parent/carer feedback data

Three parents/carers who agreed to participate completed a phone survey conducted by clinical staff, with responses recorded directly into REDCap.

The survey questions were:

1. Has the BSP increased staff's ability to address your child's needs?
2. Has anyone asked you to update the BSP?
3. If you had access to the BSP at home, would you update it?
4. What is missing, or what would you add to improve the BSP?

4.3 Audit of engagement data

To assess user engagement since the BSP's implementation, an EMR audit was conducted in July 2024. The Centre for Health Analytics (CHA) assisted with report extraction and the inclusion of specific variables of interest. This audit examined 1,784 BSP records, covering data from 26 June 2019 to 12 July 2024, to provide insights into the frequency of BSP creation and updates, user roles, and section completion patterns.

5. Data analysis

Quantitative data, including survey responses and EMR audit findings, were analysed using descriptive statistics in Statistical Package for the Social Sciences (SPSS) (IBM SPSS Statistics, 2010). The survey responses provided insights into staff familiarity with and usage of the BSP, as well as perceived barriers and enablers. The EMR audit examined the number of BSPs created and updated, user roles (eg nursing, medical, allied health), and completion patterns across BSP sections. Free-text responses were further examined to identify emerging categories of patient needs, with commonly referenced items (over 20 occurrences) recommended for inclusion in future BSP updates.

Qualitative analysis was conducted on open-ended survey responses, focus group transcripts, and parent/carer feedback collected through phone surveys. Focus group data were transcribed and analysed using NVivo version 15 (Lumivero, 2024) through inductive content analysis, which enabled the identification of recurring themes. Initially, one team member coded all four focus groups. A second member coded two groups independently, establishing categories that were collaboratively refined. Lastly, a third member reviewed one coded group to confirm inter-rater reliability. Regular team meetings ensured alignment and accuracy throughout.

Parent/carer feedback was analysed alongside staff data to provide a comprehensive view of BSP usability and impact. Using the same thematic framework, two team members reviewed parent/carer responses to capture unique perspectives on the BSP's effectiveness and to identify suggested improvements.

Evaluation results

The audit evaluation revealed the amount of existing BSPs and who created them, as well as how staff had been using the tool. The focus groups and staff survey revealed staff knowledge and opinions about the tool, while parent/carer feedback highlighted their experiences and suggestions for improvement. Results are presented categorically for ease.

1. Number of existing BSPs

The audit of existing BSP data within the RCH EMR system found that 1,784 BSPs had been created since the tool's implementation in 2019 (Table 3). During the same period, 314,619 individual patients aged 21 years or younger accessed inpatient or outpatient care at the RCH. This indicates that between 26 June 2019 and 12 July 2024, around 0.57% of these patients at the RCH had a BSP created.

The usage data also indicated that the number of new BSPs created has increased each year since 2019 (except for 2022), and that one third of all BSPs were created between 2023 and the first half of 2024. Overall, there has been an upward trend in the number of new staff creators over time.

Table 3: BSPs created in the EMR (2019 - July 2024)

Year	BSP *n* (%)	Staff creators	
		Unique *n*	New *n* (%)
2019	230 (12.9)	78	78 (100)
2020	263 (14.7)	93	54 (58.1)
2021	343 (19.2)	83	45 (54.2)
2022	312 (17.5)	85	55 (64.7)
2023	376 (21.1)	124	76 (61.3)
2024 (as of July)	245 (13.7)	94	40 (42.6)
Missing*	15 (0.8)	12	1
Total	**1784 (100)**	**	**349**

Percentages may not total 100% due to rounding.
**Missing category refers to BSPs recorded without complete data for the year created. This may be due to documentation inconsistencies or system limitations.*
***The total number of Unique staff creators is not applicable since individuals may be counted in multiple years.*

1.1 Staff creators

According to the EMR data, 349 individual staff members created BSPs during the audit period, which represented 8.4% of the total clinical and patient-facing staff employed at the RCH (4,161). Registered nurses (RNs) were found to have created the most BSPs of all other craft groups (1068, or 59.9%; see Table 4), followed by CLTs (299, 16.8%) and physiotherapists (120, 6.7%). However, when reviewing the average number of BSPs created per staff member, the five physiotherapists had the highest average (24 per staff member) followed by CLTs (23 staff created an average of 13 BSPs each), compared to the 245 RNs who had an average of 4.4 BSPs per staff member.

Table 4: Number of different staff creators and updaters of BSPs in the EMR, by role

Role	BSP *n* (%)	Staff *n* (%)	Average *n* BSPs per staff member	Unique BSPs updated in the EMR *n* (%)
Registered nurse	1068 (59.9)	245 (70.0)	4.4	149 (19.2)
Child life therapist	299 (16.8)	23 (6.6)	13.0	23 (3.0)
Physiotherapist	120 (6.7)	5 (1.4)	24.0	30 (3.9)
Enrolled nurse	75 (4.2)	7 (2.0)	10.7	19 (2.4)
Missing*	55 (3.1)	4 (1.2)	13.8	516 (66.4)
Psychologist	40 (2.2)	16 (4.6)	2.5	17 (2.2)
Social worker	24 (1.3)	9 (2.6)	2.7	5 (0.6)
Occupational therapist	23 (1.3)	5 (1.4)	4.6	7 (1.0)
Nursing student	16 (1.0)	9 (2.6)	1.8	2 (0.3)
Nurse practitioner candidate	16 (1.0)	1 (0.3)	16.0	4 (0.5)
Consultant	11 (0.6)	9 (2.6)	1.2	2 (0.3)
Teacher	10 (0.6)	1 (0.3)	10.0	1 (0.1)
Nurse practitioner	7 (0.4)	1 (0.3)	7.0	-
Provisional Psychologist	6 (0.3)	4 (1.2)	1.5	-
Fellow	5 (0.3)	3 (0.9)	1.7	-
Administration	2 (0.1)	1 (0.3)	2.0	-
Registrar	2 (0.1)	2 (0.6)	1.0	-
Speech pathologist	2 (0.1)	1 (0.3)	2.0	-
Midwife	1 (0.1)	1 (0.3)	1.0	-
Pharmacist	1 (0.1)	1 (0.3)	1.0	-
Resident	1 (0.1)	1 (0.3)	1.0	1 (0.1)
Total	**1784 (100)**	**349 (100)**	**5.1**	**777 (100)**

**This row represents BSPs where the provider role was not recorded in the EMR. As a result, these entries could not be attributed to a specific staff role. Percentages listed have excluded missing data and have been rounded.*

2. Staff awareness and understanding

Out of the 220 participants who began the survey, 174 completed it. Of these, 66% (115 staff) completed the survey beyond question 4A, indicating familiarity with the BSP. The remaining 34% (59 staff) indicated they did not know about the BSP and only completed the survey up to Q4A (see Appendix D). Additionally, there were 46 incomplete surveys where respondents either did not fully complete the survey or submitted incomplete answers. Given this, percentages in these results (as shown in Appendix D) reflect the proportion of staff who answered each question.

Of the five participants who identified their role as administration, two did not provide any further responses and the remaining three were unaware of the BSP in the EMR. When asked where they document non-medical information, one participant mentioned doing so in the patient history or disability identifier, while the other two responded with "N/A". As the survey focused on BSP usage and access, these participants were not asked any further questions.

2.1 Knowledge sources

67.2% of staff reported being aware of the BSP in the EMR, while 33.8% were not. Among those familiar with the tool, 45.5% learned about it from a colleague, 35.8% through a ward or team education session, and 34% selected "other". When analysed by role (Table 5), nursing and allied health staff most often reported learning about the BSP through education sessions or colleagues, whereas medical staff more frequently selected "colleague" or "other". Common responses under "other" included learning about the BSP via the EMR, internal hospital resources, or word of mouth.

Table 5: Responses to the question "How did you find out about the BSP?", by role (*N=123*)

Check all that apply	Role *n* (%)				Total
	Nursing *n=59*	Allied health *n=34*	Medical *n=28*	Other *n=2*	*N=123*
Ward/team education session	26 (44.1)	13 (38.2)	5 (17.9)	-	44 (35.8)
The screening questions in the nursing admission assessment	11 (18.6)	-	1 (3.6)	-	12 (9.8)
The short cut video on the Intranet	1 (1.7)	-	-	-	1 (0.8)
A colleague showed me/told me about the BSP	25 (42.4)	20 (58.8)	11 (39.3)	-	56 (45.5)
Tuesdays @ 2 Nursing Forum	4 (6.8)	-	-	-	4 (3.3)
Other	15 (25.4)	6 (17.6)	11 (39.3)	2 (100)	34 (27.6)

Percentages listed have excluded missing data and have been rounded.

2.2 Locating, creating, and updating BSPs

Of those who knew the BSP tool existed, 87% agreed they knew where to find it within the EMR. However, only half (49.6%) knew how to create one for a patient. There were notable differences in staff knowledge by role (see Table 6). For example, while 94.9% of nursing staff reported knowing how to locate the BSP, 39% did not know how to create one. Similarly, 55.9% of allied health staff and 64.3% of medical staff indicated they did not know how to create a BSP.

Table 6: Number of staff who answered "yes" to survey items, by role

Survey item	Role *n* (%)				Total n (%)
	Nursing *n=59*	Allied health *n=34*	Medical *n=28*	Other *n=2*	*N= 123*
Do you know where to find the BSP in Epic?	56 (94.9)	26 (76.5)	24 (85.7)	1 (50)	107 (87.0)
Do you know how to create a BSP in Epic?	36 (61)	15 (44.1)	10 (35.7)	-	61 (49.6)
Do you update the BSP with new information?	31 (52.5)	15 (44.1)	9 (32.1)	-	55 (44.7)

Percentages listed have excluded missing data and have been rounded.

Of the surveyed staff, 55.3% reported that they do not update the BSP with new information. When asked why (see Table 7), the most common reasons were a lack of awareness or knowledge about how to update BSPs. Nearly two-thirds of respondents who provided explanations reported either not knowing how to update BSPs or being unaware they could. These findings align with the audit data shown in Table 4, which revealed only 43.6% of BSPs had ever been updated (*n=777*). Most updates were made by RNs (19.2%), followed by physiotherapists (3.9%) and CLTs (3.0%).

Table 7: Responses to why staff do not update the BSP with new information

Survey response	Role *n* (%)				Total
	Nursing *n=28*	Allied health *n=19*	Medical *n=19*	Other *n=2*	*N= 68*
Not aware that I could	10 (35.7)	7 (36.8)	8 (42.1)	1 (50)	26 (38.2)
Not sure how to do this	10 (35.7)	8 (24.1)	8 (42.1)	-	26 (38.2)
Don't have time	5 (17.9)	2 (10.5)	5 (26.3)	-	12 (17.6)
Other	7 (25)	5 (26.3)	4 (21.1)	1 (50)	17 (25)

Percentages in this table reflect responses to a "check all that apply" question, where participants could select multiple options. Percentages are calculated based on the total responses within each role group.

These findings are reinforced by the child/young person and parent/carer feedback data where two out of three parents/carers indicated that they had not been asked to update their BSP (see Table 8). A third parent/carer expressed uncertainty, stating, "Staff often ask us questions, but we don't know whether that information is formally updated to the tool" (Parent/Carer, phone survey).

Table 8: Parent/carer phone survey coded themes

Survey item and theme	Frequency	Parent/carer *n (%)*
Has the BSP increased staff's ability to address your child's needs?	***N*=3**	**3 (100)**
Staff unaware of or not using the BSP	1	1 (33.3)
The BSP helps with recognising triggers	1	1 (33.3)
Provides support but outcomes can be unpredictable	1	1 (33.3)
Has anyone asked you to update the BSP?	***N*=3**	**3 (100)**
No	2	2 (66.7)
Not sure – staff often ask questions, but unsure whether the information is updated	1	1 (33.3)
If you had access to the BSP at home, would you update it?	***N*=3**	**3 (100)**
Yes	3	3 (100)
What is missing/what would you add to improve the BSP?	***N*=3**	**3 (100)**
Make BSP easier for staff to read/use	1	1 (33.3)
Increase parent knowledge of the BSP	1	1 (33.3)
Nothing	1	1 (33.3)

Frequencies refer to the number of times a concept was mentioned, and n refers the number of staff members. Percentages listed have been rounded.

