

SPECIALLING: INCREASING LEVEL OF NURSING CARE FOR PATIENTS REQUIRING HIGHER LEVELS OF CLINICAL CARE OR GENERAL SUPERVISION PRACTICE GUIDELINE®

DOCUMENT SUMMARY/KEY POINTS

Note: This document is limited to the increased nursing care requirements for patients due to their clinical condition or the fact that they are at risk from a safety perspective. Increased nursing care requirements required for patients with psychiatric diagnoses is governed by the [Engagement and Observation in Mental Health Inpatient Units Policy: PD2017_025](#)

- A decision to change the level of nursing care is made when a patient's clinical or physical safety risk exceeds the normal observation requirements of standard nursing care provision.
- A patient may also require increased nursing care in line with ward/unit specific procedure or policy.
- Nursing and medical staff must plan the management collaboratively and document this in the clinical progress notes. This plan must incorporate the level of nursing care required in order to facilitate safe care. Approval needs to be sought from the site Director of Nursing (DoN) or After Hours Nurse Manager (AHNM).
- When the staff allocated to support care is an Enrolled Nurse (EN), Assistant in Nursing (AIN) or Undergraduate AINs Registered Nurse (RN) retains ultimate responsibility for the patient's care and must be allocated to oversee the management.
- Review of the patient's condition and the need to continue to provide an increased level of care must be undertaken on each shift by a senior medical officer (when medically initiated) the Nursing Unit Manager (NUM) or delegate.
- An increased level of nursing care required for clinical acuity is termed 'clinical specialling' and should be fulfilled by an EN or RN.
- An increased level of nursing care required for safety reasons is termed 'general supervision' and this can be fulfilled by an AIN, EN or RN.
- This document does not pertain to ventilated patients outside of ICU who require 1:1 care by an accredited carer or ventilator competent RN/EN or Long Term Ventilation Unit (LTVU) AIN.

This document reflects what is currently regarded as safe practice. However, as in any clinical situation, there may be factors which cannot be covered by a single set of guidelines. This document does not replace the need for the application of clinical judgement to each individual presentation.

Approved by:	SCHN Policy, Procedure and Guideline Committee	
Date Effective:	1 st September 2020	Review Period: 3 years
Team Leader:	Director of Nursing	Area/Dept: Nursing - CHW

CHANGE SUMMARY

- New Network guideline: replaces One to One (1:1) Nursing Care of Patient (Specialling) – CHW Policy and High Acuity Patients - SCH
- Development of Risk Assessment Algorithm to support decision making
- Policy updates added

READ ACKNOWLEDGEMENT

- Medical and Nursing staff working in clinical areas should read and acknowledge this document.

TABLE OF CONTENTS

Rationale/ Background	3
Statement of Intent.....	3
Deteriorating patient	3
Definition of Terms.....	4
Increased Nursing Care Requirements – General Principles	5
The Nurse Providing Care	6
References	6
Appendix 1: SPOC chart zone guidance	7
Appendix 2: Risk Assessment Algorithm	8
Appendix 3: Sample Specialling form	10

Rationale/ Background

An increase in the level of nursing care is at times required in order to facilitate a more intensive level of nursing care and ensure that risk to the patient is managed. Patients may require a more resource intensive model of care for reasons that are clinical in nature such as deterioration in their clinical condition or the implementation of a form of treatment for which there is a mandated increase in the level of nursing care required.

Statement of Intent

This document is intended to direct the care provided to children and young people with medical and behavioural concerns that require close observation, supervision and/or high intensity nursing care to ensure the patient's safety and medical stability. This document does not cover the care of children with mental health conditions.

Clinical specials initiated by a medical officer MUST be documented with reasons in the notes, the Admitting Medical Officer (AMO) notified, and the patient is to be reviewed by a medical officer at least every 8 hours.

Deteriorating patient

Nursing staff **MUST** follow the local Clinical Emergency Response System (CERS) escalation policy for any patient who is clinically deteriorating and whose observations fall outside the normal range, where an Altered Calling Criteria Order is not in place and valid.

Appendix 1 outlines suggested response for observations breaching the various zones as indicated on Standard Paediatric Observation Charts (SPOC).

