Cheshire and Wirral Partnership
NHS Foundation Trust

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Crisis Support Team policy

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Type of document	Policy
Target audience	All inpatient staff
Document purpose	To ensure that crisis incidents occurring within inpatient services have an effective and appropriate level of response which promotes safety, communication and care.

Approving meeting	Health and Safety Sub-Committee	Date 23-Jul-20
Implementation date	23-Jul-20	

CWP documents to be read in conjunction with	
HR6	Mandatory Employee Learning (MEL) policy
GR1	Incident reporting and management policy
GR3	Risk management policy
GR8	Security policy
CP6	Management of violence and aggression policy (incorporating verbal threat to staff and offensive weapons)
CP10	Safeguarding adult policy
CP40	Safeguarding children's policy
HR3.8	How to raise and escalate concerns within work incorporating whistleblowing policy
MP10	Rapid tranquilisation policy
CP35	Physical health mental health pathway and policy
SOP3	Physical observations assessment and the management of altered levels of consciousness

Document change history	
What is different?	Changes made to reflect new inpatient build within East inpatient services Policy now includes new Restraint Reduction Standards (2019) i.e. post incident support procedures/pre-shift huddles
Appendices / electronic forms	Updated quick reference flowchart
What is the impact of change?	Safer practice for all individuals

Training requirements	Yes - Training requirements for this policy are in accordance with the CWP Training Needs Analysis (TNA) with Education CWP.

Document consultation	
Clinical Services	All inpatient leads
Corporate services	PACE Associate Director
External agencies	LEVEN network

Financial resource implications	None

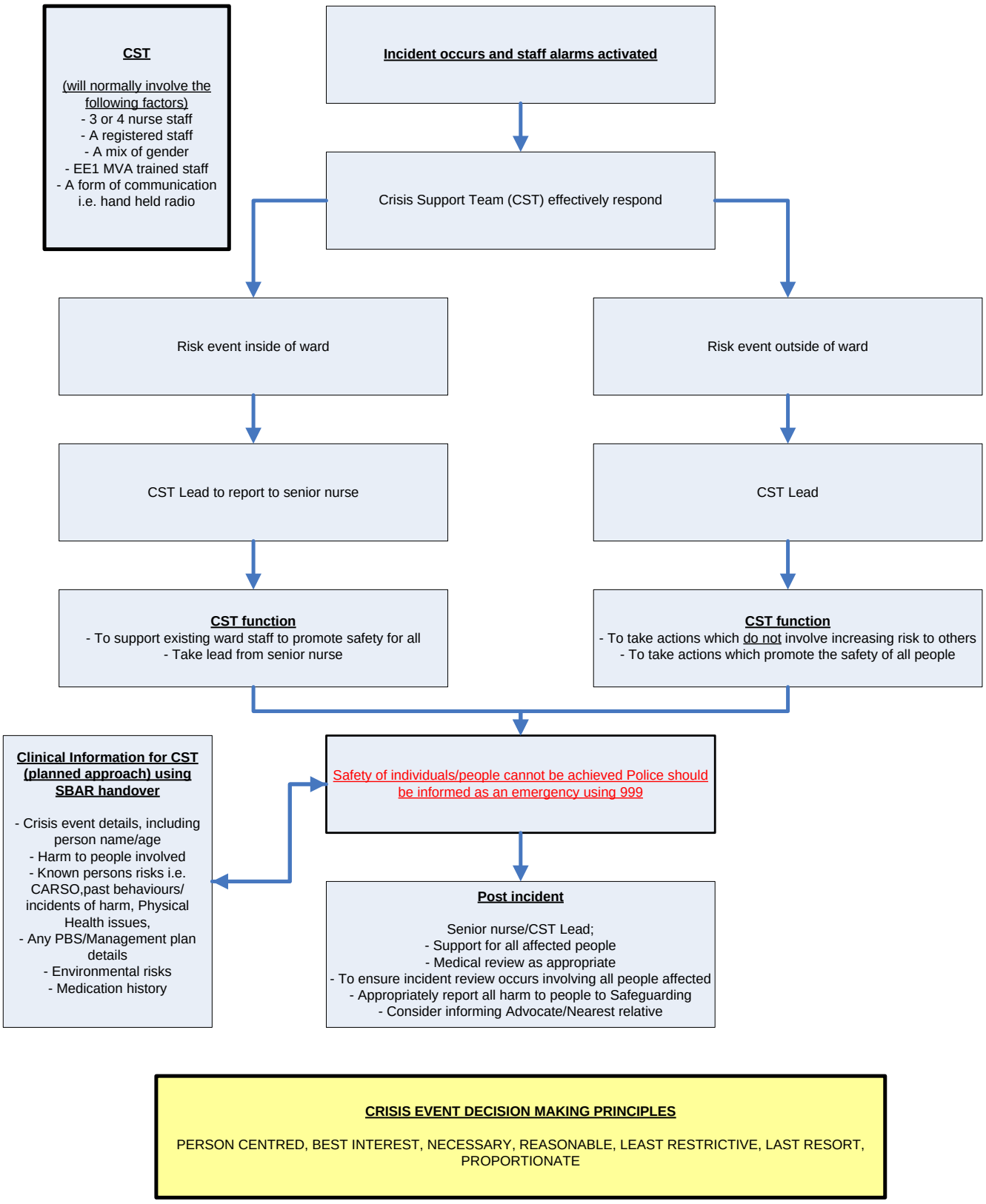
External references
1. Health and Safety at Work Act 1974 2. Personal Protective Equipment Regulations 3. Care Quality Commission 'Essential standards of quality and safety' (2009) Chapter 10F - have a system to enable staff to summon urgent assistance. 4. Mental Health Act 'Code of Practice' (1999)

