Companion Special Management Procedure

1. Purpose

The WA Country Health Service (WACHS) South-West is committed to ensuring that decisions about care and the level of patient observation are based on the assessment of the patient's level of risk, and that their safety and well-being and that of others will be safeguarded. This includes ensuring that staffing numbers are adequate for the safe management of all patients.

Specialling is a patient care intervention required for 'at risk' patients due to an identified need for a higher level of care or observation, which may require a change to staffing resources. The clinical condition of the patient will determine the level/type of visual observation and the category of staff required to provide care.

Companion Specials are only implemented in conjunction with appropriate clinical oversight and are not used as stand-alone risk mitigation strategies. There is a requirement for:

- patient safety and well-being
- staff safety
- compliance with trauma-informed principles and person-centred care standards
- legal accountability of observational practice.

The purpose of this procedure is to provide information and define the scope of practice for all staff (clinical and non-clinical) specialling patients to promote safety for all.

Refer to Appendix A: Assessment and Management of Companion Special Flowchart WACHS South-West

2. Procedure

Every inpatient will undergo a comprehensive risk assessment on admission, which will be documented on relevant risk assessment tool and in the patient's integrated notes. Refer to Nursing/Patient Care Plan/Inpatient Management Plan or Patient Admission Assessment and Care Plan, as appropriate to area.

Staff must consider cultural, gender diversity, age, ethical and communication and safety needs and preferences when considering specialling requirements.

For Aboriginal and Torres Strait Islander people, consider contacting the Aboriginal Liaison Officer in the discussions as they can be fully understanding of the situation and can help explain the reasons requiring the "special".

Decisions about the level of patient observation should be based on assessment of the patient's level of risk, their safety and wellbeing, and the safety of others.

The least restrictive form of observation will be applied while still managing for the assessed level of risk and will incorporate trauma-informed care principles.

'At Risk' patients can be identified by members of the multi-disciplinary team (MDT) i.e. Medical, Nursing and/or Allied Health staff both in hours and after hours and either on admission and/or at any time during the patient's stay – e.g. use of shift safety huddles.

'At Risk' patients require an associated management plan with the risk assessment which should include the need and recommendation for a Special. If a companion/special is recommended, then this means it should be commenced. Staff members undertaking specialling are to consider the potential impact of the intervention and take an active role to engage positively whenever possible. Patients (and, with patient consent, family/Personal Support Person/s [PSP]) are to be informed where practicable to support engagement and delivery of person-centred approaches.

The rationale for specialling and an explanation of the level of observation is to be discussed with the patient and next of kin with the patient's consent and documented by the clinician initiating the Special in the patient's Healthcare Record/client management plan (CMP).

Direct patient care, therapeutic interventions provided, physiological/cognitive/mental state is to be recorded in the patient's integrated notes by the patient's nurse. Non-clinical staff are to inform patients allocated nurse of any changes which will then be documented directly into medical records.

When possible, staff will seek to discuss the patient's experience of special observations with them, aiming to make the experience healing and compassionate whenever possible.

Within Mental Health (MH) Inpatient Services all MH admissions will have a Risk Assessment and Management Plan (RAMP) completed.

2.1 Identifying Patients Requiring Increased Levels of Observation

Specialling and closer levels of observation may be required for a patient assessed as at risk of:

- clinical deterioration (physiological/cognitive/mental state)
- known or suspected cognitive impairment, including delirium and/or disengaging from reality
- potential injury to self - e.g. interfering with treatment interventions such as the removal of invasive lines, requiring regular re-orientation and diversion communication
- falls where other falls prevention strategies have been unsuccessful
- going missing/absconding
- self-injury or suicidal ideation
- harm to others
- harm from others
- compromising or breaching their own or others' sexual safety
- behavioural disturbances requiring continuous evaluation and/or de-escalation.

If patient is admitted from Immigration or Custodial Services, they may have guards in place to prevent them absconding from hospital site. The patient may also require a Special to support with mental health and/or physical care needs.

