This Protocol supersedes all previous procedures and/or protocols relating to post discharge follow-up
## 72 Hour Post Discharge Follow-Up Protocol (Inpatient Wards)

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**Membership of the policy development/review team**  
Business and Performance Manager, Performance and Regulation Compliance Manager and Clinical and Corporate Policy Manager  

**Consultation**  
Associate Divisional Managers  

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Further copies of this document can be found on the Foundation Trust intranet.
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1. **INTRODUCTION**

The Trust is required to follow up all service users within 7 days of discharge from an inpatient unit for both patients on CPA and those not on CPA. This is a key indicator for the Trust in terms of performance. It is also considered to be a very important part of the care we provide to our patients and is primarily aimed at reducing suicides. It has been found that for service users recently discharged from hospital there is a peak in suicide in the first 1-2 weeks following discharge. It has also been found that 40% of suicides occur before the first follow up appointment after discharge.

Since 2002, following on from The National Suicide Prevention Strategy for England it has been a national target to follow up service users within 7 days of discharge. However when a service user does not attend a follow up appointment arranged for 7 days after discharge the target is not reached. This is reflected in service users’ experiences of follow up. In the 2009 Trust Service User Survey, 43% of service users felt that they were not contacted by mental health services for over a week after discharge.

**Therefore in order to improve performance in this area it has been agreed that the Trust will move to follow up service users within a 72 hour period from the date and time of discharge (Trust target).**

2. **AIM**

The aim of this document is to provide a protocol for Trust staff to follow in ensuring that inpatient service users are followed up within 72 hours of discharge.

3. **PROTOCOL**

3.1 When a service user is admitted to hospital, the admitting team will check the service user’s record on the electronic patient record (EPR) system which is currently RiO. This will indicate whether the service user is on Care Programme Approach (CPA) and who their care coordinator is, if one has been assigned.

3.2 If the service user does not have a care coordinator and CPA status is not clear it should be discussed early during admission. Consideration should also be given as to whether the service user is likely to meet the criteria for CPA and to plan the allocation of a care coordinator on discharge. The inpatient team will refer the service user to the relevant Community Mental Health Team (CMHT) for assessment as early as possible during the admissions. The CMHT will assess the service user as soon as possible following referral from the inpatient team.

3.3 If the service user meets the criteria for CPA, it should be recorded on EPR (RiO) by the inpatient team as early as possible during the admission process.

3.4 If the service user meets the criteria for CPA a care coordinator must be allocated as soon as possible and this information recorded clearly in RiO by the community team.
3.5 The primary nurse looking after the service user on the ward is responsible for ensuring that the care coordinator is made aware of the admission as early as possible and for ensuring that the care co-ordinator is invited to any discharge planning meetings.

3.6 Care coordinators are responsible for attending their service user’s discharge planning meetings and if they are unable to attend to ensure that someone is nominated to attend in their place.

3.7 The 72 hour follow-up plan will be decided at the discharge planning meeting. It should be clearly documented on RiO in the progress notes relating to the discharge meeting. The date, time and location, as well as the nominated healthcare professional (HCP) to carry out the follow-up will be noted. The nominated HCP should book the contact into their RiO diary as soon as possible – ideally before or on the day of discharge.

3.8 Care Co-ordinators will be responsible for ensuring the follow-up plan is carried out within the set timescale although follow-up contacts may not always be carried out directly by the Care Co-ordinator. For example, if a service user has been referred to a Crisis Resolution Team or Drug or Alcohol Service following discharge, it will be appropriate for this team to make contact with the service user within 72 hours of discharge from hospital. The care coordinator is responsible for ensuring that this contact is arranged and takes place within the timescale.

3.9 If the care coordinator is unavailable to oversee this process the Recovery and Rehabilitation (R&R) Manager must ensure this responsibility is delegated to someone else from the community team.

3.10 Follow-up contacts need to be face to face. Where this is not possible, telephone contact must be made with the service user and a face to face contact arranged for as soon as practicable and this must be within 7 days of discharge. The reasons for this should be clearly documented in the progress notes in RiO.

3.11 It will be the responsibility of the ward team to ensure a follow-up plan is in place at the point of discharge. If the follow-up plan has not been confirmed in person with the Care Co-ordinator or someone from the relevant Community Team the ward must take responsibility for carrying out the follow up (e.g. by telephone call to the patient within 72 hours of discharge).

3.12 When it is appropriate, a follow up can be done with the service user returning to the ward for review. This may be because of bank holidays or may be as part of a period of planned home leave in preparation for discharge. However, in the latter circumstance, contact with the ward must be within 72 hours of the leave start date to meet the Trust target, or within 7 days of the leave start date to meet the national target. If neither of these two targets is met a 72 hour contact must be planned as indicated in this protocol from the formal discharge date.
3.13 Any 72 hour follow up contact carried out by the wards must be clearly identified as “72 hour follow up” in the progress notes on RiO.

3.14 The CMHT Manager should be aware of all service users known to the CMHT who are approaching discharge. The CMHT manager is responsible for checking on RiO that a service user has been followed up within 72 hours of discharge. It is crucial that the CMHT manager notifies the service user’s care coordinator immediately if the service user has not been seen.

3.15 Staff should note that when service users are transferred out of Trust services, for example to a private hospital, such transfers do not count towards the Trust’s performance for this indicator.

4. Documentation

4.1 The above process should be adhered to for all admissions where a service user has been identified as having a clinical need for follow-up or on CPA. Actions are to be documented on service users’ progress notes.

4.2 For service users not deemed to be in need of a follow-up, reasons leading to the decision must be documented on their progress notes.

Staff should be aware that all contacts will be monitored to meet the Trust’s target of 72 hour post discharge contacts which in turn will enable the Trust to meet the national target of 7 days.
5. **PROCEDURE FLOW-CHART**

On admission, EPR (RiO) is checked to see if patient has a Care Coordinator and on CPA

Is the patient on CPA or is there a clinical need for follow up? (CMHT to allocate Care Coordinator if needed prior to discharge)

- **YES**
  - Care Coordinator to attend Discharge Meeting
  - 72 hour follow-up plan is recorded on EPR (RiO) at discharge meeting
  - **Documented:** Who / When / Where

- **NO**
  - Inpatient team to enter on EPR (RiO) that there is no clinical need for 72 hour follow-up on discharge
  - NOT COUNTED IN STATS

72 hour contact is recorded in the HCP Diary (RiO) of the person carrying out the follow up (e.g. the Care Co-ordinator or other agency such as Crisis Team if appropriate) and documented in EPR (RiO) progress notes.

If the follow-up happens on the ward this is documented in the progress notes only but must be clearly labelled “72 hour Follow up”

CMHT Manager to check 72 hour follow up has been achieved for all clients on CMHT caseload.
6. DISSEMINATION AND IMPLEMENTATION

This document will be circulated to all managers who will be required to cascade the information to members of their teams and to confirm receipt of the updated protocol. It will be available to all staff via the Trust Intranet. Managers will ensure that all staff are briefed on its contents and on what it means for them and the Trust.

7. AUDIT AND REVIEW

This protocol will be audited quarterly through the balanced scorecard process and monitored through Performance Accelerator.

- 72 hour contacts for those on CPA
- 72 hour contacts for those identified as in clinical need of follow-up

This policy will be reviewed in 2 years or earlier should a significant change in practice need to be implemented.

8. REFERENCES

Trust Care Programme Approach Operational Policy.

Other references inserted as endnotes below.

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3 Camden and Islington NHS Foundation Trust (2009) Listening to patients Mental Health Acute Inpatient Service User Survey Results