Equality Impact Assessment (EIA) - Initial assessment	**Yes/No**	**Comments**
Does this document affect one group less or more favourably than another on the basis of:		
- Race	No	
- Ethnic origins (including gypsies and travellers)	No	
- Nationality	No	
- Gender	No	
- Culture	No	
- Religion or belief	No	
- Sexual orientation including lesbian, gay and bisexual people	No	
- Age	No	
- Disability - learning disabilities, physical disability, sensory impairment and mental health problems	No	
Is there any evidence that some groups are affected differently?	No	
If you have identified potential discrimination, are there any exceptions valid, legal and/or justifiable?		
Select		
Is the impact of the document likely to be negative?	No	
- If so can the impact be avoided?	N/A	
- What alternatives are there to achieving the document without the impact?	N/A	
- Can we reduce the impact by taking different action?	N/A	
Where an adverse or negative impact on equality group(s) has been identified during the initial screening process a full EIA assessment should be conducted. If you have identified a potential discriminatory impact of this procedural document, please refer it to the human resource department together with any suggestions as to the action required to avoid / reduce this impact. For advice in respect of answering the above questions, please contact the human resource department.		
Was a full impact assessment required?	No	
What is the level of impact?	Select	

Contents

Quick reference flowchart

For quick reference the guide below is a summary of actions required.



1. Introduction

CWP takes seriously the responsibility to maintain safe environments and promote safety for all people who work and use trust services.

2. Background

This policy refers to all clinical inpatient areas where there is an external response to crisis events by CWP staff. The purpose of this policy is to ensure that during any crisis event which requires additional staff support there is a clinically co-ordinated, person centred focused and effective response procedure in place to keep people safe. This policy will complement existing clinical support systems and is intended to be used as part of the clinical resource where the management of risk events is required.

3. Procedure

The Crisis Support Team [CST] must be called when there is:

- a medical emergency that requires an immediate additional staff response;
- a significant risk of harm to others or self which cannot be managed safely with existing clinical resource

When alerted the Crisis Support Team [CST] primary function is to provide an additional staff resource which supports the management of any risk event. Due to specific clinical knowledge the CST will not normally be expected to take charge of the management of any risk event but will support existing staff to maintain appropriate levels of safety.

Within East inpatient areas due to the geographical distances a CWP vehicle available this will be used to collect the additional staff and locate them to the summoning ward. This vehicle will be based at Mulberry Unit and any nominated driver must adhere to road traffic laws when operating the vehicle. In the event that a vehicle is not available this must be communicated to the summoning ward to enable them to take all actions necessary to maintain the safety of all people. Any staff response must be conducted in a safe and coordinated manner without jeopardising any safety principles.

4. CST Pre-shift huddles (excluding East inpatient wards*).

Post clinical handover at the commencement of each shift the CST should meet for a huddle to discuss individual ward clinical demands. These will include;

- General ward milieu
- Observation levels
- Seclusion/segregation incidents
- Staffing levels (including any planned escorts/Leave of Absence)

*Within East inpatient areas where there may be increased clinical demand which prevents a CST response this will be communicated to all other wards by the relevant nurse in charge.