Survey findings were aligned with focus group discussions where accessibility challenges with locating and updating BSPs in the EMR emerged as a prominent theme. Staff reported significant difficulties in navigating the EMR interface, with one participant noting, "It's hard to find them for outpatients... I make BSPs, and I can't find them" (RCH staff member, focus group one). Another added, "Sometimes I struggle to find it if there's not one completed... I end up going to the sedation hub, and then it appears under the behaviour support section" (RCH staff member, focus group two).

Variability in the EMR interfaces across different clinical settings further complicated access. As one staff member described, "It's like, 'Oh, your Epic looks different than mine,' making it difficult to understand why others can't find what they need" (RCH staff member, focus group four). These challenges were echoed in survey comments, with one respondent observing, "Finding it on EMR, knowing that families report on it that it isn't looked at" (RCH staff member, online survey).

2.3 Patient applicability

Staff in the focus groups identified the BSP as primarily useful for children and young people with "...additional needs, including those experiencing anxiety, who have had traumatic hospital experiences, or who have complex needs" (RCH staff member, focus group one). Another participant emphasised its value, particularly for "addressing children and young people with autism, procedural anxiety, sensory issues, and other mental health concerns" (RCH staff member, focus group three).

However, staff underscored the BSP's versatility, noting its benefit to any child entering the hospital, not just those with additional needs or mental health difficulties. As one participant explained, "I think anyone can use it, and we can use it for anyone" (RCH staff member, focus group four).

2.4 Perceived purpose

Key themes regarding the purpose of the BSP emerged consistently across the open-ended survey responses and the focus group data. Overall, staff described the BSP as primarily an information and communication tool.

In the 122 open-ended survey responses, staff described the BSP as a tool for documenting behaviour and communication strategies, particularly to reduce distress and capture children's preferences. It was commended for its role in supporting patients with differentiated needs, including neurodiverse children or those with emotional regulation challenges. Staff noted the BSP's utility in planning and preparing for procedures, as well as before patient admissions. One survey participant summarised its purpose as "a way to clearly document behavioural challenges and, importantly, the child's preferences, needs, and what strategies work well or do not."

Focus group discussions similarly emphasised the BSP's function as a central repository for non-medical information about children, young people, and parents/carers. This ensures transparency and enables staff to follow consistent processes. As one staff member explained:

> **"It ultimately takes away any ambiguity by actually having something documented" (RCH staff member, focus group two).**

Another added, "I'm doing it so that we can share it with everybody in the hospital. It goes on to EMR. Everyone can see it, the information is there" (RCH staff member, focus group one).

Focus group staff also mentioned how the BSP can help staff prepare and plan before engaging with a patient. One participant described it as "a tool to help staff make reasonable adjustments based on a child's and family's individual needs and to prevent unnecessary escalations or negative experiences and trauma" (RCH staff member, focus group two).

Additionally, staff from both the survey and focus groups highlighted that the BSP helps support children, young people, and parents/carers during hospital visits by reducing the need to repeat information.

One focus group member shared, "I always tell families that if I'm doing a BSP with them, I'm collecting information so that they don't have to repeat the information" (RCH staff member, focus group one). The tool was described as useful for fostering accountability among staff, with another participant stating it "...helps keep staff accountable for knowing their patient, as it's a clear indicator to check the support profile" (RCH staff member, focus group three).

2.5 Role responsibility

When surveyed, 81 staff members (65.9%) agreed that completing the BSP was part of their role, citing its use in collaborative and interdisciplinary care, responding to patient needs, and providing patient-centred care. Many also emphasised duty of care and clinical responsibility. The remaining 42 staff members (34.1%) disagreed, pointing to a lack of clarity about the process for completing a BSP and time constraints as reasons why.

Table 9: Responses to the survey question, "Do you think it is your role to complete the BSP?", by role (*N*=123)

Survey response	Role *n* (%)				Total
	Nursing *n=59*	Allied health *n=34*	Medical *n=28*	Other *n=2*	(*N=123*)
Yes	43 (72.9)	22 (64.7)	16 (57.1)	-	81 (65.9)
No	16 (27.1)	12 (35.3)	12 (42.9)	2 (40.0)	42 (34.1)

Percentages listed have excluded missing data and have been rounded.

The view of focus group participants emphasised that the BSP is a crucial tool for all patient-facing staff. One staff member stated it is, "for anyone interacting with children in hospital" (RCH staff member, focus group four). However, discussions highlighted that certain teams like CK and allied health are particularly involved in creating BSPs. As one staff member described, "Usually, we are the first to complete a BSP with them, and if they're referred to me, they benefit from having a BSP completed" (RCH staff member, focus group four).

Staff also reported that the responsibility for creating, updating, and maintaining the BSP lies with specific groups or individuals rather than being a collective responsibility. One staff member noted, "I think other people think it's someone else's responsibility to start it or recognise it or update it" (RCH staff member, focus group two). This perception was compounded by the belief that updating the BSP is not within everyone's role, with some staff feeling "it should be managed by specific groups like Comfort Kids or just nurses" (RCH staff member, focus group three). However, the lack of clarity about who should handle the BSP subsequently contributes to its inconsistent use. As another participant described:

> **"People think there is a domain for it and it's someone's job, so they don't want to step on toes" (RCH staff member, focus group three).**

Perceived burden also contributes to reluctance to use the BSP. As one staff member noted, "Some people are amazing at reading and knowing them, and some just gloss past it. So there is a feeling of, is it worth it sometimes?"(RCH staff member, focus group one). This sentiment reinforces the perception of the BSP as an additional task that increases workload without clear ownership or demonstrated benefit.

2.6 BSP alternatives

The survey showed that 60 (32.8%) staff members did not know about the BSP in the EMR (see Table 10). They were asked how they identified or documented the non-medical needs of patients in the EMR (eg communication preferences and behaviours of concern). Over one-third of survey responses described using the EMR to identify non-medical needs through patient documentation. Many participants referred to the notes section in the patient chart, with over half indicating reliance on progress notes and a quarter mentioning "for your information" (FYI) flags as a key source of this information. Other ways to identify non-medical needs included communication with clinicians and parents/carers, or as part of admission planning and patient assessment. In a small number of responses, participants said they do not identify or document non-medical needs or that this question is not applicable.

Table 10: Number of "no" responses to the survey question, "Do you know about the BSP in the EMR?", by role (*N*=60)

Survey response	Role *n* (%)					Total
	Nursing *n=81*	Allied health *n=47*	Medical *n=47*	Admin *n=3*	Other *n=5*	*N*=183
No	22 (27.2)	13 (27.7)	19 (40.4)	3 (100)	3 (60.0)	60 (32.8)

Percentages listed may not total 100% and have been rounded.

Staff familiar with the BSP were asked where they documented non-medical needs and preferences in the EMR before its implementation. The most common responses across all disciplines were progress notes (78.4%), FYI flags (51.7%), and verbal handover (49.1%). "Other" methods (11.2%) included the anaesthesia chart, anaesthesia pre-operative consult, and encounter notes, among others.

Table 11: Responses to, "Before the BSP, where would you document non-medical needs and preferences of your patients in EMR? Check all that apply" by role (*N=116*)

Check all that apply	Role *n* (%)			
	Nursing *n=54*	Allied health *n=33*	Medical *n=27*	Other *n=2*
In the progress notes	43 (79.6)	28 (84.8)	18 (66.7)	2 (100)
In an FYI flag	36 (66.7)	12 (36.4)	11 (40.7)	1 (50)
On a paper-based profile or plan	2 (3.7)	5 (15.2)	3 (11.1)	1 (50)
Verbally at handover	36 (66.7)	9 (27.3)	10 (37.0)	2 (100)
Nowhere	-	2 (6.1)	4 (14.8)	-
Other	2 (3.7)	4 (12.1)	6 (22.2)	1 (50)

Percentages listed may not total 100% and have been rounded. Percentages in the table below reflect responses to a "check all that apply" question, where participants could select multiple options. Percentages are calculated based on the total responses within each role group.

3. Engagement with the BSP

Surveyed staff were asked whether they used the BSP, and if so, what their engagement involved. Results are presented according to the timing and frequency of reported staff use (Table 12). This is followed by focus group findings related to staff usage of the BSP and data from the EMR audit revealing BSP field engagement (see Appendix B).

3.1 Frequency and timing of use

When asked whether they used the BSP, 35.0% of surveyed staff reported using it "often" or "always", 37.4% said they "sometimes" used it, and 27.6% indicated they "rarely" or "never" used it. By role, the proportion of staff reporting their use as "often" or "always" was approximately one-third for allied health (32.6%) and medical staff (32.1%), and slightly higher for nursing staff (37.4%). However, the proportion of medical staff who indicated they "rarely" or "never" use the BSP (39.3%) was greater than that of allied health (29.4%) and nearly double that of nursing staff (20.3%).

Of the staff surveyed, 64.2% reported referring to the BSP in their day-to-day role, with nursing staff reporting this most frequently. Those who refer to it were asked when, with "before interacting with a patient" being the most selected response (58.2%), followed by "before an admission" (21.5%). The next most common response was "other" (17.7%). Open-text responses highlighted various contexts, such as reviewing patient files, during clinical work, and addressing specific situations, including neurodivergent patients, new referrals, or patient transfers to adult care.

Table 12: Responses to survey questions related to the timing and frequency of BSP use

Survey item	Role *n* (%)				Total
	Nursing	Allied health	Medical	Other	
Do you use the BSP?	***n=59***	***n=24***	***n=28***	***n=2***	***N= 123***
Never	1 (1.7)	6 (17.6)	3 (10.7)	-	10 (8.1)
Rarely	11 (18.6)	4 (11.8)	8 (28.6)	1 (50)	24 (19.5)
Sometimes	25 (42.4)	13 (38.2)	8 (28.6)	-	46 (37.4)
Often	19 (32.2)	8 (23.5)	7 (25.0)	1 (50)	35 (28.5)
Always	3 (5.1)	3 (8.8)	2 (7.1)	-	8 (6.5)
Do you refer to the BSP in your day-to-day role?	***n=59***	***n=34***	***n=28***	***n=2***	***N=123***
Yes	41 (69.5)	21 (61.8)	16 (57.1)	1 (50)	79 (64.2)
No	18 (30.5)	13 (38.2)	12 (42.9)	1 (50)	44 (35.8)
When do you refer to the BSP? Check all that apply	***n=41***	***n=21***	***n=16***	***n=1***	***N=79***
Once per shift	6 (14.6)	-	-	-	6 (7.6)
Multiple times per shift	7 (17.1)	5 (23.8)	1 (6.3)	-	13 (16.5)
At handover	7 (17.1)	-	-	-	7 (8.9)

Before an admission	13 (31.7)	3 (14.3)	1 (6.3)	-	17 (21.5)
On the ward round	3 (7.3)	-	1 (6.3)	-	4 (5.1)
Before a clinic appointment	4 (9.8)	5 (23.8)	-	-	9 (11.4)
Before interacting with a patient	23 (56.1)	13 (61.9)	10 (62.5)	-	46 (58.2)
Other	6 (14.6)	4 (19)	3 (18.8)	1 (100)	14 (17.7)

Percentages listed may not total 100% and have been rounded. Percentages in this table reflect responses to a "check all that apply" question, where participants could select multiple options. Percentages are calculated based on the total responses within each role group.

4. How the BSP is used

Within the focus groups, the BSP was discussed as a tool used throughout the patient journey. This included pre-admission, during clinic, ward follow-ups, and engaging parents/carers.

4.1 In daily use

Both focus group and survey data emphasised the BSP's significance as a tool for guiding care and enhancing communication in daily practice. Staff frequently described using BSPs to prepare for procedures and admissions by creating, updating, and reading BSPs. One respondent shared, "I always look at the BSP prior to working with any young person, to see how best I can communicate with them" (RCH staff member, online survey), while another participant explained, "...guides all of my care for the day" (RCH staff member, focus group one).

