Kent and Medway
NHS and Social Care Partnership Trust

72 Hours Follow up Post Discharge Protocol

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DOCUMENT TRACKING SHEET

72 Hours Follow up Post Discharge Protocol

Version	Status	Date	Issued to/approved by	Comments
0.1	Draft	04.11.2019		Younger Adults Community Care Group and Older Adults Care Group
0.2	Draft	06.01.2020		Addition of Scope
0.3	Final	24.06.2020	Trust Wide Patient Safety and Mortality Review Group	Minor amendments to be made before final ratification
1.0	Final	July 2020	Trust Wide Patient Safety and Mortality Review Group	Virtually ratified

REFERENCES

RELATED POLICIES/PROCEDURES/protocols/forms/leaflets

Did Not Attend policy	
Transfer & Discharge of Care of KMPT Patients Policy	

SUMMARY OF CHANGES

Date	Author	Page	Changes (brief summary)

CONTENTS

1 INTRODUCTION

1.1 The period following discharge from mental health Inpatient units to community settings can come with increased risk of self-harm for people. Mental health services currently adhere to a standard of ensuring follow-up from Inpatient care within seven days of hospital discharge for, all people receiving support through the Care Programme Approach (CPA). However, recent findings from the National Confidential Inquiry into Suicide and Safety in Mental Health showed that most post-discharge deaths by suicide occurred in the first week after leaving Inpatient care, with the highest frequency on the third day after discharge. Many of these people died by suicide before their first follow-up appointment. Based on this new evidence many services already aim to complete follow-up within 2-3 days post discharge for **all** people from Inpatient care (not only those on CPA).

1.2 **Scope**

1.2.1 It is the responsibility of the Trust to follow up all service users that are discharged within 72hours, unless they are:

- Transferred to another NHS psychiatric hospital to continue psychiatric care and then on this occasion the responsibility lies with the receiving hospital.
- Where a client has been transferred to prison, the Inpatient area should arrange a suitable follow up with another body.
- A Service User who dies within three days of discharge
- Where legal precedence has forced the removal of a client from the country

1.2.2 The follow up period should be measured in **days not hours** and should start at midnight on the day of discharge. A follow-up contact on the same day as discharge will not be counted as meeting the criteria.

1.2.3 All service users admitted to Inpatient care by the very nature are deemed as complex or at risk and therefore when discharged from a psychiatric Inpatient ward, are required to be followed up regardless of CPA status or the clinical need for ongoing care.

1.2.4 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.

1.2.5 Telephone follow ups should only be used as a rare exception, examples may be that the person has gone out of area post discharge and is not contactable or the person refuses to allow a face to face contact. In such cases a risk assessment must have been updated and/or client's progress notes updated to state rationale for telephone contact to qualify as a follow up.

1.2.6 If a service user has been discharged to a nursing home, residential care, managed step down facility or a local acute NHS bed telephone follow up is acceptable and should be documented as a clinical contact on RiO.

1.2.7 Staff will need to diarise and outcome all appointments.

1.2.8 Service users who are non-Kent residents, but who will be discharged to community teams should be followed up as this indicator describes.

1.2.9 Service users, who are non-Kent residents and are discharged to non-host commissioner teams, should be followed up by the new provider. Wards should contact the provider of the service in the non-host area and inform them of the

discharge, so that they may arrange the follow up. This information should then be recorded on RiO.

1.2.10 All service users discharged to their place of residence, care home, residential accommodation, or to non-psychiatric care must be followed up within 72 hours of discharge. This includes service users who discharge against medical advice. It is the responsibility of the Trust to ensure that discharged service users are provided with appropriate follow up. Links will need to be established with the receiving institution if a client is discharged to, for example, a care home, to enable follow up to take place. However, if a client is transferred to another mental health hospital to continue psychiatric care, the responsibility lies with the receiving hospital to follow up on the client after they have been discharged providing this is a NHS funded facility.

