Appendix 2

Crisis Team - 12 Hour Observational Shift

Introduction

When 'Think Healthy' was conceptualised, our aim was always to try and capture as much service feedback as we could. We were aware that it would not be possible to do a full indepth analysis of all services, but hoped that we could look at some specific services in greater detail.

Healthwatch Derby has designed an unique observational format which has previously been used to study services such as A&E and EMAS. With the consent of the Trust, we embarked upon a 12 Hour Observational Assessment of the Crisis Team based at the Radbourne Unit. The 12 Hour Observational Shift was carried out by Healthwatch Derby's Quality Assurance & Compliance Officer on the 24th July 2014.

Our aim at Healthwatch Derby is to take the mystery and the unknown away from health and social care services. Accessing the crisis team is not something everyone experiences. This report has been written to give as much information as possible without compromising patient safety or confidentiality. The observations started at 8:00am on the 24th July 2014. For the duration of the observations section, Healthwatch Derby's Quality Assurance & Compliance Officer is going to be referred to as HWD.

Methodology

The methodology for the 12 hour observational shift was discussed with the management of the Crisis Team. It was agreed that:

1. Notes will be taken by HWD during the shift, but **NO** details identifying either patient, carer, NHS staff, or any other sensitive information about the patient would be recorded.

2. HWD's notes will be available to DHFCT at any time during the shift.

3. During accompanied home visits HWD would have to abide by instructions of DHFCT staff in terms of being present at any assessments – these would have to be agreed by the patient/carer/family present. If there is any difficulty or they prefer privacy, HWD to step out to accommodate this.

4. At no point during the shift will HWD's presence in any way cause disruption to services.

5. HWD will speak to staff about any recommendations they may have for service improvements, and their suggestions will be noted down as anonymous.

6. At no point will HWD ask service users about their current patient experience (for instance during an assessment observed etc). The service is dealing with patients who are at various stages of a crisis – it would be unfair to subject them to any further intrusive questions. All observations are to be undertaken in an empathetic and sensitive manner keeping the patient's welfare and dignity as paramount to all other considerations.

7. If HWD comes across any instances where a patient is under threat and the service is not aware of this, or sees anything where HWD feels the service user may be at risk, HWD to immediately highlight any concerns to the service manager at Crisis, as an agreed escalation and safeguarding policy for the observational shift.

8. If any safeguarding/escalation risks are highlighted Crisis team reserves the right to terminate the shift at that point to deal with the patient as a matter of urgency. If the shift is terminated HWD and DHFCT will work together to reschedule another observational shift at mutual convenience.

From The Trust's own website, the following information is available about the Crisis Team:

Derby City and South County Crisis Resolution and Home Treatment Team

The CRHTT is a service designed to offer a robust alternative to in-patient admission. The team acts as the 'gatekeeper' to in-patient beds at the Radbourne Unit and assesses all clients referred to the team to identify the least restrictive and most supportive route to successful treatment and management of a clients needs. The team is focussed upon promoting both recovery and resilience in clients to help them understand the mechanisms of their relapse and distress and also to reduce the potential or impact of further episodes. The team is made up of Social Care staff, Occupational Therapist, Community Support Workers, Nursing and Medical staff to provide a multi-disciplinary approach.

The service is for any client whose Psychiatric relapse and risk would indicate that they are vulnerable to Psychiatric admission.