A Special may **not** be required if alternative strategies are implemented to achieve an improved level of safety and significantly lower risk, this may include but is not limited to:

- revised staff-patient allocation
- revised room allocation
- use of family members or carers
- other risk minimisation strategies (e.g. medication, falls/alarm mats, ultra-low beds, known triggers/relievers, safety plan).

Alternative patient management strategies must be clearly documented in the patient's integrated notes/specific care/Clinical Management Plan. If a Special is required for Cognitive Impairment Management refer to WACHS Cognitive Impairment Clinical Practice Standard for additional care and strategies

2.2 Request and Initiation of a 'Companion Special'

A recommendation/request for a Companion Special will be made by a member of the Multi-Disciplinary Team (MDT) and the decision must have the following:

- A Companion Special, Nurse (PCA/AIN/EN/RN) Special must only be initiated alongside a documented clinical assessment and care plan written in the integrated notes, with a clinical rationale/indication provided.
- Be supported by Ward/Unit Leader/Emergency Department Senior Registered Nurse (ED SRN) or After Hours (AH) Clinical Nurse Specialist (CNS) and Medical Officer, following patient review.
- The Companion Special request must be communicated as per site process to BIONIC (BHC), Operation Managers/Executive On-Call for final approval.

In the Emergency Department

Patients requiring a mental health Special in ED are assessed and reviewed periodically (each shift as minimum) by the Mental Health Team (when available) and with senior staff on site. Where practicable, patients requiring mental health Specials will be reviewed by the mental health teams.

Across all WACHS SW sites

The Ward/Unit Leader/ED CN or AH CNS will review the patient in a timely manner, and at **least two (2) hours** prior to shift change time (every 24 hours in Mental Health environment) in order to:

- review the current risk assessment
- consider existing staffing resources /risk minimisation strategies
- determine if a Special is required or not, including assessment of:
  - type and grade of Special required skill mix and experience of staff in regard to Special required
  - level of observation required (ratio of staff to patient, clinical/non-clinical)
  - any modifications to the initial request for a Special
  - other considerations relating to the patient – e.g. sexual safety, gender, ethnicity, religious needs, age and development stage (where practicable)
- document in the patient's integrated notes:
  - the outcome of the patient assessment
  - the determination of the Special with explanation of the reasons including those relating to any modifications to the initial request

- The level of observation required (Refer to Appendix B Visual Observation Procedure).

Within MH Services

Once the level of Special is determined and approved, the Ward/Unit Leader/ED CN or CNS will determine the most appropriate staff member to provide specialling, based on staff skills, knowledge, and experience appropriate to the needs of the patient. Approval must first be obtained from:

- in hours: Clinical Nurse Manager (CNM)
- after hours: BIONIC Hospital Coordinator.

Consider the following:

- Provision of a Special will only be considered if it can be safely provided within the ward setting and will consider existing and projected nursing resources, overall acuity within the unit and the clinical needs of the patient.
- Consideration will be given to a 2:1 (2 staff to 1 patient) Special when required to ensure safety of patient, staff and/or others.
- If additional staff are required, the Ward/Unit Leader or most senior nurse communicates the request for a Special to the On Call Executive Officer and staffing is sourced from elsewhere.

Specials

Specials will be:

- directed to work within their scope of practice (and under the supervision of the RN/Midwife where appropriate)
- orientated to the ward including ward exits, alarms, processes, emergency procedures
- orientated to use of relevant documentation, e.g. visual observation charts, Adult Observation and Response Chart (A-ORC), Companion Leaflet etc. orientated to patient specific management, e.g. diversional strategies
- informed how to escalate identified needs and/or risks and who to inform – e.g. supervising RN/Midwife/Shift Coordinator/NUM/MUM.

2.3 Where a Special Request Cannot be Provided

The patient risk assessment and review in relation to the staffing requirement is to be performed by Shift Coordinator/NUM/MUM/CNM/CNS in a timely manner and at least two hours prior to shift change time in order that adequate nursing or patient support staff can be requested, accessed, and provided.