5. The Crisis Support Team

a) All staff allocated to the CST must have completed their EE1 Proactive Approach Training programme (Previously MVA) as per trust Training Needs Analysis policy.

b) The CST will where possible normally consist of a minimum of four staff (3 staff for East inpatient wards). One of these will be a registered nurse. The CST lead will normally be a registered nurse and will be highlighted on the CST rota. At night or at times when a registered staff may be unavailable the CST Lead staff will then be an experienced unqualified staff member.

c) There must be a mix of gender and experience within the team. It is acknowledged that in some circumstances that this may not always be possible due to clinical demand in certain areas. There will always be other Management of Behaviour which Challenges trained members of staff that will respond when called upon by the CST lead.
d) At the beginning of each shift all staff will check the CST rota to note if they are to be part of the emergency response for that day and notify the CST lead of any difficulties or problems. In areas, which have a bleep / pager system, the nominated CST staff must ensure that they have the bleep / pager before commencing each shift.
e) Within inpatient areas where there are CST resource a staff member must be identified who will complete the CST rota on a weekly basis. The CST allocation for each ward will be placed with the duty rota or accessible to all staff
f) The inpatient Modern Matrons have overall responsibility for compliance with the CST policy, ensuring all relevant documentation is completed and for reporting any issues through the local Health and Safety groups.

5.1 The CST team member responsibilities

The nominated CST staff must ensure that they:

- Respond effectively and timely each time the alarms are activated and assist the requesting ward staff to maintain safety of all;
- At the end of every shift, each team member will personally hand over his or her responsibility to the subsequent team member on that ward (if nominated).

a) Role of the CST lead

- On arrival to the summoning ward/unit make themselves known to the senior nurse
- Discuss risk event details and agree/support the clinical decisions made which to promote safe practices and environments.
- Assist with post incident support of CST and affected others
- Contribute information to support the review of individuals PBS/care plan and risk tool

b) Role of the senior nurse on the summoning ward/unit

- The senior nurse on the summoning ward/unit will have overall responsibility for clinical decisions and for coordinating the CST throughout that risk event.
- Using SBAR process feedback crisis event details to CST and/or Lead
- Provide specifics of known risks i.e. Physical Health, previous violence/assaultive behaviour, mobility, current mental state/capacity, environmental, vulnerability.
- Positive Behavioural Support (PBS)/Care plan details i.e. One Page profile tools 'What's important to and important for the person', strengths and weaknesses, agreed actions

Post incident this includes ensuring completion of all documentation and the support of people affected in compliance with CWP CP6 policy The Management of Violence and Aggression and Behaviours of Concern

Where the CST is responding to a risk event outside of the clinical environment where there is no senior nurse the CST lead is expected to act reasonably for making appropriate clinical decisions using best interest principles and for coordinating the CST. This responsibility will also involve ensuring completion of Datix report and for post incident support of all persons affected by any incident. If this involves the safe relocation of people back to clinical areas the CST lead will on arrival to the ward immediately report to the senior nurse and conduct a 'hand over' process

5.2 How will the CST be summoned?

a) Within East inpatient areas due to the geographical distances of the inpatient wards hand held radios or a telephone call will be made to summon additional staff support.
b) If a ward or any staff member requires assistance they will activate the personal alarm or the emergency alarm call / button. Any staff member needing assistance or supporting an incident can activate the alarm.
c) The individual CST member must leave immediately to attend the area requesting their assistance and will pass a message to a member of ward staff to inform them they are leaving the ward.
d) If the CST staff is involved in other clinical activities they must ensure that they are replaced before leaving the ward or activity.
e) If CST staff for medical reasons cannot safely respond, then they must allocate another person from within their ward team. The original nominated staff is responsible for ensuring that the person they hand over to is of same gender and professional status i.e. registered/unregistered
f) If an allocated CST member is off sick, it is the responsibility of the shift leader / nurse in charge to allocate another member of staff to carry the bleep to respond to an emergency.
g) If any staff member has a physical impairment which effectively inhibits their involvement with the CST they must make this known to their line manager and to the CST rota creator. If their impairment improves to the point where that staff member is able to be considered part of the CST team they must as soon as practical possible notify their line manager and to the CST rota creator.

5.3 Unavailability of CST due to emergency pressures

The safety of all people remains a priority and all measures must be explored to ensure that people and CWP environments are safe. In the absence of a CST response and where the risk of harm cannot safely be managed using other available resources the manager/bleep holder informed and Police notified if necessary.