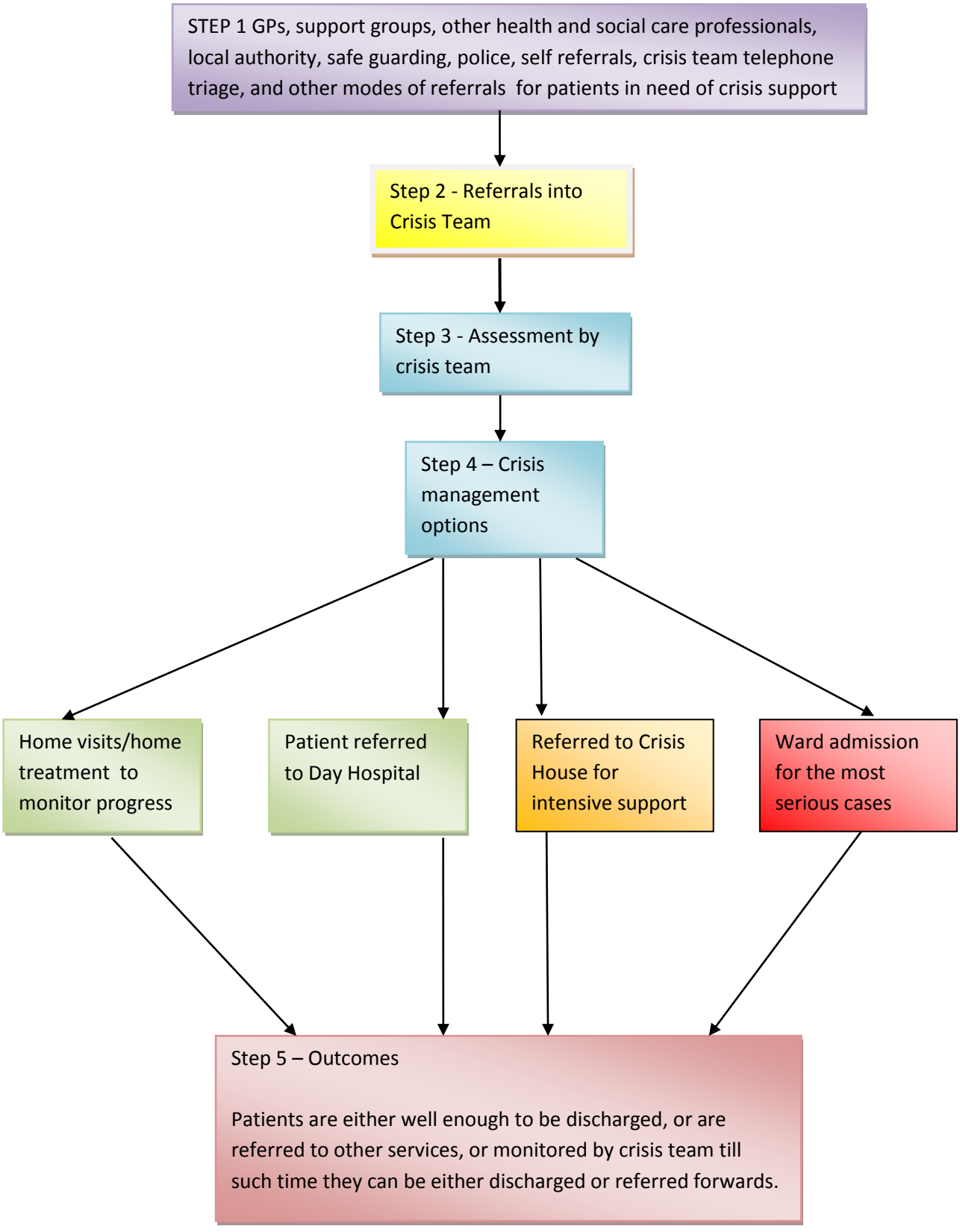
Referral mechanism

Via GP or Care Co-ordinator, clients with an agreed Crisis contingency plan can also contact the team directly to access advice and support.

Referrals received from:

GP services, CMHT / Recovery teams, A&E department, Police, Derbyshire Health United. A screening assessment to rule out any underlying physical health concern is requested for all clients who are not currently known to Derbyshire Healthcare Foundation Trust as a matter of safety and precaution.