Where the Special cannot be provided:

- the Shift Coordinator/NUM/MUM/CNM/CNS will escalate to the DON-HSM or delegate and inform the person who had made the initial request
- the staff allocation of patients is to be reviewed and re-allocated to accommodate the needs of the patient to be specialled and the patient acuity/case-mix of the ward and document in the patient's integrated notes.

2.4 Special Request Declined/Special Unavailable

If the request for a Special is not approved, staff are to continue to monitor the patient's condition closely and regularly review risk assessment and effectiveness of risk minimisation strategies. The decision must be clearly documented in the patient's integrated notes including the reasons why the request was declined and by whom. This outcome is to be escalated to the person who had made the initial request or delegate.

2.5 Special Review

Patients who are being specialled will be reviewed by nursing staff every shift and by Medical Staff and the Senior Nurse within 24 hours and at the end of the 24-hour point, or more frequently if required, to determine the ongoing need for the Special. Any Patients who are specialled for longer than 24 hours must be reviewed daily by the Treating Medical Team and discussed with the Consultant. The review and outcome of all reviews must be documented in the patient's medical record.

With regard to the special observation being reviewed, the period of time outlined above is a minimum standard. The situation concerning constant observation can be reviewed and changed at any time providing that the Responsible MO or Nominated Deputy and the Nurse in Charge agree.

Evidence of review and outcomes are required to be documented in the integrated notes. Examples of this include:

- If the special observation is only intended for specific times of day (e.g. not overnight when doors are locked if patient is assessed as at risk of absconding), this must be documented clearly in the patient's integrated notes and medical record by Medical Staff.
- As the patient's condition improves, staff are required to demonstrate there has been no undue delay in revising the patient's observation to the lowest level appropriate.
- Where there has been a marked deterioration in the patient's status, the next of kin/carer will be notified.
- The decision to continue or cease the order for a Special must be documented in the patient's integrated notes.

2.6 Discontinuation of a Special

ATTENTION

After hours: no Special is to be ceased after hours, unless patient at Regional Resource Centre (Bunbury Hospital) or District Site with After Hours (AH) Hospital Coordinator role.

The decision to discontinue a special must be made by the Medical team and NUM/AH Hospital Coordinator.

The NUM/MUM/CNM AH Manager and Medical Officer has the delegated authority to discontinue a non-mental health Special via a collaborative approach following patient reassessment which is to be documented in the patient's integrated notes.

If a Special is no longer required, the following NUM/MUM/CNM/CNS or their delegates must be informed immediately to ensure that any staff booked are cancelled in a timely manner.

2.7 Mental Health Considerations

Patients who are admitted with mental health conditions have additional involvement with the mental health team:

- Patients will have a risk assessment completed on admission to a mental inpatient unit.
- Whilst on the inpatient unit, the patients risk assessment will be reviewed and updated whenever there is a changed in the current risk level.
- Mental Health Specials in general health areas require consultation with mental health staff and speciality treating teams before the removal of the Special.
- Patients requiring a mental health Special in ED are assessed and reviewed periodically (each shift as minimum) by the Acute Psychiatry Team with Liaison with Medical Staff and ED Senior Nurse.
- Where practicable, patients requiring mental health Specials will be reviewed by the mental health on call teams.

The specialling staff member will remain as close as required by the level of observation determined at the initiation of the special (Appendix B Vital Observations Procedure). Any deviation from the prescribed/agreed level of observation is done in consultation and under direction of the clinical team as the need to maintain safety will be prioritised.

The patient may attend ward programs in the company of the special if deemed appropriate by the treating team and therapy facilitator.

In line with trauma informed care principles, when requesting a special, consideration will be given to the patient's gender, ethnicity, religious and cultural needs and the patient's age and developmental stage.