Further information can be found in the [NSW Recognition and Management of a Patient Who is Clinically Deteriorating Policy 2013_049](#) and [SCHN Between the Flags – Emergency Response System Procedure 2013-7058](#)

Definition of Terms

Clinical Specialling	General Supervision	Mental Health Special
<p>A patient requires an increased level of nursing care due to clinical acuity.</p> <p>This care must be provided by a suitably experienced/accredited EN or RN.</p> <p>This includes but is not limited to patients who are:</p> <ul style="list-style-type: none"> • Clinically unstable • Undergoing treatment for which policy mandates that a specified higher level of nursing care is required. e.g. a midazolam infusion Initiated by medical officer 	<p>Patient requiring supervision to minimise risk to self and/or others due to pre-morbid condition related to behaviour.</p> <p>This care can be provided by an RN, EN or AIN.</p> <p>It is important to consider the skill level required.</p> <p>This includes, but is not limited to patients who:</p> <ul style="list-style-type: none"> • Are at risk of falling out of bed (PRAT) • Require significant support with normal daily activities • At risk of wandering or absconding • Have behavioural patterns associated with intellectual disability 	<ul style="list-style-type: none"> • A young person who under the care of the mental health team in hospital and their level of observation is prescribed by treating psychiatrist. See Engagement and Observation in Mental Health inpatient units PD 2017_025 • Nurse initiated special for young person whom is or is not yet known to mental health team who presents with an acute risk to self or others in context of their mental state. This is covered by the Engagement and Observation in Mental Health inpatient units PD 2017_025 • Mental health skill set special: Child or Young person requires a RN with specialist skills in areas of emotional regulation and/or behaviour support. This type of request does not require review by psychiatrist, rather the allocation occurs following clear team agreement with

Note: This list is not exhaustive and each case must be considered on an individual basis.

If any patient is identified as requiring an increased level of nursing care, the decision **must be** reviewed at a minimum every 24 hours. This should be undertaken by the Nursing Unit Manager or delegate. Document in the patients Powerchart record in Adhoc Charting/Inpatient Forms/Daily Special Review and Request

Increased Nursing Care Requirements – General Principles

- A decision is made by the medical officer, Nursing Unit Manager/Nurse Manager (NUM/NM) or delegate that a patient requires an increased level of nursing care based on the patient's clinical condition and/or safety issues. This decision and reasons are documented in the medical records and the Admitting Medical Officer (AMO) informed.
- The Risk Assessment Algorithm (Appendix 2) can be used as a tool to support this decision and assist in identifying the type of nurse required.
- A medically initiated increase in level of nursing care MUST include minimum level of observations if it is outside the normal parameters of the SPOC charts. AMO must be made aware and approve medically initiated requests.
- A review of the ward activity and staffing to be undertaken by the NUM/ delegate. Can a change in the nurse patient allocation be achieved by a reallocation of workload?
- Consideration of the location of the patient within the ward.
- Approval to increase the level of nursing care must be sought from the Director of Nursing (DoN) or After Hours Nurse Manager (AHNM). (Quick start is available [here](#) for online approval).
- The AHNM must email the NUM, NM, Patient Flow Manager, DoN and the CPD of the increase in nursing care requirements after hours. Discussion should occur regarding strategies to resource the management plan which may include review of current patient allocation, additional staffing, delaying admissions, or reducing bed availability.
- Reducing bed availability (capping beds) due to specialling requires the authorisation of the site Director of Nursing in hours or the AHNM in consultation with the Executive On-Call (where reasonable).
- A Daily Specialling Form must be completed once a patient has been identified as requiring a special and then every day following until it is no longer required (form can be found in Powerchart under Ad Hoc Charting, inpatient forms – Appendix 3). (Quick start available [here](#)).
- **Note:** If *no* extra staff are available a risk assessment is to be performed and documented. Prioritisation of workload is carried out and an increased level of care provided from within the existing team. Escalate information up to DoN, CPD and / or AHNM as required.
- **The team leader MUST ensure that the member of staff providing care:**
 - Receives handover on the patient's condition, including a summary of concerns and risk factors. Is clear about increased patient needs – ie observations
 - Has meal breaks during the shift
 - Is aware of how to call for help using the emergency buzzer
 - Receives support and assistance from other members of the team
 - Has all of the necessary equipment, including play/hygiene etc. required for the provision of care available in the patient's room

The Nurse Providing Care

- The nurse providing care is responsible for the provision of all care required for the patient in partnership with the patient's carer.
- All care and observations are to be documented.
- If the patient's condition changes and requirements change, the nurse providing care should inform the team leader and escalate care appropriately.
- The nurse providing care must be aware of any restrictions or requirements related to the patient leaving the ward or unit. Permission to leave the ward **MUST** be clearly documented in the clinical notes.

Note: The team leader must always be informed that the nurse and patient are leaving the ward, and when they return.

- Patients requiring general supervision should be observed at all times.