However, participants noted variability in how consistently BSPs are accessed, with some colleagues requiring reminders or printed copies. One staff member explained, "I'll gently mention, 'Oh, and there's also a BSP'" (RCH staff member, focus group one) while another admitted, "I feel like a broken record but I'm constantly spruiking it" (RCH staff member, focus group one).

Challenges with creating and updating BSPs were a recurring theme. Some participants expressed uncertainty about the process with one asking, "No, I wouldn't know how to create a new one. Is that different from editing it?" (RCH staff member, focus group three). This aligned with survey findings indicating only half of surveyed staff knew how to create a BSP.

Inconsistent use led staff to question whether completing the BSP is worthwhile if others do not use the information. As one participant noted, "The time associated with asking questions to get the right information is significant" (RCH staff member, focus group two). Another added, "We set them up, but we're so time-poor that we only have 5 minutes before moving on to the next appointment" (RCH staff member, focus group two).

4.2 Engaging parents, carers, and supporters

Staff specified how the BSP facilitates direct engagement with parents/carers for comprehensive care planning across different stages. For example, one participant mentioned using it at the start of care, saying "It's part of our conversation when we introduce ourselves and our services" (RCH staff member, focus group two), while another mentioned using it before procedures: "I call the family the night before their procedure. If they haven't started it, I'll initiate it, and then we go through it together" (RCH staff member, focus group two). It was also reported that some teams incorporate the BSP into their assessment process, due to the similar information it provides. Parents/carers often request printed copies as well:

> **"Quite often families want a copy, so if there are any changes to care, we will implement them and share them with families, so they understand the routines and instructions for care" - RCH staff member, focus group one.**

There were also concerns expressed by focus group members about the BSP not being consistently updated or utilised effectively. This included documented information not being used during patient care, causing confusion and frustration for parents/carers. One participant mentioned, "We've had feedback from families that have voiced frustration that they spent a long time on the phone, and then the procedure didn't follow the BSP" (RCH staff member, focus group one). This concern was echoed in parent/carer feedback, with one parent/carer expressing that the BSP had not improved staff's ability to address their child's needs (see Table 8). They explained, "Staff don't seem to read it, [I] have said to people before, 'Have you seen these things on his file?' and staff say no" (parent/carer, phone survey).

According to the staff survey, 83.5% reported feeling comfortable asking parents/carers all the questions in the BSP. However, when examining the data by role (see Table 13), a higher proportion of nursing staff indicated feeling comfortable compared to allied health and medical staff. Among the 16.5% of staff who selected "no", the reasons cited included: not knowing what the questions are, never having completed a BSP, and lacking experience in their role.

Table 13: Proportion of respondents who answered "yes" to survey items, by role (*N=121*)

Survey item	Role *n* (%)			
	Nursing *n=58*	Allied health *n=33*	Medical *n=28*	Other *n=2*
Do you feel comfortable asking families all the questions in the BSP?	53 (91.4)	25 (75.8)	21 (75)	2 (100)

Percentages listed have excluded missing data and have been rounded.

4.3 Field usage

According to the audit, the BSP fields with the highest usage were related to patient communication preferences and strategies, including "Likes" (91.8%), "I Communicate" (87.8%), and "You Communicate" (86.8%). The fields with the lowest completion rates related to specific behaviours like "Harm Myself (Specify)" (19.1%) and "Harm Others Purpose (Specify)" (9.8%). Full data related to the field usage extracted from the EMR is displayed in Appendix B.

4.4 “Other” fields

A review of the open text “other” fields on the BSP revealed common responses that could be added as checkboxes to the BSP tool during optimisation. For example, staff communicating with patients by only giving two choices, giving “first... then...” instructions, and using clear, direct, and literal language were frequently mentioned and are not current options within the tool. The most common responses within the “other” fields are displayed in Appendix B.

4.5 Missing qualifiers

Whilst identifying further relevant checkbox options via the data audit of existing BSPs in EMR, it became clear that staff were also using the “other” fields to add details that were not captured elsewhere in the tool. This included qualifying information such as severity, frequency, likelihood, specific circumstances when something may occur, patients’ history and past experiences, or other explaining information. This revealed limitations in the current structure of the tool that impact its effectiveness at capturing all relevant information in a clear and accessible way.

4.6 Categorisation of information

In the audit of BSP data, “other” responses frequently contained paragraphs of information, much of which was related but not always exclusively to the field where it was located. An overlap in field use was also observed across the different “other” fields, where similar information was found in different sections of the tool. A lack of clarity of where different information belongs may limit the effectiveness of the tool and impact efficiency when searching for that information.

Analysis of data in the “other” fields revealed that most of this information could be understood as expressions of unmet needs and safety vs threat perception. This included communication requirements (eg needing extra processing time to comprehend information), predictability (eg feeling informed and knowing what to expect and when), sense of control (eg being given choice and space for self-regulation), relational factors (eg feeling included or consulted, establishing trust), physical/sensory experience (eg low sensory environment, pace, being touched unexpectedly), and how a patient expresses that they are overstimulated and/or do not feel safe (eg attempting to escape, self-harm, physical behaviour).

For this tool, this information could be categorised as communication information or strategies and information about a patient’s safety vs threat perception. Examples with subthemes are displayed in Table 14 on the next page.

Table 14: Examples of communication strategies and safety information from the BSP data audit, by theme

Theme	Subtheme/s	Examples (to enhance comfort/prevent distress)
Communication strategies	Requirements for comprehension	Providing extra processing time, using short sentences, eye contact, visual information, unobstructed view of speaker (lipreading)
	Style	Direct and literal language, indirect/non-specific language, relaxed/non-demanding
	Level of information and detail	None, need-to-know only, general information about what is happening without full detail, as much detail as possible as soon as possible
	Timing	Ahead of time (to help prepare expectations/ transition), at the time (to avoid anticipation anxiety)
Information about patient safety vs threat perception	Predictability and sense of control	Routine, knowing the schedule, having the same staff, no surprises, being given choice, having preferences considered, providing consent
	Relational factors	Feeling heard, presence of safe person, staff explaining actions and ensuring understanding/ time to ask questions, being included in conversations, co-regulation, avoiding hearing others in distress, staff engaging with me about my likes/interests
	Physical/sensory experience	Avoiding/reducing things that commonly create sensory overwhelm/rejection: bright lights, loud noises, crowding, lack of personal space, foreign things touching skin (eg tapes/band aids/creams/hospital gown or tag), unfamiliar smells, tastes or textures
	How a patient expresses that they are overstimulated and/or do not feel safe	Unable to make decisions, going mute or quiet, attempting to stop/interrupt/slow down what is making me feel unsafe, attempting to run away or leave the situation, self-defence (verbal or physical), stimming, self-harm (directly/ indirectly), harming others (directly/indirectly)

These findings were included with staff feedback to inform recommendations for BSP optimisation.

5. Impact

Overall, staff in the survey and focus groups agreed that the BSP is an effective tool for supporting the non-medical needs of their patients. Reports detailed its usefulness and impact in improving understanding and response to patients' non-medical needs, de-escalating

behaviour, care planning, service provision, information-sharing across services, rapport-building with children, young people and parents/carers and supporting comfort.

5.1 Understanding and responding to patients' non-medical needs

According to the staff survey, users of the BSP consistently agreed that the tool enhanced their ability to understand and address their patients' needs and preferences. Specifically, 88.2% agreed that the BSP improved their understanding of patients' sensory needs and sensitivities, while 87.0% felt it assisted in managing triggers and behaviours of concern, and 86.6% reported it helped in implementing calming strategies. Additionally, 85.7% indicated an increased ability to address communication needs and preferences, and 77.3% agreed it supported them in managing patients' pain and distress. Table 15 provides a breakdown of these responses by role, showing that nursing staff consistently reported the highest agreement across all categories.

Table 15: Proportion of survey respondents who answered "increased" to the following survey items, out of options "increase" or "same" (*N=119*)

Survey item	Role *n* (%)			
	Nursing *n=56*	Allied health *n=33*	Medical *n=28*	Other *n=2*
Has the BSP increased your understanding of and ability to address your patients:				
Communication needs/preferences	51 (91.1)	28 (84.8)	22 (78.6)	1
Sensory needs/sensitivities	54 (96.4)	28 (84.8)	22 (78.6)	1
Triggers or behaviours or concern	52 (92.9)	29 (87.9)	22 (78.6)	1
Calming strategies	51 (91.1)	28 (84.8)	23 (82.1)	1
Pain/distress	46 (82.1)	26 (78.8)	19 (67.9)	1

Percentages listed have excluded missing data and have been rounded.

In the survey, staff were asked whether they could provide an example of how the BSP helped address their patient's needs. 22.7% answered "yes" and provided examples highlighting the BSP's role as an advocacy tool for accommodating the needs of the child, young person, and their parent/carer. Staff shared how the BSP improves understanding of communication preferences, involves families in care decisions, facilitates proactive arrangements for specific needs, and addresses sensory sensitivities.

One staff member described how the BSP supports patient comfort, sharing, "...such an easy way to anticipate a patient's needs. For example, knowing to avoid noisy toys but use a particular song helped a patient who was escalating in their room" (RCH staff member, online survey). The BSP was also noted as a source of reassurance for parents/carers, because it provides a place to document critical information they may otherwise need to repeat.

As one staff member explained:

> **"The pressure this removes from parents is huge, sometimes you can see the relief when you're asking the BSP questions because it's all the information they have stored in their brains and may be unsure of they need to repeat their concerns to each staff member. [It] just feels like a small thing to do to help reduce their stress" – RCH staff member, online survey.**

This is supported by parent/carer feedback with families highlighting how the BSP increases staff's ability to address their needs (displayed in Table 8). One parent/carer shared, "Yes, recognising triggers and what not to say to escalate or heighten them" (parent/carer, phone survey). Another noted, "Overall, having information on file for [child name] helps, although she is very unpredictable, so we understand that things don't always go to plan" (parent/carer, phone survey). This feedback suggests even in unpredictable situations, the BSP facilitates information sharing and understanding, helping parents/carers feel that staff are better equipped to meet their needs.

5.2 De-escalating behaviour and avoiding Code Greys

When surveyed, 65% of staff indicated the BSP has helped them de-escalate a patient's behaviour (see Table 16) and 40 provided examples. Staff described how the BSP has been useful in preparing for patient visits by empowering them with the information to create personalised approaches that avoided triggers and involved effective distraction, de-escalation, and rapport-building strategies.

For example, one staff member described how they used the BSP to identify that a patient would benefit from a quiet, dark room with their favourite TV show. They explained how this knowledge had improved outcomes for both the patient and staff, compared to previous interactions where the patient had become distressed. They said, "This allowed the [patient] to have... a smooth pre-op journey into theatre whereas in the past these had not been identified, and the patient had ended up needing a Code Grey called due to escalation" (RCH staff member, online survey).

Table 16: Proportion of respondents who answered "yes" to the survey item, by role (*n=78*)

Survey item	Role *n* (%)			
	Nursing *n=57*	Allied health *n=33*	Medical *n=28*	Other *n=2*
Has the BSP helped you to deescalate a patient's behaviour?	45 (78.9)	19 (57.6)	13 (46.4)	1 (50)

Percentages listed have excluded missing data and have been rounded.

In the focus groups, staff spoke of how the BSP had been instrumental in supporting patient behaviour and managing and preventing escalation. One participant gave an example of using the tool to gather detailed information about a child from their parent and how this had reduced the need for Code Grey intervention. They said, "We ended up being able to finish our procedure, sent Code Grey away. It was all good. I'm glad I had that conversation on the phone with mum" (RCH staff member, focus group one).