How does the crisis team work? A step by step guide

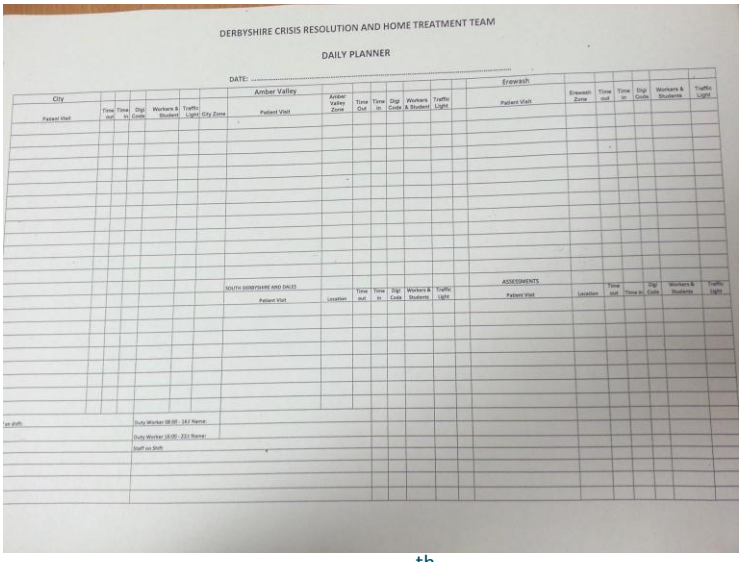


Our Observations

Upon arrival HWD was met by the lead nurse who was finishing the 8pm to 8am night shift functions of the crisis team. The lead nurse advised HWD that it had been a fairly good night with some phonecalls from GPs, and some from people having trouble sleeping. They also gave a brief overview of how the service runs. HWD had previously met with Crisis Team Service Manager, as well as spent some time with the Clinical Lead for the crisis team. When seen by the crisis team, nurses can do some physical observations of patients with physical health problems. Qualified nurses do a full mental health assessment of each patient they see. The assessments usually take place as home visits by lead nurses. Unfortunately sometimes patients avoid contact and nurses have made a fruitless journey. There are no sanctions for any missed appointments/visits. Each patient's care is extensively reviewed. Nurses travel in pairs to do assessments to reduce risks and to get a more balanced view of the subject being assessed.

(Crisis team members, 24th July 2014)

The crisis team operates a 72 hour assessment system with the team's headquarters displaying several large white boards with patient details, visits done or scheduled, and a RAG system (red amber green) is used to monitor each patient's wellbeing. Some patients will just require a medication review, whereas others may be well enough to be referred to the Day Hospital. The team have many useful tools which help them cover their geographical area which includes city and county. One of these tools is the 'flight planner'.


DERBYSHIRE CRISIS RESOLUTION AND HOME TREATMENT TEAM

DAILY PLANNER

DATE: .....

(Flight planner sheet, 24th July 2014)

The flightplanner is a diary system which enables the crisis team to plan assessments, review visits, medication checks etc. Another useful resource is the crisis house which allows the team to remove patients from their own surroundings into a safe environment – but not hospital admission. Nurses will also do visits to the crisis house to ensure patients are progressing well, and have their individual mental health needs met. The Day hospital is a valuable resource which allows the crisis team to refer individuals who may be better in a supervised yet friendly environment, learning together with other patients how to mange their condition. There is a daily data exchange with the crisis team.

(Confidential records being transferred to the Day Hospital, 24th July 2014)

On an average the crisis team monitors around 80 patients, however at peak period this can exceed 100. Some of these patients will need to be admitted as their condition is no longer suitable to be managed at home. Inpatient admissions take place at the Radbourne Unit, and the crisis team are able to make referrals for urgent cases. As part of the observations HWD attended an 'inreach' round at Ward 33, accompanied by a band 6 nurse.

Inreach Observations

On the day, the ward had 20 patients in its care. 17 were on the ward, 2 were granted leave, and 1 patient was in seclusion. The 'inreach' consists of a meeting held with doctors, nurses, and a continuous monitoring is in place to ensure patients get the best care possible. The inreach meeting had three doctors, a junior doctor and nurses present.

During the meeting all patients on the ward are carefully reviewed. It was confirmed that some patients have presented challenging/violent behaviour. HWD observed one of the nurses had a visible bruise to their face, but was very positive and fully committed to dispensing duties despite the discomfort. Verbal warnings have helped reduce aggravation on the ward and no physical restraint was needed. Medication reviews were done as part of the inreach. HWD spoke to the doctors present about 'Healthwatch' as an independent watchdog, and also about the aims of the 'Think Healthy' consultation.

Sectioning of patients and tribunals were discussed. Nurses will help with positive affirmation techniques such as mindfulness to help manage their condition better. If one patient displays challenging behaviour it can have a domino effect and adversely affect others, especially newcomers to the wards. Some patients are allowed escorted leave, especially with the help of support groups. Patients also have use of the communal area/shop/restaurant known as Jackie's Pantry. There are a range of activities patients can take part in which includes a birthday tea for patients, karaoke etc. Within the ward patients are kept on four varying levels of supervision according to their need.

Level	Supervision details
1	Constant supervision and support
2	Regular and irregular supervision but kept in line of sight to provide support as needed.
3	Not observed in ward but observed off ward when attending appointments etc
4	Patients can go off ward to Jackie's Pantry or to see the Occupational Therapist unobserved

The inreach session ended with a quick walkabout the ward, and a chance to see the ward's de-escalation room. Seats are specifically designed so that furniture cannot be thrown as a weapon. The emphasis is on talking down threats and getting the patient to engage in breathing and relaxation techniques.