References

1. Engagement and observation in mental health units. PD2017_025, NSW Health 2017
2. Recognition and Management of a Patient who is Clinically Deteriorating PD2013_049, NSW Health 2013
3. SCHN Between the Flags – Clinical Emergency Response System 2013-7058

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Appendix 1: SPOC chart zone guidance

REFER TO YOUR LOCAL CLINICAL EMERGENCY RESPONSE SYSTEM (CERS) PROTOCOL FOR INSTRUCTIONS ON HOW TO MAKE A CALL TO ESCALATE CARE FOR YOUR PATIENT

CHECK THE HEALTH CARE RECORD FOR AN END OF LIFE CARE PLAN WHICH MAY ALTER THE MANAGEMENT OF YOUR PATIENT

Blue Zone Response

IF YOUR PATIENT HAS ANY BLUE ZONE OBSERVATIONS YOU MUST

1. Initiate appropriate clinical care
2. Increase the frequency of observations, as indicated by your patient's condition
3. Manage anxiety, pain and review oxygenation in consultation with the **NURSE IN CHARGE**
4. You can make a call to escalate the care of your patient at any time if you are worried or unsure whether to call

Consider the following:

1. What is usual for your patient and are there documented 'ALTERATIONS TO CALLING CRITERIA'?
2. Does the abnormal observation reflect deterioration in your patient?
3. Is there an adverse trend in observations?

Yellow Zone Response

IF YOUR PATIENT HAS ANY YELLOW ZONE OBSERVATIONS OR ADDITIONAL CRITERIA* YOU MUST

1. Initiate appropriate clinical care
2. Repeat and increase the frequency of observations, as indicated by your patient's condition
3. Consult promptly with the **NURSE IN CHARGE** to decide whether a **CLINICAL REVIEW** (or other CERS) call should be made

Consider the following:

- What is usual for your patient and are there documented 'ALTERATIONS TO CALLING CRITERIA'?
- Does the trend in observations suggest deterioration?
- Is there more than one Yellow Zone observation or additional criteria?
- Are you concerned about your patient?

IF A CLINICAL REVIEW IS CALLED:

1. Reassess your patient and escalate according to your local CERS if the call is not attended within 30 minutes or you are becoming more concerned
2. Document an A-G assessment, reason for escalation, treatment and outcome in your patient's health care record
3. Inform the Attending Medical Officer that a call was made as soon as it is practicable

***Additional YELLOW ZONE Criteria**

<ul style="list-style-type: none"> • Increasing oxygen requirement • Poor peripheral circulation • Greater than expected fluid loss • Reduced urine output or anuria (< 1mL/kg/hr) 	<ul style="list-style-type: none"> • Altered mental state: Agitation, Combative or Inconsolable • New, increasing or uncontrolled pain • New onset of fever > 38.5°C • BGL 2-3mmol/L • Concern by you or any staff or family member
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CONSIDER IF YOUR PATIENT'S DETERIORATION COULD BE DUE TO SEPSIS, DEHYDRATION / HYPOVOLAEMIA / HAEMORRHAGE, OR AN OVERDOSE / OVER SEDATION

Red Zone Response

IF YOUR PATIENT HAS ANY RED ZONE OBSERVATIONS OR ADDITIONAL CRITERIA# YOU MUST CALL FOR A RAPID RESPONSE (as per local CERS) AND