1.3 **Protocol**

1.3.1 When a client is admitted to hospital, the admitting team will check the client's record on the electronic patient record (EPR) system which is currently RiO. This will indicate whether the client is currently open to a Community Mental Health Team (CMHT) and who their worker is, if one has been assigned.

1.3.2 If the client is unknown to the service and does not have an allocated worker it should be discussed early during admission. The Inpatient team will refer the service user to the relevant CMHT for assessment as early as possible during the admissions.

1.3.3 The clinical staff looking after the client on the ward is responsible for ensuring that the client's worker and/or team leader of the community team is made aware of the admission as early as possible.

1.3.4 The 72 hour follow-up plan will be decided at the client's discharge planning meeting or point of discharge. The process for each service in the Trust is outlined below:

2 YOUNGER ADULTS COMMUNITY CARE GROUP PROTOCOL

The Process

2.1 This protocol outlines the agreement between the Community Recovery Care Group (CRCG) and Acute Services regarding the process of how care will be transferred from Inpatient units to younger adults' community care group.

2.2 Post Discharge follows up will be arranged from the ward through the Trust's Single Point of Access (SPoA). SPoA will either book the client into a 72 hours appointment slot with the local CMHT or arrange with the local Crisis Team to make contact with the client, depending on the time of the week the client is discharged from the ward.

2.3 If the client has a Lead Health Care Professional in the community, SPoA will check the client's records to see if the worker or HCP has scheduled an appointment to follow up within 72 hours post discharge in which case SPOA will not book another appointment.

2.4 The process is:

- Client to be discharged from the ward to CRHT for treatment or Post discharge follow up as per appendix B

- Client to be discharged from the ward to CMHT. Ward contact SPoA to arrange date, time and place of 72 hours follow up appointment. Client to be given appointment details to attend.
- Client that is known to our services and has a Lead Health Professional if they have agreed with the client to meet prior to discharge then the above process is not applicable. If no plan is in place with Lead HCP the process above will apply.

2.5 The SPoA team have a designated telephone number for the 72hours follow up calls and bookings and the mobile phone is kept with the shift coordinator (Please see Appendix B for telephone number).

2.6 Each CRHT have specific contact numbers which only SPoA can use for this purpose. The shift coordinator keeps this in their possession all shift.

2.7 **Discharge to CMHT (Saturday to Wednesday Midnight)**

- Ward staff will contact SPoA to arrange an appointment with the local CMHT via the 72 hours clinic slots.
- SPoA will confirm client demographics with the ward
- SPoA will book the appointment into the 72 hours clinic slot available
- Ward staff will inform the client of the booked appointment for them to attend
- Ward admin will forward e-mail appointment information to CMHT's admin e-mail address
- If the client is known to services and has a Lead Health Professional, SPOA will review the client's notes to establish if a 72hour appointment has been booked by the worker. If not, SPOA will book the client into a slot as per process above. If the client has a 72hour appointment booked then the above will not apply.

2.8 **Discharge from wards (Thursday, Friday and Bank Holidays)**

- The younger adult Inpatient ward staff will contact SPoA who will inform the Crisis Resolution Home Treatment Team (CRHT) of the client's discharge. CRHT will arrange a 72 hours follow up appointment
- CRHT will open a referral for the client at this point and document the purpose of the referral
- CRHT will contact the client to arrange a date, time and place to carry out the face to face contact within the 72hr contact period
- CRHT will ensure the face to face contact appointment is outcomed on RiO
- CRHT will then close the client's referral to the crisis team

- CRHT will cover the bank holidays (Thursday, Friday, Saturday, Good Friday and Easter Monday). The same process (section 2.1.2) will apply.

2.9 **Ward Discharge to Early Intervention in Psychosis (EIP) via SPoA (Saturday Wednesday midnight)**

- Younger adult Inpatient ward staff will contact SPoA to inform them of client's discharge
- SPoA will verify client's demographics are accurate.