For further information, refer to the Statewide Standardised Clinical Documentation (SSCD) Resources

3. Roles and Responsibilities

The **Assistant in Nursing/Patient Care Assistant/Patient Service Assistant Special** is utilised for a physiologically **stable** patient (often for patients with cognitive impairment) requiring close observation and provision of essential/general nursing care under the direction and supervision of the RN/Midwife.
The AIN/PCA/PSA Special is responsible for:

- assisting with activities of daily living and general/essential nursing care
- providing continuous visual observation
- regular re-orientation and diversion communication assisting with patient management and safety
- implementing strategies agreed at an MDT level to address identified risks
- escalating any concerns to overseeing Nurse.

The **Nurse Special** (Enrolled Nurse, Registered Nurse or Midwife) required for the care of a physiologically or cognitively impaired patient with high acuity/complex care requirements is responsible for:

- assisting with activities of daily living and general/essential nursing care
- providing continuous visual observation
- frequent recording and interpretation of physiological/cognitive observations (hourly or more frequent)
- implementation of very demanding or frequent variations in treatment/care and updating care-plans
- the need for frequent de-escalation of behaviours.
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Security Contractors

Where a consumer has been risk assessed and is demonstrating aggressive behaviour, a security contractor may be engaged to assist. Their involvement must be part of an ongoing clinical risk assessment process and should be treated as a temporary, risk-based measure. Strategies must be prioritised to transition to a more appropriate companion or support option as soon as it is safe to do so.

Security contractors must operate under the direction of the supervising clinician and provide safety support for patients demonstrating aggressive behaviour or a risk of absconding. They must not undertake clinical tasks, must not act as the sole staff member present, and must immediately escalate any concerns to the allocated nurse responsible for the patient's care.

The use of security contractors must also be documented within the patient's care plan and regularly reviewed to ensure it remains necessary and appropriate.

The **Mental Health Nurse Special (**Registered Nurse or Registered Mental health Nurse are responsible for providing all aspects of care including:

- specific assessment and management of acute/complex mental illness for mental health/behavioural issues requiring continuous evaluation, de-escalation and/or very challenging behaviours
- attending to patients' physical needs while working within scope of practice.

All staff are required to comply with the directions in WACHS policies and procedures as per their roles and responsibilities. Guidelines are the recommended course of action for WACHS and staff are expected to use this information to guide practice. If staff are unsure which policies procedures and guidelines apply to their role or scope of practice, and/or are unsure of the application of directions they should consult their manager in the first instance.

4. Monitoring and Evaluation

Incident Reporting across all WACHS SW sites:

- Any identified risks of aggression or self-injury are to be documented in the patient integrated notes and reflected in the relevant care plan and alerted as per Service protocol
- Any incidents are to be documented in the DATIX Clinical Incident Monitoring System (CIMS) by relevant clinician/supervising RN where appropriate.
- Monitoring of compliance with this document is to be carried out by individual sites as requested

5. References

We acknowledge the previous site endorsed work and contributors used to compile this document, Royal Perth Hospital, Bentley Hospital Rockingham/Peel Hospital:

Government of Western Australia East Metropolitan Health Service [Intranet] Specialling Management for Inpatients Policy. Royal Perth Bentley Group. July 2019.
Government of Western Australia South Metropolitan Health Service [Intranet] Specialling or requesting additional staffing for specialling of patients in inpatient areas policy and procedure. Rockingham Peel Group Corporate Manual. June 2020.