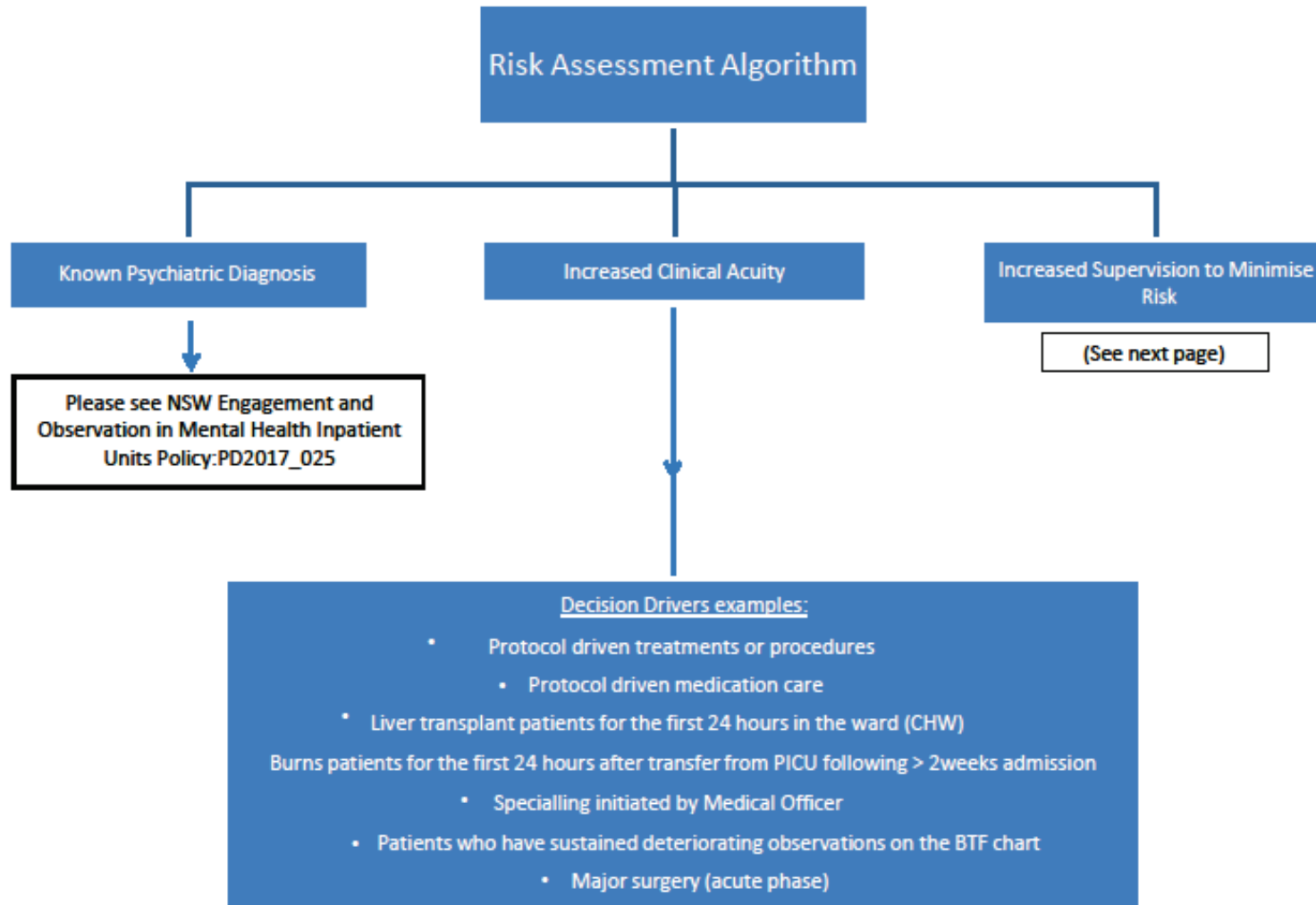
1. Initiate appropriate clinical care
2. Inform the **NURSE IN CHARGE** that you have called for a Rapid Response
3. Repeat and increase the frequency of observations, as indicated by your patient's condition
4. Document an A-G assessment, reason for escalation, treatment and outcome in your patient's health care record
5. Inform the Attending Medical Officer that a call was made as soon as it is practicable

