Failure to recognise and treat clinical deterioration remains a source of serious preventable harm for children in hospitals. Huddles can be a valuable tool in improving situational awareness, however it is important clinicians are speaking the same language when raising concerns over potential patient deterioration. A “Watcher”, is a term used to describe a child who may be at risk of deterioration.

Five risk factors are associated with preventing deterioration, as detailed in studies from Cincinnati Children's Hospital Medical Centre.

- **Family concerns** should always be taken seriously, even if vital signs are normal.
- **High-risk therapies** raise the risk and make the child a potential candidate for deterioration.
- Presence of **observations outside the flags** (including additional Red & Yellow Zone criteria).
- **Watcher/clinician gut feeling** is where any member of staff senses that the child is not right.
- **Concerns about communication** between teams is discussed. This includes the patient, parent or their family.

The identification of children with “Watcher” criteria provides an early opportunity for intervention. Staff can start to plan for a patient’s potential deterioration, rather than having to wait, consult, formulate, and then begin a plan following deterioration.

### Children who are “Watchers” may have the following risk factors:

<table>
<thead>
<tr>
<th>Red Zone criteria in the last 8 hours</th>
<th>Three simultaneous Yellow Zone criteria in the last 8 hours</th>
<th>Altered calling criteria in last 24 hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients on high-risk treatment</td>
<td>Patients with unfamiliar conditions or treatments</td>
<td>Outliers e.g. oncology patients on a general medical ward</td>
</tr>
<tr>
<td>Social concerns</td>
<td>Child protection concerns</td>
<td>Absconding risk</td>
</tr>
<tr>
<td>A member of the team has a ‘gut feeling’ about a patient</td>
<td>Communication concerns with the patient’s care e.g. multiple teams involved in care</td>
<td>Patient or family concern</td>
</tr>
</tbody>
</table>

Reference
Brady et al, Improving Situation Awareness to Reduce Unrecognized Clinical Deterioration and Serious Safety Events. Pediatrics, 2013. 131; e298-e308

**About the Paediatric Patient Safety Program**
The CEC’s Paediatric Patient Safety Program aims to work across a range of areas to improve the quality and safety of health care for children and young people in NSW.

For further information, please visit
http://www.cec.health.nsw.gov.au

To be read in conjunction with the CEC Safety Huddles Implementation Guide.