- SPoA will email West Kent or East Kent EIP Teams to inform them of discharge
- The ward staff will advise client that EIP will make contact with them within 72 hours
- For discharges from the ward Thursday, Friday and Saturday the process outline in appendix B will be followed.

2.10 **Escalation Process**

2.10.1 Any concerns in relation to compliance with this protocol should be discussed between the relevant CRHT, Ward and CMHT locality Service Managers and Operational Team Managers.

2.11 **Out of area client admitted to KMPT bed follow up process**

2.11.1 If the client is not Kent based, the client record will be updated to reflect the fact that the 72 hours follow up will be completed by the local team of the client. The ward will be responsible for contacting the receiving team of discharge and will contact them, to confirm client has been followed up within 72hours post discharge and record confirmation and discussion in client's progress note.

3 OLDER ADULTS CARE GROUP PROTOCOL

3.1 **The process on admission**

3.1.1 Wards are to contact the localities generic CMHSOP email address and relevant Service Manager, to alert them if no Ward occupational therapists (O.T) are able to complete the 72 hrs follow up appointment. If a Ward O.T is unable to attend then CMHSOP will organise and complete the 72 hrs follow up appointment.

- Expected Discharge Date (EDD) should be set at admission, the EDD should then be entered onto RiO and shown on the meridian board and regularly reviewed and updated at board meetings.
- Discharge CPA dates will be set in a timely way and communicated to the CMHSOP. The 72 hrs and CMHSOP follow up appointment dates are to be agreed prior to discharge and sent out in the Care plan letter.

3.1.2 **72 hrs Follow up appointment**

- The 72hrs face to face follow up appointment is to be arranged by a Ward O.T and then the follow up appointment conducted by a qualified O.T. Once the 72 hrs follow up contact has taken place, the appointment should be outcomed on RiO by a Ward O.T, documented on progress notes and have an updated risk assessment. CMHSOP/CMHT to book a follow up review to be undertaken after the 72 hrs follow up appointment in a timely way, with the date being agreed prior to discharge.

3.2 **Escalation process of KMPT client discharged to a different locality**

3.2.1 If concerns are identified by the Ward O.T at the 72hrs appointment, the Ward O.T will liaise with the Community team and handover their concerns.

3.2.2 If the client being discharged is moving out of Kent, the 72 hrs follow up appointment will be undertaken by telephone by the Ward O.T. If the Ward O.T's are unable to undertake the 72 hrs appointment due to lack of staffing on the ward, the CMHSOP/CMHT will be requested to undertake this within 72 hrs and outcome the appointment on RiO.

3.2.3 If the client lives in a different locality to the Ward, the 72 hrs follow up appointment and transition work will be completed by a Ward O.T from that locality to reduce travel. This is dependent on client-centred clinical reasoning and to be documented within the Multi-disciplinary team notes on RiO.

3.3 Out of area client admitted to KMPT bed follow up process

3.3.1 If the client is not Kent based, the client record will be updated to reflect the fact that the 72 hours follow up will be completed by the local team of the client. The ward will be responsible for contacting the receiving team of discharge and will contact them, to confirm client has been followed up within 72hours post discharge and record confirmation and discussion in client's progress note.

4 FORENSIC AND SPECIALIST CARE GROUP PROTOCOL

4.1 Mother and Baby Unit

4.1.1 The process on admission

- When a client is admitted onto the Mother and Baby unit (MBU) an estimated discharge date is agreed and updated on RiO. If the Lead Health Care Professional is known, ward staff would inform the worker of admission to MBU. If no Lead Health Care Professional is identified following admission, then for Kent and Medway clients a referral is made to the Mother and infant Mental Health Services (MIMHS) or for non Kent clients a referral is made to the appropriate local specialist Perinatal Community Mental Health Team or their Community Mental Health Team. Once completed a Lead Health Care Professional is allocated and they will be made aware of the MBU admission.