6. Definitions

Term	Definition
Aboriginal	Within Western Australia, the term Aboriginal is used in preference to Aboriginal and Torres Strait Islander, in recognition that Aboriginal people are the original inhabitants of Western Australia. No disrespect is intended to our Torres Strait Islander colleagues and community.
At Risk	At Risk refers to Aa patient whose physiological condition/cognitive and/or mental state is deemed to put them at high risk of clinical deterioration, being unsafe and/or experiencing an adverse event (actual or potential harm).
Clinically Stable Patient	A clinically stable patient is Aa patient with vital signs within Adult Observation and Response Chart (AORC)/Maternity Adult Observation and Response Chart documented parameters with low to no risk of physiological/cognitive/mental state deterioration.
Clinically Unstable Patient	A clinically unstable patient is Aa patient with vital signs outside AORC/MORC documented parameters with high risk of physiological/ cognitive/mental state deterioration.
Companion	A companion is Aan Assistant in Nursing (AIN)/Patient Care Assistant (PCA)/Patient Service Assistant (PSA) or approved WACHS SW volunteer employed to provide care which does not require an EN/RN skill set.
Complex Care	Complex care is the provision of high level and/ or frequent nursing care requiring defined skills, knowledge and/or experience appropriate for the patient's condition and/ or treatment interventions.
Indicators of Deterioration in Mental State	Indicators of deterioration in Mental State include: • reported change for the worse, • distress • loss of touch with reality or consequence of behavior's • loss of function • elevated risk to self, others, or property (ACHS 2018)

Nurse Special	A Registered Nurse, Enrolled Nurse, or Assistant in Nursing employed to provide close visual observation and/or physical proximity to prevent/reduce risk and/or manage a possible adverse event and to assist in the provision of total patient care within their scope of practice and classification and as outlined in this policy. The special is accountable to the unit manager or delegate in which they are allocated.
Specialling	A special is a designated staff member that is allocated to provide a close level of observation and care for a defined period of time. There may be circumstances where the ratio of staff to patient will vary - this will be addressed on an individual basis following clinical assessment. Students may not undertake the role of a Special.
Security Contractors	Security Contractors must operate under the direction of the supervising clinician and provide safety support for patients demonstrating aggressive behaviour or a risk of absconding.
Trauma-Informed Care Principles	The guiding trauma-informed care principles are safety, choice, collaboration, trustworthiness, and empowerment. Ensuring that the physical and emotional safety of an individual is addressed is the first important step to providing trauma-informed care.
Ward/Unit Leader	Ward/Unit Leaders include Ward/Unit based Senior Registered Nurse/Nurse Unit Manager/Midwifery Unit Manager and /Clinical Nurse Manager After Hours.
Mental Health Team	A Mental Health Team can include Mental Health liaison nurse working in emergency departments or consultation liaison roles; consultant psychiatrist; Senior Medical practitioners, Psychiatry Registrars. This may mean the home team or Emergency Telehealth Service Mental Health

7. Document Summary

Coverage	WACHS South-West
Audience	Shift Coordinators, Security Supervisors, Nurse Unit Managers, after-hour Managers and Medical Teams
Records Management	Non Clinical: Corporate Recordkeeping Compliance Policy Clinical: Health Record Management Policy
Related Legislation	*Mental Health Act 2014* (WA)
Related Mandatory Policies / Frameworks	• MP0095/18 Clinical Handover Policy • MP 0181/24 Safety Planning for Mental Health Consumers Policy • Clinical Governance Safety and Quality Framework
Related WACHS Policy Documents	• Clinical Observations and Assessment (Physiological, Neurovascular, Neurological and Fluid Balance) Clinical Practice Standard • Cognitive Impairment Clinical Practice Standard • Falls Prevention and Management Clinical Practice Standard • Medication Prescribing and Administration Policy • Security Risk Management Policy • Recognising and Responding to Acute Deterioration (RRAD) Policy • Restraint Minimisation Policy
Other Related Documents	• DoH Statewide Standardised Clinical Documentation (SSCD) Resources • DoH Post Fall Multidisciplinary Management Guidelines for WA Health Care Settings 2023 • Management of Agitation in Older Adults with Dementia or Delirium • Nursing/Midwifery Shift to Shift Bedside Clinical Handover Flowchart • Requesting Additional Security Personnel Procedure Flowchart – Bunbury Hospital
Related Forms	• ZMR120B WACHS-SW Cognitive Care Chart • MR111 WACHS Nursing Admission, Screening and Assessment Tool - Adults • MR111P WACHS Paediatric Nursing Admission, Screening – Discharge Assessment Form • MR120 WACHS Adult Nursing Care Plan • MR120P WACHS Paediatric Nursing Care Plan • MR12 WACHS Emergency Department Procedural Sedation Record • MR12A WACHS Sedation Assessment Tool • MR140A Adult Observation & Response Chart • MR46 WACHS Suicide Risk Assessment and Safety Plan • MR147 WACHS Adult Neurological Chart