(De-escalation Room, 24th July 2014)

Patients may also suffer from physical health issues as well as mental health issues, and can refuse treatment or food intake. An innovative way of ensuring at least some food and hydration is received by patients is through the offer of ice lollies for those patients who are seriously neglecting to take in any nutrition at all. Patients are allowed leave away from the ward if deemed well enough. Community groups such as Derbyshire Mind, Touchwood amongst others can help patients with escorted leave. Patients are also able to attend occupational therapy sessions within the Radbourne Unit depending on their supervision levels.

Assessment Observations – Assessment 1

Nurses do assessments in pairs for risk management and also to ensure a balanced view of the subject being assessed. For the first assessment HWD was accompanied by two nurses. Details of the assessment follows:

Patient was not known to services. Upon arrival nurses clearly explained what they were going to do and how they were going to use an assessment tool to see what support they could offer. Patient was clearly very distressed and at times found it hard to speak. In summary there

were family problems from the past spilling into the present as well as an amount of work related stress. Patient felt out of control and had thoughts about ending their life. They communicated these intentions to family members who then got the GP involved and a crisis referral was made.

A full assessment was done of the patient's current situation with key details noted down for instance:

!. What was their physical health like and were there any physical symptoms such as recurring headaches, lack of sleep.
2. What medication were they on? In this case antidepressants were stopped abruptly without consulting a GP.
3. What was their memory like, and what were moods generally like, were they sleeping?
4. What were family dynamics and relationships like, did they have a support network. Fortunately for this patient they had a strong immediate family.
5. What had led to them feeling such despair, a brief summation of issues that had bothered them in the past and in the present day
6. What were their aspirations and goals, what made them happy
7. What was their employment and financial situation
8. If they had any children then a report would need to be done to the Safeguarding team. This visibly upset the patient and family, but nurses were very patient and took care to sensitively explain why this was needed, and that it was not a negative measure rather it was a means of protection.
9. Patient asked about what needs to change in their current situation for them to feel better – this allows them to take ownership and be proactive in thinking about recovery plans and moving towards a resolution.

Following a full assessment it was confirmed that although patient had thought of ending their life, in actual fact there not at high risk of suicide. There were many underlying family issues from the past, patient would benefit from counselling and also taking medication as prescribed by GP. Nurses mentioned that follow up home visits would ensure patient's progress was being monitored. Post assessment nurses returned to the office and rang the GP immediately to advise them of the assessment, and the medication concerns (stopped abruptly). GPs need to take on board recommendations by the crisis team – there is a difference in approach as the GP sees the patient for a short consultation regularly as opposed to the crisis team doing an intensive assessment and providing

comprehensive details and suggestions about medication reviews or changes as needed.

Nurses write handwritten notes and do a written assessment. It would benefit the service to invest in electronic note taking via the means of a tablet etc as this could be shared with the rest of the team in real time and allow for better planning and distribution of resources. Throughout the assessment the patient was made to feel relaxed as much as possible with time taken to explain what information was being taken and why, and for what purpose. The assessment was at the patient's pace, allowing for breaks when the patient felt extremely distressed (when disclosing family issues). Patient and family stated they were apprehensive about who would come to do the assessment and what may/may not happen to the patient. There was a lot of anxiety about the patient perhaps being taken away against their will. These negative perceptions of how the service runs is still rife with powerful negative imagery. The patient was highly educated and held a demanding professional job, but was clearly unaware of how mental health and crisis conditions were treated or managed by the NHS. Perception and awareness raising are clearly areas where not just the Trust but the whole NHS needs to work hard to dispel negative stereotypes, prejudices and perceptions.

At the end of the assessment the patient said they felt much better for having spoken to the nurses, and were no longer afraid of asking for help. They were able to form a plan of action as to what to do next. The patient was going to return to see their GP and take medication as prescribed and also accept any referrals for counselling. There is a waiting list for counselling referrals, and it may be beneficial for the crisis team to have a full time counsellor who is able to provide interim support while people wait for their full counselling referral to come through. It is investing in the interim that may take away some of the pressures of the long time waiting times, and also ensure patients are not left without therapeutic support while they receive home treatment.