5.4 System testing

Each nominated CST staff will be responsible for:

- Testing the alarm system at the start of each morning shift. Night shift staff do not have to test the alarm unless there a fault has been detected;
- All system faults identified to be reported to estates and line / ward manager and all relevant staff and noted into the ward diary for handover to oncoming staff to note.

6 Agency staffing

All non-CWP employees such as agency will not be part of the CST unless evidence of EE1 Proactive Approach Training can be produced and ratified by the Clinical Education Co-ordinator/Lead.

7. Student Nurses

Student staff on placements **must not** be part of the CST or allocation of responsibility to directly assist in any incident. In the event of any incident occurring staff unable to assist in the possible physical interventions must be allocated supportive roles i.e. observation of other patients, liaison between incident and office.

8. Therapies Staff

Therapies staff will not be part of the CST rota. Therapies staff who have completed the mandated Management of Behaviour which Challenges training can make themselves known to the senior nurse and take direction from them.

9. Reflective post Incident support

All people affected by an incident, including witnesses and affected staff must be offered reflective post incident reflective support on conclusion of any incident. This should be provided to, and be entered into the clinical notes of any person being cared for within inpatient services. The CST should meet post incident and discuss if there are any learning which can be used to manage future incidents. It is key that all CST staff have the opportunity to discuss and share their opinions in a supported manner. The senior nurse or CST Lead will be responsible for ensuring support is provided to all affected people. Clinical Education staff are available to support the development of management plans post incident and also to assist with the post incident review process.

10. Post incident documentation

Post incident the senior nurse will be responsible for ensuring the review and/or development of all BSP/care plans and risk tools. The CST Lead can also contribute to the care document review and development of new plans

11. Safeguarding

All staff must fully adhere to CWP Safeguarding adult policy and Safeguarding Children policy for any referrals which need to be made to the safeguarding team following the conclusion of an incident.

12. Notifying the Police

Due to the nature of CWP care services not all incidents are reportable to the Police. The decision to report an incident which has occurred either within CWP premises or within the community to the Police must only be where there are clear reasons for doing so and normally only by the senior nurse involved. The timely reporting of all alleged incidents to the police must be undertaken in all instances using the emergency or non-emergency number.

When it is deemed or believed that a person's behaviour has resulted due to lack of capacity, arising from clinical factors or without the intent to harm the injured staff must consult with the persons Care Team to seek advice and to agree an appropriate course of clinical action. This would also be immediately following an incident where staff are unable make an objective opinion regarding a person's capacity and can request an immediate team meeting to discuss the incident details and appropriateness of reporting the matter to the Police.

Police emergencies - These are situations where control cannot be managed safely and/or there is significant risk of harm to person or persons, this could include incidents both inside and outside of the clinical areas. These incidents are emergencies and will require a rapid police attendance.

Police non-emergency - These are non-urgent clinical situations where a Police response is required and may involve attendance to the clinical areas e.g. missing persons, non-clinical assault incidents, theft incidents (significant loss), damage to property, threats to cause damage / to harm to another, to obtain Police Incident Number (PIN)

Police must be contacted via:

- 101 **(Non-emergency only);**
- 999 **(Emergency only).**

13. Safe systems of management for alarms, pagers and keys

a) Personal Protection Equipment (PPE)

It is essential that all staff have access to Personal Protection Equipment (PPE) this includes staff attack alarms / fobs, pagers and keys [where appropriate]. In all the Low Secure environments this process is undertaken by a nominated 'Security Nurse'. In all other inpatient areas staff (including student nurses) must ensure that on arrival at ward and before each commencement of duty they will:

- Have an alarm;
- Have a ward key / fob or have access to a key / fob (student nurses only).

b) Missing or faulty or damaged fobs

In the event of any alarm becoming damaged or faulty staff must immediately:

- Obtain a replacement device;
- Contact the estates department;
- Notify the ward / line manager;
- Complete Datix Incident form.

In the event of a missing alarm the nurse in charge must contact the last known previous allocated staff and ascertain its exact whereabouts. All missing, damaged or faulty devices must be reported onto the DATIX system.

In the event of system failure or insufficient alarms available staff must:

- Contact other clinical areas for temporary loan of alarm / fobs;
- Complete Datix incident form;
- Discuss interim response measures with bleep holder and other wards;
- Use hand held radios (where available) or ward phones as an emergency or interim measure.

14. CST and system effectiveness

CWP Security Services Manager will monitor the overall efficiency and effectiveness of this policy. If there are any opportunities to discuss and enable learning from any incident this will initially be through the local Health and Safety groups by CWP Security Services Manager