Companion / Special Inpatient Management Procedure

1. Guiding Principles

Effective: 17 September 2020

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.

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

WACHS South West is committed to ensuring that decisions about care and the level of patient observations are based on a risk assessment of the patient, staffing and the environment.

- Refer to Appendix1: Assessment and Management of Companion/ Specials 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.

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/PSP 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 patients 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 - which may include but are 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.

2.2 Request and Initiation of a 'Companion/Special'

A recommendation/request for a Special will be made by a member of the Multi Disiplinary Team (MDT) and the decision must:

- Be documented in the patient's integrated notes.
- If a Special is required for behavioural management commence Agitation and Arousal Chart (as applicable to area).
- Include indication(s) for a Special.
- Be supported by Ward/Unit Leader/Emergency Department Senior Registered Nurse (ED SRN) or After Hours (AH) Clinical Nurse Specialist (CNS) following patient review.
- Be reviewed each shift (at least 2 hours prior to shift change).

- **In the Emergency Department**
    - 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.

- **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 **(every 24 hours in Mental Health Environment)** prior to shift change time 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 regards 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.

- **Within MH Services**
  - Once the level of Special is determined and approved, the Ward/Unit Leader/ED CNor AH 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.
  - Provision of a Special will only be considered if it can be safely provided within the ward setting and will take into account 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.
  - Approval must first be obtained from: In hours: Nurse Unit Manager (NUM) / Maternity Unit Manager (MUM) / Clinical Nurse Manager (CNM) / Coordinator of Nursing (CON). After hours: the CON/District Manager (DM). Who will discuss with other members of the executive team.

- **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 (include CNS)

The patient risk assessment and review in relation to the staffing requirement is to be performed by Shift Coordinator / NUM / MUM / CNM 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 CON/DM 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.
- 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.
- 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.
- The review and outcome of all reviews must be documented in the patient's medical record.
- 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

After hours: No Special is to be ceased after hours.
A decision must be made by the Medical Team / NUM / MUM / CNM / CNM AH

- The NUM / MUM / CNM AH Manager 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.
- Mental Health Specials in general health areas require consultation with mental health staff and speciality treating teams before the removal of the Special.

- 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 – Refer: Statewide Standardised Clinical Documentation (SSCD) Resources

- All 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.

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.

2.8 Emergency Department Considerations

- 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.

3. Definitions

At Risk	A 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 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 patient with vital signs outside AORC/MORC documented parameters with high risk of physiological/ cognitive/mental state deterioration
Companion	An 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	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	Reported change for the worse, Distress Loss of touch with reality or consequence of behaviours Loss of function Elevated risk to self, others or property (ACHS 2018)
MET/ MER	Medical Emergency Team / Medical Emergency Review
Special (Note: the term 'Companion' is integrated within the term 'Special' within this document)	A Registered Nurse, Enrolled Nurse, Assistant in Nursing or Patient Care Assistant 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 designated staff member 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 Special	Security are employed for patients who are assessed to be at risk of absconding, aggression or deliberate self-injury, and/or requiring close observation and actual or potential preventative actions. Security specials are only to be used in addition to appropriate clinical supervision.
Trauma-Informed Care Principles	The guiding 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
Variations of Specialling	Staff:Patient Ratio 2:1 1:1 1:2 1: Room
Ward / Unit Leader	Ward/Unit based Senior Registered Nurse / Nurse Unit Manager / Midwifery Unit Manager / Clinical Nurse Manager After Hours

4. Roles and Responsibilities

AIN/PCA Special

AIN/PCA/PSA 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 which includes:

- Assistance with activities of daily living and general/essential nursing care
- 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.

Nurse Special

RN/Registered Midwife or EN required for the care of a physiologically or cognitively impaired patient with high acuity / complex care requirements which include:

- 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.
- The need for frequent de-escalation of behaviours.

Mental Health Nurse Special

Registered Mental Health Nurse or Comprehensive Nurse (i.e. with general and mental health competencies) required for 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.