Assessment Observations – Assessment 2

Although normally nurses do assessments in pairs, for some exceptional cases a single practitioner may go out to do the assessment. This is pertinent if the patient is well known to the service, and has a trust issue with new or unknown nurses. For the second assessment, HWD was accompanied by the clinical lead who had extensive knowledge of the patient as there had been many contacts with the crisis team in the past. Details of the assessment follows:

Patient has been referred due to various concerns about potentially harmful liaisons and a chaotic lifestyle which may be affecting their mental health. Patient is vulnerable to being manipulated, and has already had significant support from the crisis team and was previously discharged into the care of the GP.

Upon arrival, patient seemed to be in an excitable state, although this did not border on aggression but was more high spirited and a sense of mania. Patient made many claims about a dangerous chaotic lifestyle. Patient had physical health problems, and also boasted about use of drugs. Patient wanted to pursue neighbours for drug trafficking, and stated they were in contact/liaison with local criminals. Discussions and a full assessment (see questions in assessment 1 above) revealed the patient was suffering from hallucinations, paranoia and many fears associated with real or imagined contacts.

It was good to observe a calm and focused attempt to find out the real narrative amongst the jumbled and nonlinear declarations made by the patient about their situation. Patients suffering from complex mental health problems may not always be coherent, and often unable to provide direct responses. This may mean patients lost out on vital support if care is not taken to acknowledge this feature of their condition. Patient was allowed to speak at their own pace while the clinical lead patched together a narrative from the facts (the assessment took a very long time). It was clearly evident that the clinical lead and the patient had worked together over a number of years and overcome difficult phases in the patient's life – this led to a warm rapport and a willingness to listen with honesty. Patient made further claims about being financially abused and wanted the police to be involved. Patient was encouraged to reveal full details of their situation to their social worker. Patient would like to be admitted to the crisis house but it is not feasible as there is no lift, and patient has mobility issues.

Patient was asked about what would help their current situation, giving them ownership. Full physical observations and assessment done. Patient's carer arrived and joined in the assessment. The assessment concluded that there were concerns of a social nature which require help of the police, safeguarding, and the local authority – but this was not a mental health crisis situation. Clinical lead to follow up assessment with immediate contact with the police, social services, safeguarding, and the community mental health team. Carer's view also taken into account. Carer advised about patient being financially abused. Despite the very

lengthy assessment with many sections being repeated to get the correct facts, the patient remained calm and totally relaxed with the clinical lead, displaying a willingness to open up and take support. Crisis team will make the referrals to agencies listed above, and will do a follow up home visit the next day to see how patient is.

Following up from the assessment upon returning to the office, the clinical lead rang other family members of the patient, spoke to the police, and sent information across to social services and safeguarding. It was confirmed that there is no evidence of mental health crisis but the mental health outpatient pathfinder to be advised. Crisis team is concerned about patient being alone due to manipulation and abuse issues – patient's friends and family have confirmed they will not be left alone. Police will be referring specialised units to fully investigate the complex allegations made by the patient.

A lot of work generated for a callout which was not actually about a mental health crisis – however it is doubtful if any other service professional could have pieced together the facts, or been able to negotiate with the patient in a manner that revealed their true problems. The physical/emotional symptoms were soon dismissed by the patient s as the crisis team member was willing to listen to what was really the matter – and the real causes for distress were social rather than mental health related. There needs to be some recognition of the significant work done by the crisis team to help support other agencies/authorities. The service does not work as a vacuum, and interlinks with many different professionals on a daily basis to ensure patients get the best possible outcomes for the problems they present with.

Home Visit Observations – Visit 1

Home visits are generally done by individual nurses although if needed they can go out in pairs. Home visits follow on from assessments, so the team has a good idea of what the patient is like, and how they will react to offers of home treatment or advice about their condition. For both observations HWD was accompanied by a single nurse. Two home visits were done for this consultation with two different nurses. Details of first visit follows:

Patient presented themselves to their GP and there were some suspected serious health concerns. This led to the patient's mental state deteriorating. GP was concerned and a referral was made to the crisis

team. Upon assessment patient was deemed to be not at imminent risk, but suffering from a state of heightened anxiety. Alternatives for patient's health conditions recommended, as well as counselling. Home visit done to monitor patient's progress.