5.3 Care planning and service provision

Staff focus group participants detailed the BSP's role in improving patient outcomes and how this benefits the individual as well as staff, teams, and service/s involved. One example of this is the way the BSP enhances care planning. As explained by one staff member, the detailed information in the tool enables healthcare teams to tailor plans according to individual needs. This results in a more comfortable experience for patients, which in turn enables smoother and more successful healthcare provision:

> **"The team used the BSP and made plans around his specific needs, such as avoiding crowded areas and ensuring fewer people were present during the procedure. The surgery was successful because these strategies were followed" - RCH staff member, focus group three.**

This impact was shared across services. Another staff member noted in medical and specialist clinics that the BSP has been useful in pre-planning for sedations, "... as it helps make the process smoother and more effective" (RCH staff member, focus group three).

5.4 Information-sharing across services

While the BSP was deemed useful for supplying information to clinicians providing care, it was also praised for enhancing information-sharing across services. One staff member described how being able to access and share detailed patient-specific information has supported continuity of care:

> **"We will print out the procedure support or behaviour support profile and send it over to the transplant team. This handover ensures that relevant information is shared and updated across different hospitals and services" - RCH staff member, focus group one.**

Survey respondents highlighted similar benefits with one staff member reflecting, "Sharing the BSP with external teams helped streamline care during transitions" (RCH staff member, online survey).

5.5 Empowering families through involvement

Participants emphasised how the BSP empowered parents/carers by involving them in their child's care plan. This involvement enhances their sense of control and ownership over the care process. One participant remarked, "Families appreciate having something tangible, like a printed BSP, which they can take to other organisations. It provides a sense of ownership and involvement in the care process" (RCH staff member, focus group four).

Staff indicated how engaging families in the care-planning process via the BSP promotes family-centred care and is beneficial for parents and carers. One participant said:

> **"It empowers their parenting both at home and helps them feel a part of their journey in hospital, rather than having control taken away from them" - RCH staff member, focus group one.**

Additionally, the BSP boosts families' confidence in advocating for their needs, with one participant noting that using the BSP helped families to be "... a bit more confident to advocate

5.6 Rapport-building with patients and families

Staff highlighted the BSP as a valuable tool for building rapport with children and their parents/carers. Access to personal information such as a child's interests was noted as particularly helpful. One focus group member shared, "It's so great when you open a BSP and it's like, this kid loves Thomas the Tank Engine, you're like, yes, boom. That's helpful" (RCH staff member, focus group one). Survey staff also emphasised how the BSP supports personalised interactions. One member explained, "Knowing what a patient is interested in or what calms them allows us to personalise our interactions—it makes such a difference for the child and their family" (RCH staff member, online survey).

The BSP was also praised for facilitating meaningful conversations with families. As one staff member shared:

> **"Some families have just exploded with joy when they've been talking about the likes and the strengths and the abilities" (RCH staff member, focus group one).**

In high-turnover settings, the BSP helps establish trust quickly by providing familiarity. A staff member explained, "The BSP allows us to start from a place of familiarity, which helps in building trust with the patient and family" (RCH staff member, focus group one).

5.7 Patient comfort

Finally, staff noted that by identifying specific needs the BSP allows for adjustments that improve patient comfort. As one participant explained, "The BSP helps identify triggers such as extended waiting times and crowded areas, allowing us to organise quieter settings if needed, which has been beneficial for reducing stress and improving patient comfort" (RCH staff member, focus group four). Another noted, "The BSP helped us identify that the child felt calmer in a dimly lit room, so we adjusted the environment to meet their needs. It made a huge difference in their experience" (RCH staff member, online survey).

Another participant added,"The more we know about a young person through the BSP, the better we can communicate and plan care. This leads to better outcomes as we can address their needs and fears more effectively" (RCH staff member, focus group one).

6. Recommendations for improvement

Feedback from the survey, focus groups, and parent/carer phone surveys identified key areas for improving access to and usability of the BSP, as well as suggestions for enhancements (see Tables 18 and 19). Survey responses came from two open-ended questions (see Table 17).

Table 17: Proportion of respondents who answered survey items, by role

Survey item	Response by role *n* (%)			
	Nursing	Allied health	Medical	Other
What would help you to use the BSP in your day-to-day role? *(N=115)*	53 (46.1)	33 (28.7)	27 (23.5)	2 (1.74)
What would you change about the BSP? (ie additions, improvements, or alterations) *(N=114)*	53 (46.5)	33 (29.0)	26 (22.8)	2 (1.8)

Percentages listed have excluded missing data and have been rounded.

Almost half of staff (47%) indicated they were "not sure" or found the question "not applicable" when asked for recommendations or changes to improve the BSP. Similarly, 8.8% of staff noted "not applicable" when asked what would help them use the BSP in their daily roles. Themes of recommendations provided by the remaining staff are below.

Table 18: Recommendations for increasing access and use

Recommendation and example quotes	Staff *n* (%)			Total Frequency
	Focus groups	Online survey	Phone survey	
1. Increase awareness and understanding of the tool through education, modeling, promotion, and training: • "Parents knowledge that it exists. Have been a long-term RCH patient and haven't heard of it until recently." (parent/carer, phone survey) • "Increasing awareness through regular training sessions could help new staff understand the importance of BSPs in supporting patient care." (RCH staff member, focus group one) • "Including it in induction and providing refreshers would keep us up to date." (RCH staff member, online survey) • "If we had someone show us how to integrate it into daily tasks, we'd use it more consistently." (RCH staff member, online survey) • "Cheat sheet or 5 top tips." (RCH staff member, focus group one)	6 (35.3)	38 (33.2)	1 (33.3)	47

2. Easier access in EMR: • "Needs to be easier for staff to see and read - no point having it there if staff don't use it." (parent/carer phone survey) • "I think easier access in EMR and being able to locate quickly and easily." (RCH staff member, focus group four) • "Being able to open the file from the banner." (RCH staff member, online survey) • "If it was a better 'fit' in the EMR workflow." (RCH staff member, online survey)	5 (29.4)	23 (20.1)	1 (33.3)	39
3. Enable families to access the tool: • "Families having easy access to the My RCH Portal... would be awesome." (RCH staff member, focus group four) • "For families to be able to populate/lead the information contained here and to be able to add in all relevant sections to their child." (RCH staff member, online survey)	4 (23.5)	12 (10.5)	3 (100)	22
4. Include the tool as part of vital signs: • "Whether it's part of your vital signs, please be reviewed or something like that... they brought it into their practice... something like that could be a way to close the loop a little bit more." (RCH staff member, focus group two)	3 (17.6)	-	-	4
5. Evaluation of the BSP/other EMR tools: • "An evaluation section of strategies that may be not effective since the plan was developed." (RCH staff member, online survey) • "Integrate it with other like tools." (RCH staff member, online survey)	-	6 (5.2)	-	6
6. Adaptable to different populations: • "Expand the work into the adult space and leverage off the integration of Epic across multiple health services." (RCH staff member, online survey)	-	6 (5.2)	-	6

Frequencies refer to the total number of times a concept was mentioned across all responses. Number (n) refers to the number of parents/carers or staff members who mentioned the concept. The online survey n (%) is calculated as a weighted average of responses across the two survey questions shown in Table 17. Percentages listed may not total 100% and have been rounded.

Table 19: Structural and content recommendations

Recommendation and example quote	*n* (%)		Total Frequency
	Focus groups	Online survey	
1. Modify or add clarifying questions or descriptions (calming strategies, age-appropriate questions, descriptors, occupational violence and aggression section, safety section, zones of feelings, family demographics): • "Like strategies or distraction… something that doesn't indicate you need to calm them down." (RCH staff member, focus group two) • "Creating a 'kid-friendly version' to fill out." (RCH staff member, focus group three) • "Some more descriptors/examples of the needs." (RCH staff member, online survey) • "Suggestions included using colour-coded zones or a traffic light system to express discomfort non-verbally." (RCH staff member, focus group two) • "Who are your safe people… or what would safe look like for you?" (RCH staff member, focus group three) • "Quick snapshot of some basic demographic information… to help contextualise." (RCH staff member, focus group one)	9 (52.9)	10 (8.7)	46
2. Include prompts, flags, alerts (created/updated, age, neurodivergent, previous Code Grey, not complete on first admission, medical or behaviour concerns, current community support): • "Having it as a prompt – notify the families about the BSP, and has it been completed, yes or no, does it need to be? Would it be helpful?" (RCH staff member, focus group one) • "Having a typable form that prompts for comments or checkboxes similar to our EMR smart forms would greatly assist families in providing comprehensive BSPs" (RCH staff member, focus group four) • "If it popped up like a reminder to update or flagged important information, it would help me keep track" (RCH staff member, online survey)	7 (41.2)	9 (7.9)	35

3. Refine language (eg update terminology such as "behaviours of concern" to more neutral or strengths-based alternatives): • "I find that the name Behaviour Support Profile also suggests that their child has behaviour issues... Individual Support Profile?" (RCH staff member, focus group three) • "Engagement support profile as the term 'behaviour' is challenging for parents and has negative connotations." (RCH staff member, online survey)	11 (64.7)	4 (3.5)	26
4. Simplify and streamline the form: • "It could be shorter—right now, it feels overwhelming for both staff and families." (RCH staff member, online survey) • "There's just too much information to wade through sometimes." (RCH staff member, online survey) • "Some sections just don't apply to certain kids, and it would help if we could tailor it to fit their needs more precisely." (RCH staff member, online survey)	-	16 (14.0)	17
5. Live document: • "If it could be updated live and notify us of changes, it would feel more useful and reflective of current needs." (RCH staff member, online survey)	-	5 (4.4)	6
6. Link to a parent support plan: • "Our goal is family-centred care, so why shouldn't we include the parents?" (RCH staff member, focus group three)	2 (11.8)	-	4
7. Paper copy: • "Having printed copies in our office /trolleys so we have them with us and easier to fill out in our day" (RCH staff member, online survey)	-	4 (3.5)	4

Frequencies refer to the total number of times a concept was mentioned across all responses. Number (n) refers to the number of parents/carers or staff members who mentioned the concept. The online survey n (%) is calculated as a weighted average of responses across the two survey questions shown in Table 17. Percentages listed may not total 100% and have been rounded.

Conclusions

Conclusions of the evaluation centre on the benefits of the BSP in supporting patients, parents, carers, staff, and hospital workflow, the current level of engagement and associated challenges, and ways to maximise its potential.

1. The BSP benefits children, parents/carers, and hospital workflow

Overall, this evaluation found that the BSP is an effective communication tool that has significant benefits for staff, patients, parents/carers, and hospital workflow when successfully utilised. Key benefits that align with the National Safety and Quality Health Service (NSQHS) Standards, particularly the Comprehensive Care Standard, include collaborating with children, young people, and their parents/carers, supporting consistent, whole-person care, and minimising patient harm (ACSQHC, 2021).

1.1 Supports collaboration with children, young people, and their parents/carers

The BSP presents an opportunity to collaborate with children, young people, and parents/carers and provide patient and family-centred care. Partnering with children, young people, and parents/carers has been found to reduce hospital costs and length of stay (ACSQHC, 2021), enhance rapport, streamline procedures, support shared decision-making, and improve resource allocation, which were supported by the findings of this evaluation.

Most of the information within the BSP is provided by parents/carers, which requires staff to engage them in care. This collaboration was frequently described as mutually beneficial, as staff gained the knowledge to deliver tailored care, while parents/carers felt reassured knowing their information was valued, documented, and shared across teams. This impacted patient outcomes, with reports from staff of reduced patient distress and the need for Code Grey intervention when information in the BSP was collaboratively integrated into care planning.

1.2 Supports consistent and comprehensive care

The BSP promotes consistent and comprehensive care by equipping staff with personalised knowledge to proactively address patients' non-medical needs and preferences. 85% of BSP users reported that the tool improved their understanding of patients' non-medical needs, particularly in areas like communication preferences, sensory sensitivities, and calming strategies.

Staff users of the BSP reported that parents/carers often feel burdened by having to repeatedly share non-medical information about their child with multiple staff to avoid preventable distress and ensure care is consistent. The BSP reduces this burden when used effectively, serving as a central information repository that all staff can access and use to enhance collaboration and holistic care. This continuity has several important flow-on effects, including enhanced rapport with patients and parents/carers, smoother procedures, improved collaboration between clinical teams and services, and reduced patient distress.