Mental Health Special – Security

Security are employed for patients who are assessed to be at risk of absconding, aggression or deliberate self-injury, and/or requiring close observation and actual or potential preventative actions. Security are not involved in Clinical Observations or Clinical decision making. The treating team is responsible for the Clinical care. Security are governed by the CN/CNS/NUM. Security specials are only to be used in addition to appropriate clinical supervision.

The specialling staff member will remain as close as required by the level of observation determined at the initiation of the special.

When the patient is toileting or showering their need for safety and privacy may conflict. Interventions such as *'hearing'* rather than *'seeing'* the patient and will be considered for brief periods allowing the patient a degree of privacy. However concessions to the patient need for privacy will always be restricted by the need to maintain safety.

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

5. Compliance

Failure to comply with this policy document may constitute a breach of the WA Health Code of Conduct (Code). The Code is part of the Integrity Policy Framework issued pursuant to section 26 of the *Health Services Act 2016* (WA) and is binding on all WACHS staff which for this purpose includes trainees, students, volunteers,

researchers, contractors for service (including all visiting health professionals and agency staff) and persons delivering training or education within WACHS.

WACHS staff are reminded that compliance with all policies is mandatory.

All Staff are required to work within policies and guidelines to make sure that WACHS is a safe, equitable and positive place to be.

6. Records Management

All WACHS clinical records must be managed in accordance with Health Record Management Policy.

7. Clinical Incidents 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 (e.g. PSOLIS)
- 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

8. Standards

National Safety and Quality Health Service Standards: 1.32. 2.6, 5.7; 5.8; 5.10; 5.11; 5.24; 5.29-5.35, 6.4, 8.4-8.6

9. Legislation

Mental Health Act 2014 (WA)

10. References

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

1. Government of Western Australia East Metropolitan Health Service [Intranet] Specialling Management for Inpatients Policy. Royal Perth Bentley Group. July 2019.
2. 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.

11. Related Forms

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
Adult Mental Health Risk Assessment and Management Plan
Adult Mental Health Assessment
Adult Mental health Physical Examination
Adult Mental Health Physical Appearance
Adult Mental Health Transfer Summary
Child and Adolescent Mental Health Service Risk Assessment and Management Plan (or A4 version)
Child and Adolescent Mental Health Service Initial Assessment (or A4 version)
Child and Adolescent Mental Health Service Physical Examination
Child and Adolescent Mental Health Service Care Transfer Summary

12. Related Policy Documents

WACHS Clinical Escalation and of Acute Physiological Deterioration including Medical Emergency Response Policy
WACHS Clinical Observations and Assessment (Physiological, Neurovascular, Neurological and Fluid Balance) Clinical Practice Standard
WACHS Cognitive Impairment Clinical Practice Standard
WACHS Disturbed Behaviour Management Clinical Practice Standard
WACHS Falls Prevention and Management Clinical Practice Standard
WACHS Medication Administration Policy
WACHS Nursing/Midwifery Shift to Shift Bedside Clinical Handover Flowchart
WACHS Security Risk Management Policy

WACHS South West Requesting Additional Security Personnel Procedure Flowchart – Bunbury Hospital

WACHS Restraint Minimisation Policy

Department of Health Statewide Clinical Documentation (SSCD) Mental Health Resources

13. Related WA Health System Policies

MP0095/18 Clinical Handover Policy

MP0101/18 Clinical Care of People with Mental Health Problems Who May Be At Risk of Becoming Violent or Aggressive Policy

WA Clinical Handover Guideline 2018

WA Health Post Fall Multidisciplinary Management Guidelines for WA Health Care Settings 2018

Principles and best practice for the clinical care of people who may be at risk of becoming violent or aggressive

Department of Health Triage to Discharge SSCD Guidelines

14. Policy Framework

Clinical Governance Safety & Quality

15. Appendices

Appendix 1: Assessment and Management of Companion/ Specials Flowchart

Appendix 2: Mental Health Inpatient: Visual Observation Procedure

This document can be made available in alternative formats on request for a person with a disability