Upon arrival the patient seemed relaxed and HWD observed an easy flow of conversation with the visiting crisis team nurse. Assessments and observations of a patient's mental health needs can be traumatic and distressing if it takes place within a busy A&E. There is a power imbalance where the patient has been brought to an unfamiliar place. The home visits restore this power balance and patients are on a more equal footing in their own surroundings, with a reassuring support coming to visit them.

HWD observed in a steady but unforced conversation - the nurse was carefully assessing what the patient's current condition was. Enquiries which are couched within normal conversation revealed:

1. How was the patient sleeping, and did they get any rest?
2. How was the patient eating, and what effect did their condition have on appetite? What about alcohol intake?
3. A full medication review
4. Patient's family/social/work/financial situation looked at
5. Any other things that may be bothering the patient – in this case the person felt affected by the anti social behaviour in the estate where they lived.
6. What is the plan for today?
7. Options and support given such as information about talking therapy.

Please note the above enquiries were not asked in any particular order, but rather have been recorded in this manner for ease of reporting purposes. Throughout the visit the nurse maintained good eye contact, and the manner of conversation was friendly and supportive rather than purely clinical detached. Some brief notes were taken but the majority of the time was given to the patient to speak at length about their condition, and to advice accordingly rather than just fill out paperwork.

Throughout it all the patient seemed empowered and happy with the level of contact and support received. HWD also observed that a lot of the support was about getting the person back on their feet at their pace so they were able to decide what they wanted to do next with regards to their condition – in this case, the patient clearly wanted to speak more about things that had resurfaced in their mind and was happy to accept information about talking therapy. Patient commented about how initially

they had been reluctant to open up and expected a clinician in white laboratory coat to turn up and diagnose them. The perception of mental health services and stigmatisation was something that the home visit dealt with very well and helped to reinforce a positive and caring service, open to patients rather than a quick dismissive diagnostic. Patient commented they felt reassured and calmer about the whole situation and 'really appreciated' the personal one to one support.

The visit was not rushed, nor was there any impending consultation deadline with the nurse during the visit. The patient was given ample time to speak. It became clear that the act of opening up to the GP about how they felt, and then being supported by the crisis team was a positive, and would hopefully lead on to the kind of ongoing support that the patient needs in the long term.

Post visit, the nurse was able to devote some admin time to accurately record all aspects of the conversation that took place during the home visit, and also update the team's records on the patient's progress. A small hand held tablet would help the visitors provide better information and advice, and also enable hand written notes to be inputted directly onto web based systems – this could be accessed in real time by the rest of the team to plan service provision accordingly. Nurses should also have a fully prepared home visiting pack with details of all treatment options and phone numbers handy.

Home Visit Observations – Visit 2

Patient was on seven day leave from Chesterfield, but has had a setback. Home visit is being done to do a follow up assessment. Patient known to services and has presented challenging behaviour in the past.

Upon arrival patient seemed calm and friendly – apologised to the nurse for using swear words during a previous home visit. As detailed in home visit 1, the nurse used a gentle probing conversational manner to tease out the patient's current condition. This also included a check in about the patient's current financial and debt situation and whether that was beginning to cause further anxiety.

Patient admitted having dark negative thoughts wanting to cause harm and discomfort to self. Patient stated they feel urges and feel unstable. A full medical review was done with the patient, and a discussion about what support or options the patient would like at this state. Patient was adamant they do not wish to be readmitted but would like ongoing

support. Patient will need to return to the facility in Chesterfield to be discharged, but feels unable to do this due to anxiety issues. More support and thought needs to be given with a more fluid access to Trust services. If patients have moved within the geographical area and are due for a discharge then it would be more practical for them to be re-assessed and discharge from a service near to them rather than returning to one further afield.

The nurse has treated the patient over a long period of time and was fully aware of the patient's own history as well as family history. This helped build the kind of trust required to deal with very sensitive disclosures about personal health and hygiene. Patient was very vocal and stated they 'hated' being at hospital and preferred being treated at home. It was recognised that medication may need to be changed following the setback experienced. A medication review was scheduled with reassurances given to the patient that only nurses known and approved by the patient would visit. Patient has the facility to call the crisis team at any time day or night if they felt thoughts or urges to self harm get troublesome or unmanageable.

HWD observed that although there were some aspects of the care the patient was clearly unhappy about (having to travel back to Chesterfield for discharge), overall the patient seemed happy to be seen, and welcomed the support provided by the nurse. The patient was in a relaxed state at the end of the visit and looked forward to a full medication review.