	• MR147A WACHS Paediatric Neurological Observation Chart • MR521 Falls Risk Assessment and Management Plan (FRAMP) • MR521P Paediatric Falls Risk Assessment Tool • MR66.4 WACHS Abbreviated Mental Test Score • MR66.3 Mini Mental State Examination • MR66.6 WACHS Montreal Cognitive Assessment Test 1 • MR170.8 WA Agitation and Arousal PRN Chart • RC13 WACHS Behaviour Assessment • RC21 WACHS Sleep Assessment • RC43 WACHS Restraint Chart • RC44 Restraint Chart
Related Training	Nil
Aboriginal Health Impact Statement Declaration (ISD)	ISD Record ID: 4692
National Safety and Quality Health Service (NSQHS) Standards	1.6,1.10, 1.25, 8.1, 8.5, 8.6, 8.13
Aged Care Quality Standards	Nil
Chief Psychiatrist's Standards for Clinical Care	Nil
Other Standards	Nil

8. Document Control

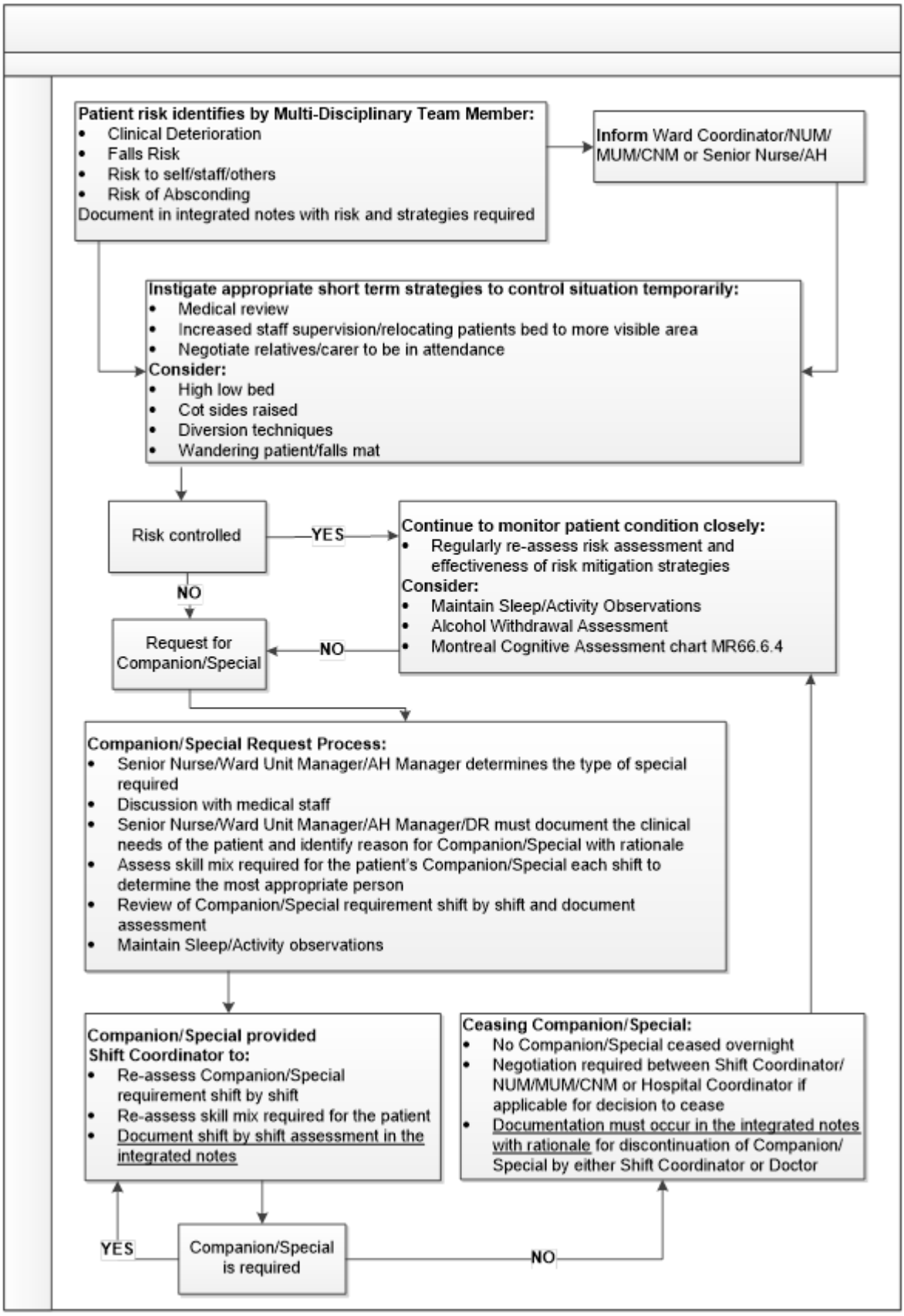
Version	Published date	Current from	Summary of changes
2.00	4 December 2025	4 December 2025	• information added in relation to clinical oversight and cognitive impairment • change to process for discontinuation of special after hours • update to role of security support officers special