1.3 Supports harm prevention and minimisation

The BSP increases staff capacity to prevent, recognise, and respond to patient discomfort, and is an asset for mitigating risks of harm. For example, awareness of a child's sensory sensitivities enables staff to integrate these needs into care planning and empowers them to more accurately interpret and respond to any distress, by identifying and alleviating sources of sensory overwhelm. As a result, staff are better equipped to prevent or de-escalate challenging situations which not only mitigates the risk of harm to patients, parents/carers, and staff but can reduce the need for additional support from mental health practitioners and Code Grey intervention.

Incorporating patients' non-medical needs and preferences into medical care is critical to harm prevention and mitigation for all patients. Research has highlighted that a child's immediate subjective experience of an event is highly impactful on the development of negative long-term impacts (Kazak et al., 2006; Marsac et al., 2014). However, hospital staff are commonly lacking in TIC knowledge to support this (Hoysted et al., 2018). The BSP tool promotes TIC by prompting consideration of patients' non-medical needs such as likes and dislikes, factors that might trigger distress, and preferences or needs related to communication and taking medication. This can prevent or reduce distress for the patient and improve their subjective experience, which may reduce the likelihood of developing psychological sequelae (Hoysted et al., 2018). Therefore, the BSP provides staff with personalised knowledge to better prevent and minimise harm which is relevant to all patients.

2. There is significant potential for wider impact

Staff testimonies substantiated that the BSP's value in harm mitigation relies on consistent staff engagement and effective collaboration with the tool across disciplines and departments. Critically, the evaluation identified that this is not occurring. Significant inconsistencies in staff awareness, understanding of the tool, and role clarity were supported by data and reports from active users as inhibitors of widespread BSP use.

The evaluation also recognised the potential of the tool beyond its initial purpose. Originally designed for patients who are neurodivergent, have severe anxiety and/or additional needs, the BSP has been praised by staff users for its relevance and usefulness for all staff and patients.

However, across the five-year audit period, it was found that around 8.4% of patient-facing staff had created BSPs for 0.6% of patients. These findings highlight an immense opportunity and potential for a larger-scale positive impact if barriers to BSP use are effectively addressed.

2.1 Lack of knowledge, role responsibility, inconsistent use, and collaboration are key barriers

Many staff are unaware of the BSP and according to the staff surveys, less than half of those who were familiar with it knew how to create one. One-third of surveyed staff had never heard of the BSP, and responsibility for its use is often siloed to teams like CK or CLT. During the audit period, RNs and CLTs accounted for most BSPs created or updated, while medical and allied health staff were significantly underrepresented.

Inconsistent awareness and use undermines the BSP's purpose as a shared tool. In focus groups, staff expressed frustration at investing time in BSPs that do not get used by others. One nurse described completing a detailed BSP for a child with sensory needs, only for the information to not be accessed or implemented by other staff. This likely impacted the audit finding that the majority of existing BSPs had never been updated. Many staff are unclear on how to update BSPs or see little value in doing so when information is inconsistently utilised. This is a common issue that reinforces silos and discourages continued BSP engagement.

Overall staff engagement with the BSP, and therefore its potential impact, could be strengthened by addressing challenges related to staff knowledge and awareness, consistent and collaborative use, role responsibility and improving EMR accessibility.

3. Increasing TIPC understanding at the RCH is integral to mitigating risk of harm

For the BSP to become embedded into practice, its value must be understood as a solution to an existing and shared problem. This will be best supported by increased TIPC understanding, which recognises the high prevalence of trauma and how it can underlie behaviour and distress. Without this understanding, behaviour, and distress can be misinterpreted and exacerbated, risking harm to the patient, parents/carers, and staff providing care, alongside delays in service provision and longer hospital stays. Conversely, understanding the high prevalence of trauma validates the necessity to consider non-medical needs in medical care from a harm mitigation perspective, thereby reinforcing the BSP's value.

This evaluation indicated a need to increase TIPC knowledge for hospital staff, aligning with research that revealed low TIC knowledge in emergency staff (Hoysted et al., 2018). Within the audit data, staff frequently noted children can become distressed within the hospital environment. These notes focused on specific factors such as bright lights, a particular gender

of staff, loud noises, not being listened to, being restrained or experiencing sudden changes to routine. While some notes explained these factors were related to past traumatic experiences, many did not contain insights into underlying causes. For example, one note detailed how staff could not understand why a child was repeating a behaviour that was documented as self-harm but indicated stimming behaviour. Attempting to stop or prevent stimming behaviour can exacerbate distress, while recognising it as an emotion regulation strategy in response to not feeling safe could alert staff to identify sources of the patient's discomfort, potentially mitigating distress.

Understanding TIPC principles can provide staff with a checklist when patients are in distress, to help identify areas of need and how best to respond. While it is not always feasible to uphold these principles, such as allowing choice during an urgent medical intervention, attending to other principles, or providing choices in these instances may offer a buffering effect to mitigate distress. The BSP evaluation provided evidence that understanding how these principles can be practically applied in healthcare has significant potential to impact positive change. The anecdote of a team creating a dark room with a child/young person's favourite TV show playing and this leading to a more successful medical procedure exemplified this.

3.1 Requires a whole organisation TIPC approach

TIPC aims to prevent and reduce harm through a universal, proactive, and preventative psychosocial approach. Embedding TIPC requires an organisation-wide commitment to prioritise common understanding through education and awareness, and to support consistent integration into clinical thinking and practice. TIPC empowers staff with the recognition of how to best support children/young people by emphasising the necessity to consider non-medical needs and preferences. Clarifying TIPC and its practical application is likely to encourage shared ownership of the BSP and motivation for staff to engage with it as a trauma-informed tool, leading to more consistent use and collaboration.

Recommendations for prioritising TIPC at the RCH include:

- upskilling management through training to become organisational champions
- ensuring organisational policies and procedures reflect TIPC values and principles
- providing protected time for TIPC education and training for staff

At the time of this report, a TIPC foundational education package developed by the CMHS and key stakeholders including RCH staff and lived experience advisors is undergoing evaluation. Once finalised, it is recommended those in leadership positions prioritise completing it to support consistency in TIPC understanding across all levels of the organisation.

3.2 Align language with TIPC principles

This evaluation identified language choice as a key area for improvement, with staff calling for changes to the terminology used in the BSP. A TIPC lens considers the question, "What happened to you?" over "What is wrong with you?". This language intentionally shifts the problem away from the individual, instead considering the whole person and how experiences, for example, lack of safety, trust, choice, collaboration, and empowerment, can impact behaviour, needs, and preferences. Considering "What happened to you?" queries the presence of unmet needs underlying behaviour, which can prevent miscommunication and further distress if identified and addressed.

Staff suggested refining language and clarifying questions to enhance the BSP's usability and inclusivity. For example, the term "calming strategies" was noted as potentially prescriptive, implying the need to "calm down" patients. This may inadvertently suggest patient distress is an unacceptable or undesirable behaviour that needs to be corrected, as opposed to an expression of needs that require support. Staff language suggestions included using alternative phrasing like "strategies or distraction" or adopting systems, such as colour-coded zones or a traffic light system, to help express discomfort.

Similarly, the name "Behaviour Support Profile" was viewed as having negative connotations, potentially stigmatising patients by implying behavioural issues. Alternative names such as "Engagement Support Profile" or "Individual Support Profile," were proposed and highlight the tool's relevance in supporting staff in their roles, as well as indicating wider patient applicability. This may assist in promoting collective staff ownership, wider engagement, and increased use.

Recommending language changes in the BSP aligns with broader language adaptations that develop over time as knowledge progresses. Similar behaviour-focused language remains within healthcare with terms such as "behaviour of concern" and "zero tolerance". Updating the BSP's language is a timely opportunity in progressing towards a trauma-informed hospital.

4. Successful integration requires tool optimisation and increased awareness

While TIPC understanding was identified as a broad BSP enabler, the evaluation also identified specific practical needs to facilitate hospital-wide integration and uptake of the tool. These include variables related to access, usability, and awareness.

4.1 Improve accessibility and usability in the EMR

To increase use and satisfaction, the BSP needs to be more visible, intuitive, and accessible within the EMR. These were consistent recommendations from staff across the surveys and focus groups, referencing usability as a common barrier to engagement. Visibility issues complicate daily use, as staff reported difficulties in locating profiles, particularly in outpatient settings. Similarly, differences in EMR view also meant the BSP's location changed depending on which craft group a staff member belonged to, which reportedly compromised ease of use when collaborating.

To enhance accessibility, it was recommended that the tool include flags to remind staff to complete or update it and that it be located with better integration into their workflow, for example, within vital signs. There were also recommendations to improve the format of the tool, including streamlining, simplifying, and adapting it, as not every section of the current tool applies to each patient. Additionally, the qualitative evaluation of audit data found a high frequency of "other" fields with themes of information repeated across different sections and often contained within long paragraphs. Frequently, long paragraphs are not conducive to the tool's aim to make information readily accessible therefore format changes

are required to achieve this. This could include adding more options to indicate current or past relevancy, severity, and quantifying information (eg how much extra processing time is required for new information) to help categorise information.

It was also common in the survey findings that staff who knew about the BSP did not know how to create or update one. This suggests the format could also be enhanced to become more intuitive, and education and training resources are needed.

4.2 Increase staff awareness of the BSP

From a data perspective, staff awareness and knowledge of how to use the tool was the area with the greatest need for improvement, and the largest capacity to impact change. However, this relies on embedding the tool within a trauma-informed context that recognises a need and benefit for all staff to engage with it. It is also logical for education and promotion to follow optimisation of the tool so resources are up to date. Therefore, increasing awareness of the BSP through a targeted campaign is recommended to follow those initial priorities.

The significant disparity between low BSP usage and its capacity to support large-scale impact indicates a critical need to increase staff knowledge through promotion, education, and training. Lack of staff awareness and understanding of the BSP was identified as the most significant barrier to the tool reaching its potential. Medical staff reported the lowest levels of engagement and understanding of the BSP's functionality and were less likely to report it as part of their role to complete.

Overall feedback from this evaluation indicated staff who knew about and used the BSP considered it highly beneficial. This suggests even without optimisations, increased engagement with the current tool will have a positive impact on patients, parents/carers, staff, and the hospital itself. However, addressing the barriers to staff satisfaction with the tool will enhance it to be more trauma-informed, user-friendly, and better fit for purpose.

4.3 Provide direct access for patients, parents, and carers

The final barrier and key area for improvement is accessibility to the tool for patients and parents/carers so they can complete it directly. While staff observations contribute to some BSP information, much of it is sourced from parents/carers, making direct access via the My RCH Portal a logical step to streamline the process. The My RCH Portal is a website and mobile app that gives patients and their parents/carers access to information in the RCH medical record, when and where it suits them. When parents/carers were asked if they would update the BSP at home if given access, all three respondents said yes, reinforcing the feasibility and demand for this feature.

Focus groups discussed how enabling parents/carers to access and update the BSP through the My RCH Portal would improve staff access to the most up-to-date information, while reducing the time required for staff to contact families and update the tool themselves. This would enhance the accuracy and relevance of the BSP while also aligning with the hospital's strategic goal of embedding the voices of young people and fostering kid-centric models of care (The Royal Children's Hospital, 2023).

However, the limitations of the current EMR system and the My RCH Portal pose implementation challenges. While staff were encouraged to think broadly about potential BSP enhancements in this evaluation, the feasibility of suggested improvements is constrained by the existing infrastructure. Integration of direct input to the BSP from children, young people, and parents/carers via the My RCH Portal requires the tool to first be updated based on recommendations from this evaluation, and for the support software to be ready to facilitate this. Additionally, it is recommended that a plan be developed to manage pre-existing BSP data, given staff may have completed these without expecting patients, parents/carers to be able to access the data.

As the BSP exists to benefit children, young people, and their parents/carers, incorporating their feedback and addressing their accessibility needs should be integral to any future evaluation.