Crisis House Observations

Another useful resource the crisis team have is the facility of placing patients in a crisis house – and giving them intensive help and support. The location of the facility has not been disclosed to ensure full patient and staff confidentiality. The property is used as a stopgap instead of admissions, and is visited daily by crisis team members. The facility is staffed overnight by care assistants and has 4 bedspaces.

The crisis house was clean and well maintained with a welcoming and homely feel. There is a big lounge and recreation area, as well as a big kitchen, and a good garden space for patients. Recreational activities include artwork and gardening. Maximum stay in the facility is two weeks. The kind of work undertaken to support patients at the crisis house include grounding techniques, anger management, sleep hygiene, and mindfulness.

(Crisis House and garden area, 24th July 2014)

MDT (multidisciplinary team) Observations

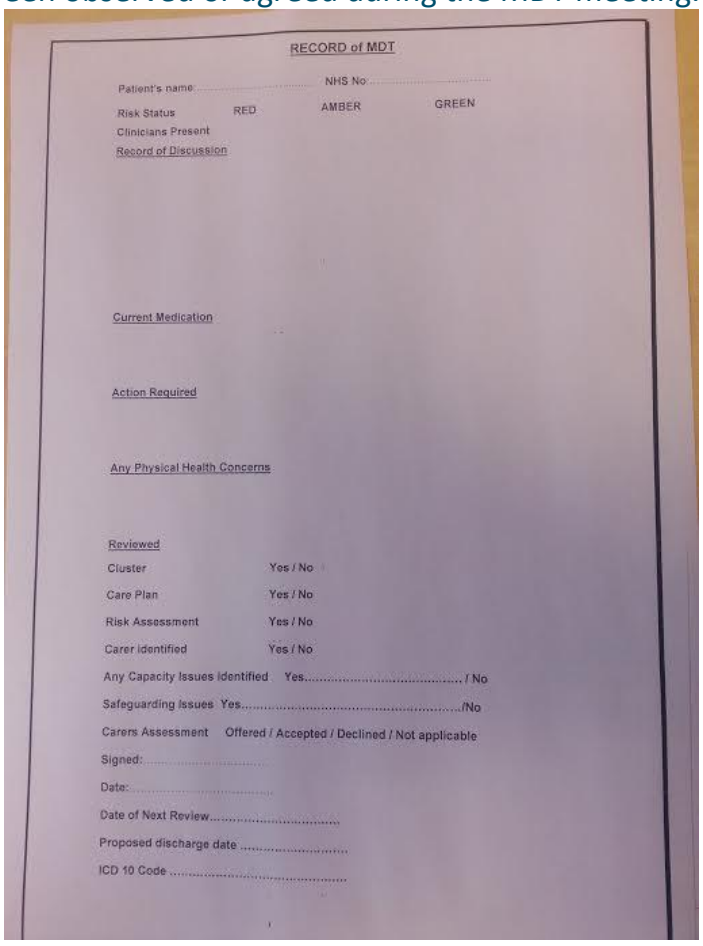
The above inreach, home visits, and assessments were completed on the 24th July 2014. Unfortunately the second assessment done with the clinical lead was extremely complex and time consuming which meant the 12 hour observational timescale did not allow for further observations of MDT. HWD returned to the crisis team on the 20th August 2014 to observe a full MDT meeting.

(MDT, Crisis Team – 20th August 2014)

The crisis team monitors the progress of an average of 80 patients at any given time, with numbers reaching up to 100 during peak periods. Patients are monitored on a daily basis with regular MDT meetings to ensure each patient's progress is fully monitored and updated. The emphasis at MDT is to try and provide as much support as possible to all patients.

Who attends MDTs?	
Role	Reasons for attending
Clinical Lead	To give an update on assessments, home visits, home treatments, medication reviews, progress within crisis house, book review visits, feedback from Day Hospital or inpatient wards, discussion about possible discharge and recommendations
Crisis Team Members	
Crisis Service Manager	
Consultant Psychiatrist	
Doctors	
Psychologist	
Any other professional specifically invited to attend to discuss a patient	

Each MDT review requires an MDT record to be signed off which details what has been observed or agreed during the MDT meeting.



RECORD of MDT

Patient's name: NHS No:

Risk Status RED AMBER GREEN

Clinicians Present

Record of Discussion

Current Medication

Action Required

Any Physical Health Concerns

Reviewed

Cluster Yes / No

Care Plan Yes / No

Risk Assessment Yes / No

Carer Identified Yes / No

Any Capacity Issues Identified Yes..... / No

Safeguarding Issues Yes...../No

Carers Assessment Offered / Accepted / Declined / Not applicable

Signed:

Date:

Date of Next Review.....