9. Approval

Policy Owner	Executive Director South West
Co-approver	Executive Director Clinical Excellence Executive Director Nursing and Midwifery Services
Contact	Regional Nurse Educator WACHS SW
Business Unit	Regional Director Nursing & Midwifery WACHS SW
EDRMS #	ED-CO-20-48477

This document can be made available in alternative formats on request.

Appendix A: Assessment and Management of Companion Special Flowchart



Appendix B: Visual Observation Procedure

Level of Observation	Description
Level 1 **1:1 Observations**	Minimum of one (1) designated nurse to be always within arm's reach of the patient. On specified occasions more than one member of staff may be necessary. Ward Coordinator to allocate designated staff. A record of patient's whereabouts, what they are doing and their respiration rate (if lying down or resting) should be recorded, and signed by staff at 15 minutes intervals, using appropriate form Positive engagement with the patient is an essential aspect of this level of observation Publication Register Database (PRD) MR MH 406A
Level 2 **1:1 Observations**	The patient should be always kept within eyesight and accessible. If deemed necessary, any tools or instruments that could be used to harm themselves or others should be removed. The patient's risk management plan should include a review of the physical environment and/or strategies to maximise safety. Ward co-ordinator to allocate one (1) designated nurse to always keep the patient within eyesight. A record of patient's whereabouts, what they are doing and their respiration rate (if lying down or resting) should be recorded and signed by staff at 15 minutes intervals using the appropriate form. Publication Register Database (PRD) MR MH 406A
Level 3 **Intermittent Observations**	The decision to determine the frequency of observations will be determined by nursing and medical staff and documented in the patient's case file. A nurse can determine any increase in requirement for observations (e.g. from 30 to 15 minutes) and must then document their reasons for doing so in the patient's health record and inform the treating team. The nurse will record and sign (to indicate) where the patient is, what they are doing and their respiration rate (if lying down or resting) at required intervals. Publication Register Database (PRD) MR MH 905F
Level 4 **General Observations**	This is the minimum acceptable level of observation, for all patients. Staff should be aware of the location of all patients for whom they are responsible, but not all patients need to be kept within sight. Safety and security checks should be carried out at specified times of day and include observation for signs of life (e.g. respirations) when patient is asleep or lying down. At least once per shift the allocated nurse should sit down and talk with each patient to assess mental state, and this should be recorded in the nursing notes. The nurse in charge/named/associate nurse will be responsible for ensuring that patient is made aware of the need to inform the nursing team when leaving and returning to the ward. Publication Register Database (PRD) MR MH 406H