5. Limitations

The main limitation of this evaluation was the low recruitment of parents/carers, resulting in feedback and recommendations for improvement being predominantly based on staff perspectives. The recruitment process relied on staff to ask questions to parents/carers as part of routine follow-up, which could have contributed to the low response rate. As the BSP is a tool designed to enhance care and communication, feedback from those receiving care is essential for a comprehensive evaluation.

While three out of the intended 20 phone survey responses were collected from parents/carers, they lacked detail and may have been influenced by participants' prior connections with the principal investigator. To better understand the perspective of children, young people, and parents/carers on the tool and any recommendations for improvement, further research prioritising the recruitment of these participants is warranted.

Another limitation included the wording of the survey question about de-escalation, which should be considered when interpreting results. This question asked staff whether the BSP assisted them in de-escalating a patient's behaviour, potentially framing it as reactive rather than preventative. Many staff reported using the tool proactively to prevent distress escalation and these instances may not have been fully represented in the data.

Positive bias in staff perspective is a further consideration, as the data may overrepresent individuals already engaged or motivated to comment on the BSP. However, this is more likely to apply to focus group findings compared to the staff survey, as a third of staff surveyed were unaware of the tool, while focus group participants were active users. Future evaluations could address potential positive bias by intentionally seeking feedback from less-engaged staff and families within focus groups, to balance perspectives and gain a more comprehensive insight.

Summary

The evaluation of the BSP revealed an underutilised tool with immense capacity to enhance hospital care for patients, parents/carers, and staff providing care. When used effectively, the BSP provides trauma-informed insight as critical guidance, enabling staff to confidently navigate complex patient interactions, consistently tailor care to individual needs, and mitigate the risk of harm. It upholds NSQHS Standards through facilitating partnerships with children, young people, and parents/carers and scaffolding comprehensive care.

Despite progress in integrating the BSP within patient-centred care since 2019, lack of staff awareness and collective ownership, consistent engagement, collaboration, and accessibility restrict its impact. To overcome existing barriers and build on the strengths of the tool, a common understanding of TIPC should be prioritised across the hospital. This will reinforce the tool's value and relevance for all patients, parents/carers, and staff, motivate widespread uptake and collaboration, and maximise potential impact.

Optimising the BSP tool is an opportunity to create a meaningful impact in paediatric healthcare at the RCH and beyond. As a valuable and unique asset, the tool directly supports the RCH's strategic vision of being a leading provider of paediatric care, both nationally and globally.

Effective integration and sustainability depend on leadership commitment, policy alignment, and resource support. Successful hospital-wide integration will model a scalable, trauma-informed, and patient-centred tool that is adaptable to other healthcare settings.

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Appendices

Appendix A: Online survey questions and response options

Question	Response options
1. What is your role at the RCH?	Nursing, Medical, Allied Health, Administration, Other
1a. Other: Describe your role at the hospital	[Open text response]
2. How many years have you worked at the RCH?	[Open numerical response]
3. Which department or team do you work in?	[Open text response]
4. Do you know about the BSP in EMR?	Yes, No
4a. If no: How do you identify or document the non-medical needs of patients in EMR (eg communication preferences, behaviours of concern)?	[Open text response]
5. Do you use the BSP?	Never, Rarely, Sometimes, Often, Always
6. How did you find out about the BSP? Check all that apply	The screening question in the nursing admission assessment, The short cut video on the intranet, A colleague showed me/told me about the BSP, CEO Forum, Tuesday's @ 2 Nursing Forum, Other
6a. Other: Please describe how you found out about the BSP	[Open text response]
7. What is your understanding of the purpose of the BSP and when to use it?	[Open text response]
8. Do you think it is your role to complete the BSP?	Yes, No
8a. Why is that so?	[Open text response]
8b. Why not?	[Open text response]
9. Do you know where to find the BSP in Epic?	Yes, No
10. Do you know how to create a BSP in Epic?	Yes, No
11. Do you refer to the BSP in your day-to-day role?	Yes, No
11a. If yes: When do you refer to the BSP?	Once per shift, Multiple times per shift, At handover, Before an admission, On the ward round, Before a clinic appointment, Before interacting with the patient, Other
11b. Other: Please describe when you would refer to the BSP	[Open text response]
12. Do you update the BSP with new information?	Yes, No
12a. Why not?	Not aware that I could, Not sure how to do this, Don't have time, Other

12b. Other: Please explain:	[Open text response]
13. Do you feel comfortable asking families all the questions in the BSP?	Yes, No
13a. Why not? (ie which sections are you less comfortable with addressing?)	[Open text response]
14. Has the BSP helped you to de-escalate a patient's behaviour?	Yes, No
14a. If yes: Do you have an example or anecdote of how the BSP helped you de-escalate a patient's behaviour?	Yes, No
14b. If yes: Please describe the example or anecdote of how the BSP helped you de-escalate a patient's behaviour	[Open text response]
15. Does the BSP change your understanding of and ability to address your patients':	
Communication needs/preferences	Increase, Same, Decrease
Sensory needs/sensitivities	Increase, Same, Decrease
Triggers or behaviours of concern	Increase, Same, Decrease
Calming strategies	Increase, Same, Decrease
Pain/distress	Increase, Same, Decrease
16. Do you have an example or anecdote of how the BSP helped you to address your patients' needs?	Yes, No
16a. If yes: Please describe the example or anecdote of how the BSP helped you address your patients' needs	[Open text response]
17. What stops you from using the BSP today?	[Open text response]
18. Before the BSP, where would you document the non-medical needs and preferences of your patients in EMR? Check all that apply	In the progress notes, In an FYI flag, On a paper-based profile or plan, Verbally at handover, Nowhere, Other
18a. Other: Where did you document the non-medical needs and preferences of your patients in EMR	[Open text response]
19. What would help you to use the BSP in your day-to-day role?	[Open text response]
20. What would you change about the BSP? (ie additions, improvements, or alterations)	[Open text response]
21. Do you have any final questions or comments that you would like to share?	[Open text response]

Appendix B: BSP fields and response options

Field	Response options	Total *N=1784*	Per cent (%)
Created by	[Open text response]	1714	95.1
Updated by	[Open text response]	284	15.9
File FYI	Yes (547, 99.6%) No (2, 0.4%)	549	30.8
Likes	[Open text response]	1,637	91.8
Dislikes	[Open text response]	1,363	76.4
Strengths/Abilities	[Open text response]	1,153	64.6
Challenges/Difficulties	[Open text response]	1,305	73.1
Motivators (toy, activity, food)	[Open text response]	1,199	67.2
I take my medications	Syrup/Liquid (676, 46.8%), Swallowing tablets (489, 33.9%), Other (208, 14.4%), Crushed/mixed in drink (61, 4.2%), Crushed in yoghurt (10, 0.7%) *Main "other" themes: Via PEG/NGT (88, 6.1%), Mixed with food (74, 5.1%)*	1,444	80.9
Meds (specify)	[Open text response]	605	33.9
I communicate with you by using	Words/Talking (1114, 71.1%), Other (119, 7.6%), Pointing (86, 5.5%), Signing/Gestures (84, 5.4%), Visual Aids (81, 5.2%), Writing things down (68, 4.3%), PODD Book (10, 0.6%), iPad (5, 0.3%) *Main "other" themes: specific non-verbal cues eg sounds, facial expressions, body language (61, 51.3%), directs or leads person to needs (23, 19.3%)*	1,567	87.8
I Communicate (specify)	[Open text response]	608	34
You should communicate with me by using	Full sentences (399, 25.7%), Give choices (313, 20.2%), Other (282, 18.2%), Visual Aids (266, 17.1%), 1-2 words/Short Phrases (134, 8.6%), Allow processing time (66, 4.3%), Don't give choices (49, 3.2%), Explain tasks in detail (26, 1.7%), 1 Step instructions (17, 1.1%) Main "other" themes: Unique/specific (54, 19.1%), only two choices (46, 16.3%), first... then... (26, 9.2%), clear/direct/ literal language (21, 7.4%), parent/carer as translator (20, 7.1%)	1,552	86.8

You Communicate (specify)	[Open text response]	592	33.1
I calm down with	Structure/Knowing what comes next (370, 24.1%), Parental presence (241, 15.7%), Tight Squeezing/Deep pressure (184, 12.0%), Reduce noise/Soft voices (153, 10.0%), Other (119, 7.8%), Water (96, 6.3%), Soft touch (90, 5.9%), Room to pace (84, 5.5%), Sensory Tool (74, 4.8%), Comfort item (35, 2.3%), Music (34, 2.2%), Distracting/ Redirecting (33, 2.2%), Being left alone/ less people (11, 0.7%), Dim lights (6, 0.4%), Comfort Food (3, 0.2%) *Main "other" themes: Unique/specific (26, 21.8%), YouTube/Netflix/devices (21, 17.6%)*	1,533	85.9
Calming (specify)	[Open text response]	1,018	57
I have a trigger word/ phrase	No (734, 60.9%), Yes (471, 39.1%)	1,205	67.6
Trigger phrases (specify)	[Open text response]	456	25.5
I have sensory triggers	Other (338, 25.7%), Touch (312, 23.7%), Loud Noises (286, 21.7%), No (206, 15.7%), Textures (79, 6.0%), Water (32, 2.4%), Hospital ID Band (22, 1.7%), Bright lights (20, 1.5%), Hospital Gown (12, 0.9%), Band-Aid (9, 0.7%) *Main "other" themes: personal space/ crowding (49, 14.5%), unique trigger (38, 11.2%), IV/needles/BP taken (37, 10.9%), people/things touching my face (23, 6.8%), unpredictability/change/surprises/being uninformed or confused (23, 6.8%)*	1,316	73.7
Sensory triggers (specify)	[Open text response]	510	28.6
Things that upset me	Transitions/Changing environments (498, 35.6%), Too many people (428, 30.6%), Separation from parents (136, 9.7%), Other (115, 8.2%), Sudden change to plan (106, 7.6%), None (48, 3.4%), Rushing (23, 1.6%), Time of day (20, 1.4%), New people (13, 0.9%), Certain Foods (9, 0.6%), Change in routine (2, 0.1%) *Main "other" themes: Lack of choice or collaboration (31, 27.0%), unique/specific (24, 20.9%)*	1,398	78.3
Upsets me (specify)	*[Open text response]*	649	36.4

I display behaviours that may harm myself	No (603, 46.0%), Other (233, 17.8%), Slapping self (196, 14.9%), Scratching self (100, 7.6%), Head banging (90, 6.9%), Picking skin (45, 3.4%), Biting self (29, 2.2%), Hair pulling (15, 1.1%) *Main "other" themes: kicking/punching/ banging on something (non-head) (43, 18.5%), comment specifying harm no intent of action (42, 18.0%), comment specifying context, timing or frequency (eg past, medication side effect, threat only) (39, 16.7%), comment flagging specific risk (38, 16.7%), information belonging elsewhere (33, 14.2%), when attempting to escape/ remove self (25, 10.7%), deliberate cutting (21, 9.0)*	1,311	73.4
Harm myself (specify)	[Open text response]	341	19.1
The purpose of this behaviour is	To make something stop (230, 35.6%), Communicate frustration (150, 23.2%), Other (82, 12.7%), To calm self-down (76, 11.8%), Unsure (52, 8.1%), To stimulate (stimming) (38, 5.9%), To gain something (18, 2.8%) *Main "other" themes: Expression of frustration, emotion or pain (43, 52.4%)*	646	36.2
Harm myself purpose (specify)	[Open text response]	156	8.7
I display behaviours that may harm others	No (525, 38.8%), Verbal aggression (252, 18.6%), Other (246, 18.2%), Throwing Objects (134, 9.9%), Kicking (79, 5.8%), Scratching (66, 4.9%), Hitting (35, 2.6%), Spitting (10, 0.7%), Biting (6, 0.4%) *Main "other" themes: pushing/pulling others away (62, 25.2%), pulling hair (20, 8.54%), attempting to run away/remove self from area (20, 8.1%)*	1,353	75.8
Harm others (specify)	[Open text response]	418	23.4
Purpose of harm to others	To make something stop (426, 56.1%), Communicate frustration (180, 23.7%), Other (83, 10.9%), Unsure (37, 4.9%), To gain something (34, 4.5%) *Main "other" themes: to communicate anxiety/fear/overwhelm/not feeling safe 28 (33.7%)*	760	42.6