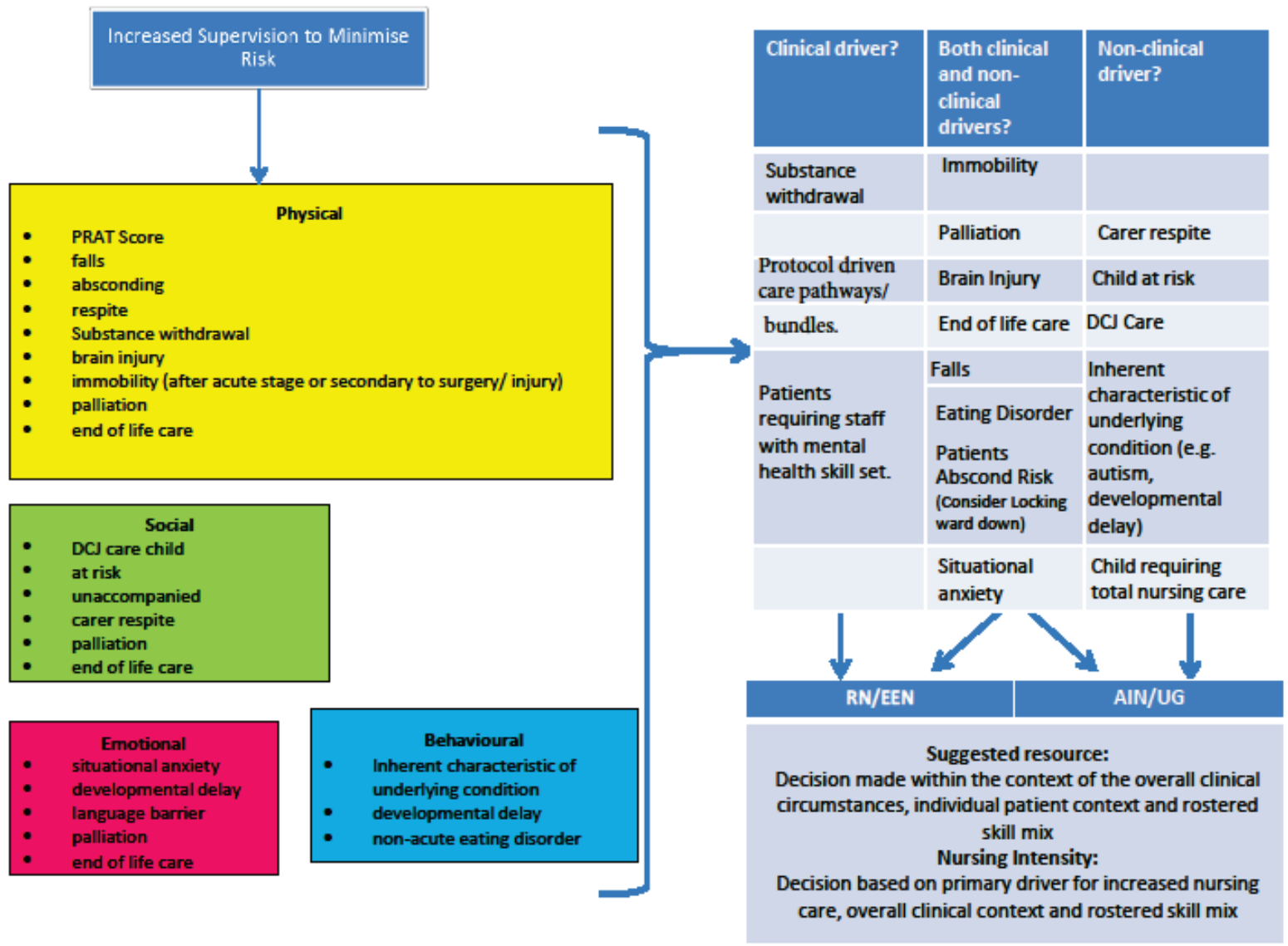
#Additional RED ZONE Criteria

<ul style="list-style-type: none"> • Cardiac or respiratory arrest • Circulatory collapse • Patient unresponsive • New onset of stridor • Deterioration not reversed within 1 hour of Clinical Review • 3 or more simultaneous 'Yellow Zone' observations 	<ul style="list-style-type: none"> • Significant bleeding • Sudden decrease in Level of Consciousness (a drop of 2 or more points on the GCS) • New or prolonged seizure activity • BGL < 2mmol/L or symptomatic • Lactate ≥ 4mmol/L • Serious concern by you or any staff or family member
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Page 4 of 4

Appendix 2: Risk Assessment Algorithm





Appendix 3: Sample Specialling form

Daily Specials Review and Request

The purpose of this form is to document the specialling requirements for this patient.

The form must be completed every 24 hours

Right click in the box to access the link to the CHW Policy and Procedure ?

This form requires completion every 24 hours for the duration of time the child will require specialling.

The form expires at 1100 each day.

Reason for Special	<input type="radio"/> Clinical supervision <input type="radio"/> Ventilated patient <input type="radio"/> Other: <input type="radio"/> General supervision <input type="radio"/> Mental Health
Nurse: Patient ratio required	<input type="radio"/> 1:1 <input type="radio"/> 1:2 <input type="radio"/> 2:1 <input type="radio"/> Other:
Shifts required	<input type="checkbox"/> Morning shift - 8 hrs <input type="checkbox"/> Evening shift <input type="checkbox"/> Night shift - 12 hrs <input type="checkbox"/> Morning shift - 12 hrs <input type="checkbox"/> Night shift - 10 hrs <input type="checkbox"/> Other:
Classification of nurse required	<input type="radio"/> Assistant in nursing <input type="radio"/> Enrolled nurse <input type="radio"/> Registered nurse <input type="radio"/> Other:
Discussed with medical officer	<input type="text"/> Pager number <input type="text"/>
<small>(document name and page number of doctor contacted)</small>	
Admitting team	<input type="text"/>
Discussed with the Clinical Program Chair or AHNM	<input type="radio"/> Yes <input type="radio"/> No
Further details of patient's condition/requirements	<div style="border: 1px solid gray; padding: 5px; min-height: 100px;"><p>Segoe UI 9</p><p></p></div>
Nursing review by	<input type="text" value="Gardo, Alan (Nurse Manager)"/> Patient's current location <input type="text" value="Clubbe Ward"/>