Proposed discharge date .....

ICD 10 Code .....

(MDT Record, 20 August 2014)

So what actually happens at the MDT?

There is a discussion about the patient's profile, past history and present crisis. Medication is reviewed, to see what has been prescribed and if there are any problems. Any actions required regarding medication is agreed upon. Physical health concerns are reviewed and actions agreed. Patients are categorised using the Health of the Nation Outcome Scale as a clustering tool. The Trust also uses the FACE risk profile during assessments.

Care plans for each patient is discussed and reviewed with considerations towards who is involved in the care of the patient, and their availability to support the patient. Mental capacity issues are discussed and decisions made regarding capacity or lack of. There is consideration given to the household of the patient – do they have children or other vulnerable individuals that may require safeguarding for instance? Discharge is discussed with proposed discharge dates looked at with a realistic view of whether a patient is likely to be ready for discharge. The Trust operates a two day follow up policy on discharges for patients deemed to be most vulnerable, and a seven day follow up policy for patients deemed to be at no risk.

Patients are identified using a RAG rating with Red for the most at risk, amber for those who are in a manageable state, and green for those who are showing signs of stability and may be ready for discharge. For the purpose of this report all sensitive personal information, and information about mental health condition that may possibly identify patients have not been included to protect patient and staff confidentiality. A full breakdown of MDT observations follows:

Patient observed	Patient's RAG category	Observations
1	Amber	Long standing mental health issues and social issues. Consultant provided details of what they had observed at ward rounds, discharge imminent.
2	Amber	Regular visits done but patient declining additional visits, patient

		presented impulsive and challenging behaviour but has good support network. To be monitored.
3	Amber	Patient is improving and some observations of stability noted. Consultant has seen patient with carer. Next home visit booked. To be monitored.
4	Amber	More than one service involved, with clear risks identified. Patient has been sectioned and currently inpatient. There are no specialist units for emotionally unstable borderline personality disorder which could benefit the patient. To be monitored
5	Amber	Patient does not wish to engage with crisis team at home visits, but is doing better. Discharge imminent but currently under review.
6	Green	Patient has social problems but has been picked up and supported by crisis team. Other services (regional) need to get involved, discharge proposed following further home visits.
7	Green	Patient under review, with an agreement that another home visit would lead to discharge. Patient receiving support from other local services and

		responding well.
8	Green	Consultant has seen the patient and it was agreed patient is not ready to be discharged, talking therapy referral done. Although not at risk consultant feels crisis needs to link patient with community mental health team and psychologist to ensure smooth transit rather than patient being left totally without support. To be monitored.
9	Green	Home visits have shown an improvement in the patient, discharge scheduled for next week following a home visit as patient is responding very well.
10	Green	Physical health problems impacting mental health adversely. Physical observational tests ongoing. Patient responding well to support for mental health symptoms. Referred to outpatients.

The above was an account of MDT observations. Patient's situations do change dramatically, as the MDT was taking place the crisis team received a call about a patient who was previously doing very well and engaging – but had deteriorated critically and was received by another NHS Trust. It was a sobering reminder of the human tragedy behind the RAG rating and risk assessments. The next section summarises our findings and recommendations from the 12 hour observational shift.

Our Findings

Positive
The crisis team works with very difficult situations and vulnerable people. Our observations indicate that the team deals with each patient with empathy, dignity, sensitivity and support at the heart of crisis service provision.
Care and support is undertaken with an aim to include patients and carers as much as possible.
The service was very open and honest about the way it works, and gave full and dedicated collaborative support and access for this exercise to be completed.
The team use good tools and resources to manage their caseload such as the day hospital, inpatient facility etc.
The crisis house is a good interim facility.
Negative
The team operates with handwritten notes, and there is a delay in getting information back to base, to better plan service provision or inform the rest of the team about a patient's progress.
Many negative perceptions and lack of awareness about how people in crisis are supported by the Trust.
Long waiting time for counselling referrals for patients may lead to their condition deteriorating.
Crisis house does not have a lift.
Patients have to return to the place of admission to be discharged if they are on leave.
Lack of provision of specialist units for emotionally unstable borderline personality disorder.