Harm other purpose (specify)	[Open text response]	175	9.8
How I present when I am settled/happy	Smile (1029, 80.7%), Squeal (96, 7.5%), Other (93, 7.3%), Poor eye contact (26, 2.0%), Good eye contact (19, 1.5%), Laugh (9, 0.7%), Moan (2, 0.2%), Slaps hands on legs (1, 0.1%) *Main "other" themes: Being chatty/talkative (23, 24.7%), engaging In hobbies/activities I like (19, 20.4%)*	1,275	71.4
Happy (specify)	[Open text response]	440	24.7
How I present when I am in pain/distress/agitated	Scream (354, 27.7%), Other (318, 24.9%), Poor eye contact (136, 10.6%), Cry (122, 9.6%), Slaps head or legs (98, 7.7%), Teeth grinding (54, 4.2%), Wringing hands (53, 4.1%), Rock back and forth (33, 2.6%), Twitch/Tic (25, 2.0%), Grimace (21, 1.6%), Picking at skin (17, 1.3%), Frown (16, 1.3%), Moan (15, 1.2%), Blank stare (9, 0.7%), Good eye contact (4, 0.3%), Cover my ears (2, 0.2%) *Main "other" themes: withdrawing/hiding/ running away (72, 22.6%), communicating verbally (70, 22.0%), physically defensive/ push others away (37, 11.6%), quiet/ nonverbal (34, 10.7%), high pain threshold (20, 6.3%)*	1,277	71.5
Pain (specify)	[Open text response]	671	37.6
I have previously become agitated or distressed	Yes (1086, 82.4%), No (232, 17.6%)	1,318	73.8
Reason for agitation	[Open text response]	812	45.5
I will tolerate having IV drips or tubes in for periods of time	Yes (561, 51.7%), No (525, 48.3%)	1,086	60.8
I need constant supervision by a parent or staff member	Yes (830, 69.2%), No (370, 30.8%)	1,200	67.2
I will tolerate being confined to a room	Yes (903, 80.3%), No (221, 19.7%)	1,124	63
What helped last time	[Open text response]	1,061	59.5
What should we avoid this time	[Open text response]	802	44.9
ED management	[Open text response]	24	4.3

Appendix C: Online survey department breakdown

Department	Nursing *n (%)*	Allied Health *n (%)*	Medical *n (%)*	Admin *n (%)*	Other *n (%)*	Total *N (%)*
Anaesthetics	-	3 (1.4)	19 (8.6)	-	-	22 (10.0)
Emergency Department	14 (14.0)	1 (0.5)	4 (1.8)	-	-	19 (8.6)
Mental Health/Banksia Ward	9 (9.0)	5 (2.3)	3 (1.4)	-	1 (0.5)	18 (8.2)
Child Life Therapy	-	11 (5.0)	-	-	-	11 (5.0)
General Medicine	2 (2.0)	-	7 (3.2)	-	-	9 (4.1)
Adolescent Medicine	4 (4.0)	2 (0.9)	1 (0.5)	-	1 (0.5)	8 (3.6)
Children's Cancer Centre	2 (2.0)	4 (1.8)	-	-	-	6 (2.7)
Surgical and Neurological Care/ Cockatoo Ward	6 (6.0)	-	-	-	-	6 (2.7)
Recovery	6 (6.0)	-	-	-	-	6 (2.7)
Complex Care Hub	3 (3.0)	1 (0.5)	1 (0.5)	-	-	5 (2.3)
Medical Short Stay/ Dolphin Ward	5 (5.0)	-	-	-	-	5 (2.3)
Occupational Therapy	-	5 (2.3)	-	-	-	5 (2.3)
Wombat Ward	4 (4.0)	-	-	-	1 (0.5)	5 (2.3)
Cardiology/Koala Ward	3 (3.0)	-	1 (0.5)	-	-	4 (1.8)
Early Childhood Intervention Service	-	2 (0.9)	-	1 (0.5)	1 (0.5)	4 (1.8)
Endocrinology and Diabetes	3 (3.0)	-	-	-	1 (0.5)	4 (1.8)
Long Stay Surgical Care/Platypus Ward	4 (4.0)	-	-	-	-	4 (1.8)
Social Work	-	4 (1.8)	-	-	-	4 (1.8)
Code Grey	3 (3.0)	-	-	-	-	3 (1.4)
Day Surgery/Possum Ward	3 (3.0)	-	-	-	-	3 (1.4)
Disability Liaison Office	-	3 (1.4)	-	-	-	3 (1.4)
Eating Disorder Unit/ Kelpie Ward	3 (3.0)	-	-	-	-	3 (1.4)
Neonatal Medicine	-	1 (0.5)	2 (0.9)	-	-	3 (1.4)
Neurodevelopment and disability	1 (1.0)	-	2 (0.9)	-	-	3 (1.4)
Dietetics	-	2 (0.9)	-	-	-	3 (1.4)

Newborn Intensive Care Unit/Butterfly Ward	2 (2.0)	-	-	-	-	2 (0.9)
Centre for Community Child Health	-	-	2 (0.9)	-	-	2 (0.9)
Child and Adolescent Mental Health Service	-	2 (0.9)	-	-	-	2 (0.9)
Equipment Distribution Services	-	-	-	2 (0.9)	-	2 (0.9)
Comfort Kids	2 (2.0)	-	-	-	-	2 (0.9)
Medical	2 (2.0)	-	-	-	-	2 (0.9)
Music Therapy	-	2 (0.9)	-	-	-	2 (0.9)
Melbourne Children's Research Unit	2 (2.0)	-	-	-	-	2 (0.9)
Nephrology	1 (1.0)	-	1 (0.5)	-	-	2 (0.9)
Nursing Education	2 (2.0)	-	-	-	-	2 (0.9)
Oncology	2 (2.0)	-	-	-	-	2 (0.9)
Paediatric Intensive Care Unit	2 (2.0)	-	-	-	-	2 (0.9)
Rehabilitation	-	1 (0.5)	1 (0.5)	-	-	2 (0.9)
Respiratory	2 (2.0)	-	-	-	-	2 (0.9)
Speech Pathology	-	2 (0.9)	-	-	-	2 (0.9)
Stepped Care	-	2 (0.9)	-	-	-	2 (0.9)
Access and Hospital Management	1 (1.0)	-	-	-	-	1 (0.5)
Allied Health	-	1 (0.5)	-	-	-	1 (0.5)
Anaesthetic Technology	-	1 (0.5)	-	-	-	1 (0.5)
Clinical Pharmacology	1 (1.0)	-	-	-	-	1 (0.5)
Burns Unit	1 (1.0)	-	-	-	-	1 (0.5)
Children's Pain Management Service	1 (1.0)	-	-	-	-	1 (0.5)
Dentistry	-	1 (0.5)	-	-	-	1 (0.5)
Dermatology	1 (1.0)	-	-	-	-	1 (0.5)
DOS	1 (1.0)	-	-	-	-	1 (0.5)
Gatehouse	-	1 (0.5)	-	-	-	1 (0.5)

Genetics	-	-	1 (0.5)	-	-	1 (0.5)
Immunisation	1 (1.0)	-	-	-	-	1 (0.5)
Medicine Operations	1 (1.0)	-	-	-	-	1 (0.5)
Neuromuscular	-	1 (0.5)	-	-	-	1 (0.5)
Neonatology	-	-	1 (0.5)	-	-	1 (0.5)
Orthopaedics	-	-	1 (0.5)	-	-	1 (0.5)
Otolaryngology	-	-	1 (0.5)	-	-	1 (0.5)
Paediatric Trainee	-	-	1 (0.5)	-	-	1 (0.5)
Paediatric Surgery	1 (1.0)	-	-	-	-	1 (0.5)
PARC	1 (1.0)	-	-	-	-	1 (0.5)
Perioperative	1 (1.0)	-	-	-	-	1 (0.5)
Research Operations	-	-	-	1 (0.5)	-	1 (0.5)
Surgery	-	-	1 (0.5)	-	-	1 (0.5)
Sugar Glider Ward	1 (1.0)	-	-	-	-	1 (0.5)
Trauma Service	1 (1.0)	-	-	-	-	1 (0.5)
Travancore	-	-	1 (0.5)	-	-	1 (0.5)
Psychology	-	1 (0.5)	-	-	-	1 (0.5)
Missing	-	-	-	1 (0.5)	-	1 (0.5)
Total department types	**39**	**24**	**19**	**3**	**5**	**-**

Percentages are calculated based on unique staff counts to account for overlaps. The total staff count is 220 unique individuals but the sum appears as 225 due to nursing staff working across multiple departments. Nursing percentages are calculated based on 100 unique nurses.

Appendix D: Online survey additional descriptive statistics

Table 20: Online survey completion rates

Survey status	*n (%)*
Complete	115 (52.3)
Complete up to Q4a	59 (26.8)
Incomplete	46 (20.9)
Started the survey	220 (100)

Percentages listed may not total 100% and have been rounded.

Table 21: Online survey completion rates by role *(N=220)*

Survey status	Role *n (%)*				
	Nursing *n=100*	Allied Health *n=59*	Medical *n=51*	Admin *n=5*	Other *n=5*
Complete	75 (75)	46 (78)	45 (88.2)	3 (60.0)	5 (100)
Incomplete	25 (25)	13 (22)	6 (11.8)	2 (40.0)	-

Percentages listed may not total 100% and have been rounded.

Table 22: Descriptive statistics for years of service at the RCH

How many years have you worked at the RCH? *(N=220)*		
	Percentiles %	Years
Mean		10.45
Median		8
Standard deviation		9.369
Range		40
Minimum		0
Maximum		40
	25	2
	50	8
	75	16

Table 23: Responses to the question "Do you know about the BSP in EMR?" answered in frequency, by role (*N=183*)

Response option	Role *n (%)*				
	Nursing *n=81*	Allied Health *n=47*	Medical *n=47*	Admin *n=3*	Other *n=5*
Yes	59 (72.8)	34 (72.3)	28 (59.6)	-	2 (40.0)
No	22 (27.2)	13 (27.7)	19 (40.4)	3 (60.0)	3 (60.0)

Percentages listed may not total 100% and have been rounded.

Table 24: Responses to "Do you have an example or anecdote of how the Behaviour Support Profile helped you to address your patients' needs?" (*N=119*)

Response option	Role *n (%)*			
	Nursing *n=56*	Allied Health *n=33*	Medical *n=28*	Other *n=2*
Yes	13 (23.2)	9 (27.3)	5 (17.9)	-
No	43 (76.8)	24 (72.3)	23 (82.1)	2 (100)

Percentages listed have excluded missing data and have been rounded.