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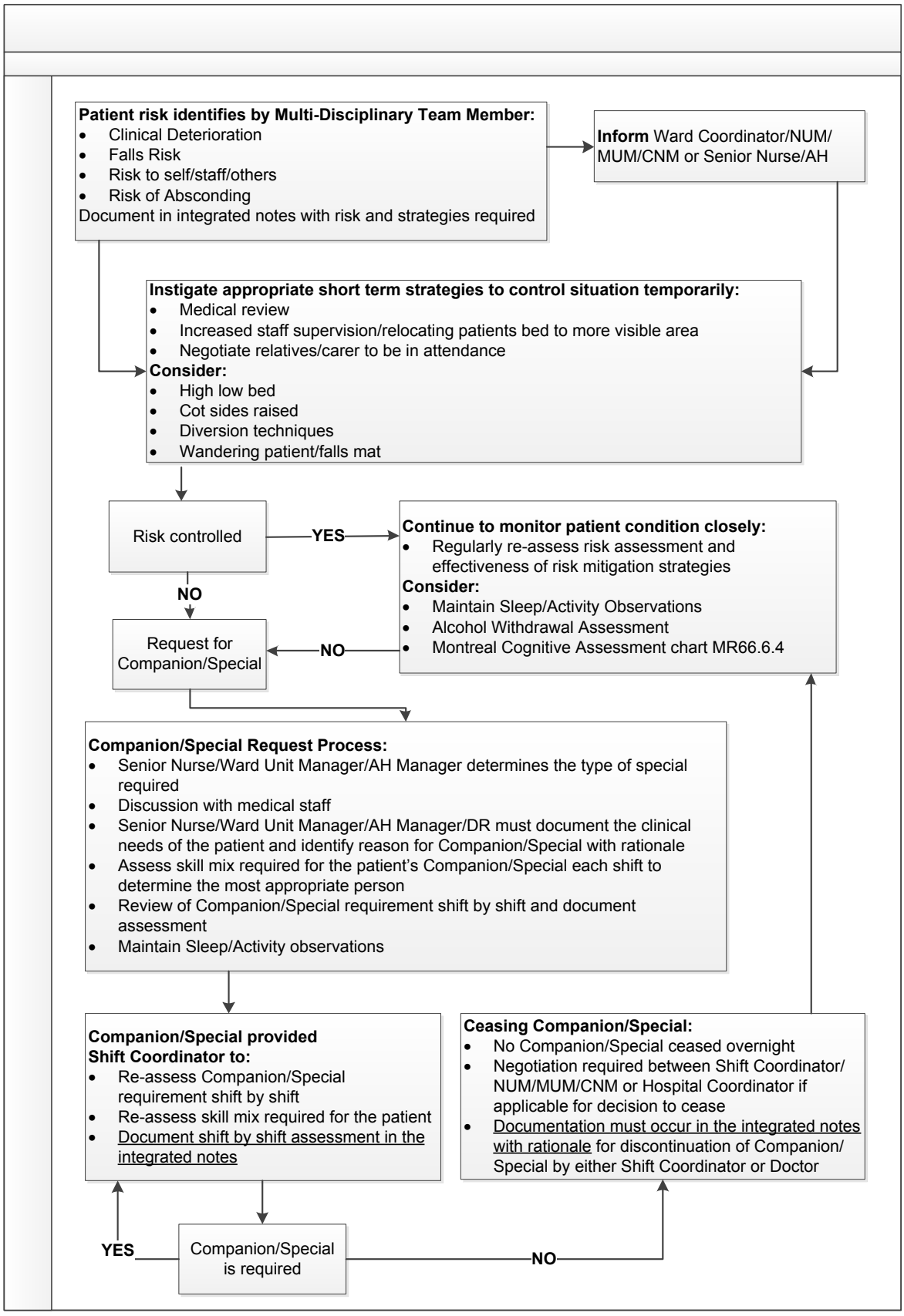
Appendix 1: Assessment and Management of Companion/ Specials Flowchart



Appendix 2: Mental Health Inpatient: Visual Observation Procedure

Level of Observation	Description
Level 1 **1:1 Observations**	Minimum of 1 designated nurse to be within arm's reach of the patient at all times. 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 kept within eyesight and accessible at all times. 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 1 designated nurse to keep the patient within eyesight at all times. 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 (eg 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 are made aware of the need to inform the nursing team when leaving and returning to the ward. Publication Register Database (PRD) MR MH 406H