Appendix E: Focus group coded themes

Table 25: Focus group coded themes and subthemes

Theme	Theme and subtheme	Frequency	Staff *n (%)* (total *N=17*)
Purpose of the BSP		32	14 (82.4)
	Communication and information sharing tool	20	10 (58.8)
	Engagement tool	5	5 (29.4)
	Enforces quality care and safety	4	3 (17.6)
	Preparation and planning	2	2 (11.8)
	Staff accountability	1	1 (5.9)
Target users of the BSP		21	8 (47.1)
	Children and young people with additional needs	14	4 (23.5)
	Anyone	6	5 (29.4)
	Staff	1	1 (5.9)
Day-to-day use of the BSP		67	14 (82.4)
	Document patient information	17	10 (58.8)
	During patient care	16	11 (64.7)
	Collaborate with families, children, young people, and staff	12	6 (35.3)
	Inconsistent use	11	8 (47.1)
	Planning procedures	8	6 (35.3)
	Code Grey risk management	2	2 (11.8)
	Research	1	1 (5.9)
Barriers		88	17 (100)
	Accessibility, finding the BSP in EMR	30	11 (64.7)
	Communication challenges with staff and children, young people, and families	15	4 (23.5)
	Time constraints	14	11 (64.7)
	Perceived ownership	9	6 (35.3)
	Lack of awareness	8	6 (35.3)
	Relevance of questions	6	2 (11.8)
	Value	2	2 (11.8)
	Difficulty integrating into workflow	2	1 (5.9)
	No perceived barriers	2	2 (11.8)

Experiences using the BSP with children, young people, and families		34	14 (82.5)
	Information does not get used	10	8 (47.1)
	Empowering for children, young people and parents/carers	9	7 (41.2)
	Improves engagement and rapport	8	6 (35.3)
	Prevents escalation	5	3 (17.6)
	Not aware that it could be used with children, young people and parents/carers	2	2 (11.8)
Ways the BSP has improved patient outcomes		23	12 (70.6)
	Improves planning and outcome of care	10	7 (41.2)
	Information sharing across services	5	5 (29.4)
	Rapport-building	4	4 (23.5)
	Provides parent choice and ownership	2	2 (11.8)
	Children, young people, and parents/carers feel needs and fears are addressed	2	2 (11.8)
Suggestions for improvement		102	15 (88.2)
	Additions to improve usability	25	12 (70.6)
	Refine language	22	10 (58.8)
	Improve access and visibility in the EMR through prompts/flags	22	6 (35.3)
	Enhance parent/carer engagement by improving access to complete BSP through the My RCH Portal	6	4 (23.5)
	Training and modeling use to increase awareness	6	6 (35.3)

Frequencies refer to the number of times a concept was mentioned, and n refers to the number of staff members.

Appendix F: Online survey coded themes

Survey item	Theme and subtheme	Frequency	Staff *n (%)*
Do you know about the BSP in EMR? Selected "No". *How do you identify or document the non-medical needs of patients in EMR (eg communication preferences, behaviours of concern).*		73	60 (100)
	In the EMR	59	45 (75.0)
	Notes (progress, clinical, specialty, care coordination, trauma)	37	37 (61.7)
	Alerts (quick updates/vulnerable child flag)	14	14 (23.3)
	During assessment	4	4 (6.7)
	Mental health tab	1	1 (1.7)
	RAD-RAM	1	1 (1.7)
	Patient history	1	1 (1.7)
	Anaesthetic chart	1	1 (1.7)
	During admissions	4	4 (6.7)
	I do not	3	3 (5.0)
	NA	3	3 (5.0)
	Contact previous clinicians	1	1 (1.7)
	Communicating with family	1	1 (1.7)
	Disability identifier	1	1 (1.7)
	During handover	1	1 (1.7)
How did you find out about the BSP? Selected "Other". *Please describe how you found out about the BSP.*		34	34 (100)
	EMR	18	18 (52.9)
	Internal resources	11	11 (32.4)
	Collaboration on BSP design	3	3 (8.8)
	Child Life Therapy	2	2 (5.9)
	Comfort Kids	2	2 (5.9)
	Nursing Guidelines	1	1 (2.9)
	Nursing Education	1	1 (2.9)
	Transferring patient out of the RCH	1	1 (2.9)
	Word of mouth	3	3 (8.8)
	External sources	2	2 (5.9)

What is your understanding of the purpose of the BSP?		142	122 (100)
	To document and share information	67	67 (54.9)
	Behaviour and regulation strategies	29	29 (23.8)
	Child preferences	24	24 (19.7)
	Identification of communication preferences	11	11 (9.0)
	Flag a patient for more support	3	3 (2.5)
	Support families and patients	35	35 (28.7)
	Understand parent/carer needs	19	19 (15.6)
	Supporting patients with higher needs (neurodiversity, emotion regulation)	10	10 (8.2)
	Improves parents'/carers' care experience	4	4 (3.3)
	Avoids parents/carers repeating information	2	2 (1.6)
	Supports staff in providing better care	26	26 (21.3)
	Prevents behaviour from escalating	12	12 (9.8)
	Never completed	2	2 (1.6)
What is your understanding of when to use the BSP?		24	122 (100)
	To plan or prepare for procedures	19	19 (15.6)
	Prior to admissions	4	4 (3.3)
	When child is distressed	1	1 (0.8)
Do you think it is your role to complete the BSP? Selected "Yes". *Why is that so?*		102	80 (100)
	Within scope of my role and responsibilities	28	28 (35)
	Clinical role	8	8 (10)
	Plan/procedural support role	7	7 (8.8)
	Duty of care	5	5 (6.3)
	Disability role	3	3 (3.8)
	Patient advocate	2	2 (2.5)
	Shared responsibility for all to complete	18	18 (22.5)
	"Everyone's role"	14	14 (17.5)
	Multi-disciplinary team	3	3 (3.8)
	Promotes shared learning	2	2 (2.5)

	Documentation reasons	14	14 (17.5)
	Document/update new patient information	11	11 (13.8)
	Part of admission process	3	3 (3.8)
	Helps us understand patients better	14	14 (17.5)
	Establishes relationship	12	12 (15.0)
	Closeness/established child/young person	8	8 (10.0)
	First point of contact	4	4 (5.0)
	Not my responsibility	2	2 (2.5)
Do you think it is your role to complete the BSP? Selected "No". *Why not?*		50	42 (100)
	Not my responsibility	20	20 (47.6)
	Role of allied health	5	5 (11.9)
	Not in a clinical role	4	4 (9.5)
	Role of parent/carer	2	2 (4.8)
	Role of those who assess behaviour	2	2 (4.8)
	Role of those who have established relationship with child/young person and parent/carer	2	2 (4.8)
	Role is reactive vs. proactive	1	1 (2.4)
	Role of nursing	1	1 (2.4)
	Unsure of the process to complete	11	11 (26.2)
	Time constraints	10	10 (23.8)
	Use of Anaesthetic documentation for this information	5	5 (11.9)
	No training	4	4 (9.5)
Do you refer to the BSP in your day-to-day role? Selected "Yes". When do you refer to the BSP? Selected "Other". *Please describe when you would refer to the BSP.*		14	14 (100)
	Context based/as needed	6	6 (42.9)
	Reviewing patient file	3	3 (21.4)
	During clinical work	1	1 (7.1)
	During Code Grey	1	1 (7.1)

	When patient is neurodivergent	1	1 (7.1)
	When receiving a new referral	1	1 (7.1)
	When transferring patient to adult care	1	1 (7.1)
Do you update the BSP with new information? Selected "No". Why not? Selected "Other". *Please explain.*		17	17 (100)
	Not my role/responsibility	7	7 (41.2)
	Lack of knowledge/awareness	6	6 (35.3)
	Rely on other methods of documentation	3	3 (17.6)
	Hard to find	1	1 (5.9)
Do you feel comfortable asking families all the questions in the BSP? *Why not? (ie which sections are you less comfortable with addressing?)*		20	20 (100)
	Lack of knowledge of BSP questions	10	10 (50)
	Lack experience in completing a BSP	7	7 (14)
	Role responsibility	2	2 (4.0)
	Length	1	1 (2.0)
Do you have an example or anecdote of how the Behaviour Support Profile helped you de-escalate a patients' behaviour? Selected "Yes". *Please describe the example or anecdote of how the BSP helped you de-escalate a patient's behaviour?*		40	40 (100)
	Effectively helped to avoid triggers	15	15 (37.5)
	Supported individualised approaches to care	6	6 (15.0)
	Rapport-building	5	5 (12.5)
	Distraction	4	4 (10)
	Creating positive hospital environments for families/patients	3	3 (7.5)
	Supports consistent care for patients and families	3	3 (7.5)
	Facilitation of staff communication and utilisation of BSP	3	3 (7.5)
	NA	1	1 (2.5)

Do you have an example or anecdote of how the Behaviour Support Profile helped you to address your patients' needs? Selected "Yes". *Please describe the example or anecdote of how the BSP helped you address your patients' needs.*		28	27 (100)
	Allows parents/carers and patients to advocate their needs leading to improved care	6	6 (22.2)
	Collaboration between staff and parents/carers/child/ young person	5	5 (18.5)
	Preparation for arranging specific needs	4	4 (14.8)
	Increased staff understanding of communication preferences	4	4 (14.8)
	Involving parents/carers and patients	4	4 (14.8)
	Address sensory sensitivities and triggers	3	3 (11.1)
	Tailors care to the individual	2	2 (7.4)
What stops you from using the BSP?		129	116 (100)
	Time constraints	31	31 (26.7)
	Nothing	22	22 (19.0)
	Relevance and priority	20	20 (17.2)
	Hard to find	18	18 (15.5)
	Lack of knowledge	11	11 (9.5)
	If one has not been created	10	10 (8.6)
	Forget	8	8 (6.9)
	Practicality issues	4	4 (3.4)
	Outdated	3	3 (2.6
	Length	2	2 (1.7)
Before the Behaviour Support Profile, where would you document the non-medical needs and preferences of your patients in EMR? Select "Other".		13	13 (100)
	Anaesthesia chart	3	3 (23.1)
	During anaesthesia pre-operative consult	3	3 (23.1)

Before the Behaviour Support Profile, where would you document the non-medical needs and preferences of your patients in EMR? Select "Other".		13	13 (100)
	Anaesthesia chart	3	3 (23.1)
	During anaesthesia pre-operative consult	3	3 (23.1)
	Encounter in EMR	1	1 (7.7)
	Post-it notes	1	1 (7.7)
	Safety plan	1	1 (7.7)
	Specialty comments	1	1 (7.7)
	Media files	1	1 (7.7)
	Secure chat	1	1 (7.7)
	NA	1	1 (7.7)
What would help you to use the BSP in your day-to-day role?		111	116 (100)
	Formatting and content changes	36	36 (31.0)
	Alerts	9	9 (7.8)
	Easier to read	4	4 (3.4)
	Paper copy	4	4 (3.4)
	Updated regularly	3	3 (2.6)
	Shorter	2	2 (1.7)
	Question descriptors	1	1 (0.9)
	Age-appropriate questions	1	1 (0.9)
	OVA section	1	1 (0.9)
	Easier access in EMR	23	23 (19.8
	Evaluation of BSP and other EMR tools	14	14 (12.1)
	NA	10	10 (8.6)
	I already use the BSP in my role	8	8 (6.9)
	Child, young person, parent/carer contribution	7	7 (6.0)
	Integrate into workflow	7	7 (6.0)
	Use during daily shifts	2	2 (1.7)
	Review at handover	3	3 (2.6)
	Time	6	6 (5.2)
What would you change about the BSP? (ie additions, improvements, or alterations)		121	115 (100)
	Nothing or not sure	54	54 (47.0)
	Format/content changes	38	38 (33.0)

	Shorten	11	11 (9.6)
	Modify questions	10	10 (8.7)
	Reminders to use, complete, update	4	4 (3.5)
	Change name	2	2 (1.7)
	Include summary section	2	2 (1.7)
	Live document	2	2 (1.7)
	Clear headings	1	1 (0.9)
	Interactive	1	1 (0.9)
	Individual focused	1	1 (0.9)
	Increase awareness	9	9 (7.8)
	Education	5	5 (4.3)
	Promotion	3	3 (2.6)
	Easier to access in EMR	9	9 (7.8)
	Adaptable to different populations	6	6 (5.2)
	Child, young person, parent/carer contribution	5	5 (4.3)
Do you have any final questions or comments that you would like to share?		56	56 (100)
	NA	20	20 (35.7)
	Great/excellent tool	15	15 (26.8)
	Knowledge about who is completing the BSP	4	4 (7.1)
	Staff need to use the BSP more	3	3 (5.4)
	Increase education	3	3 (5.4)
	Parent/carer collaboration	3	3 (5.4)
	Overlap with other tools in EMR	1	1 (1.8)
	The BSP improves health care outcomes	1	1 (1.8)
	Continue development	1	1 (1.8)
	Forget to look for the BSP	1	1 (1.8)
	This survey increased my awareness	1	1 (1.8)
	Link to care plan	1	1 (1.8)
	Not useful	1	1 (1.8)
	Too long	1	1 (1.8)

Frequencies refer to the number of times a concept was mentioned, and n refers to the number of staff members.

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