4.1.2 Discharge and follow up process

- The Lead Health Care Professional will be invited to CPA reviews and any discharge planning meetings. Once a discharge date and time has been confirmed, the lead worker will be informed by the MBU staff. The Lead Health Care Professional will advise the MBU of the follow-up date and time, this will be documented on RiO by the MBU staff. The Lead Health Care Professional will undertake the follow up visit within 72 hours post discharge, the visit will be entered onto the clients RiO diary and outcomed as either a face to face or telephone contact (Kent clients). If the client is not Kent based, the client record will be updated to reflect the fact that the 72 hours follow up will be completed by the local team of the client. The MBU team will contact the local tea, to confirm client has been followed up within 72hours post discharge and record confirmation and discussion in client's progress note.

4.1.3 Escalation process

- If concerns are raised that the process is not being followed, the issue would be escalated to the Perinatal Manager then the Service Manager for Specialist Services.

4.2 Forensic Outreach and Liaison Service (FOLS) and Specialist Community Forensic Team

4.2.1 Discharge and follow up process

FOLS, only take the lead in coordinating care in the community for clients on level 4 who are leaving secure services on a restricted discharge, life licence or on a Community treatment order with a complex forensic risk history. Clients leaving secure service not under such restrictions would be level 3, where the locality team

would lead in coordinating care with support from FOLS mental health practitioner for a 3 to 6 month period.

- Client on medium / low secure services obtain unescorted leave
- Referral made to FOLS for Level 4 follow up
- Discussion at FOLS referrals meeting
- Referral made to Community Forensic Social Work Team (CFSWT) Kent County Council by the ward
- FOLS practitioner to commence attending ward reviews and CPA's, and working on discharge planning.
- Completion of care act assessment by CFSWT to establish eligible social care need
- Once accommodation is identified FOLS practitioner allocated to that area to become involved
- FOLS practitioner involved in planning discharge and 117 meeting, facilitating discharge
- Client discussed throughout process at weekly case review meeting
- Pre discharge care plan in place
- Agreement and date for 72 hour follow up agreed at discharge planning and discussed in reviews
- Client to be notified of follow up appointment in person
- If visit is unsuccessful it will be followed up by a telephone call and further attempts for a face to face visit until contact has occurred.

5 OUTLINE OF TRACKING AND AUDIT PROCESS FOR POST DISCHARGE FOLLOW UP

5.1 Documentation and Data analysis

- 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 regardless of their pathway. Actions are to be documented on clients' 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.
- All discharges regardless of clients care pathway (CPA, standard or unassigned) will be monitored throughout the year.
- Daily discharges are emailed to the clients' worker or Lead Health Care professional (HCP), Duty email addresses and locality managers the morning after discharge.
- Data collected between April 2019 to September 2019 will be used as a baseline to monitor current compliance and to improve processes and outcomes.
- Data submission to Mental Health Services Data Set.

6 EQUALITY IMPACT ASSESSMENT

6.1 The Equality Act 2010 places a statutory duty on public bodies to have due regard in the exercise of their functions. The duty also requires public bodies to consider how the decisions they make, and the services they deliver, affect people who share equality protected characteristics and those who do not. In KMPT the culture of Equality Impact Assessment will be pursued in order to provide assurance that the Trust has carefully considered any potential negative outcomes that can occur before implementation. The Trust will monitor the implementation of the various functions/policies and refresh them in a timely manner in order to incorporate any positive changes.

7 HUMAN RIGHTS

7.1 The Human Rights Act 1998 sets out fundamental provisions with respect to the protection of individual human rights. These include;

- Maintaining dignity
- Ensuring confidentiality and protecting individuals from abuse of various kinds.
- Employees and volunteers of the Trust must ensure that the trust does not breach the human rights of any individual the trust comes into contact with.

8 MONITORING COMPLIANCE WITH AND EFFECTIVENESS OF THIS DOCUMENT

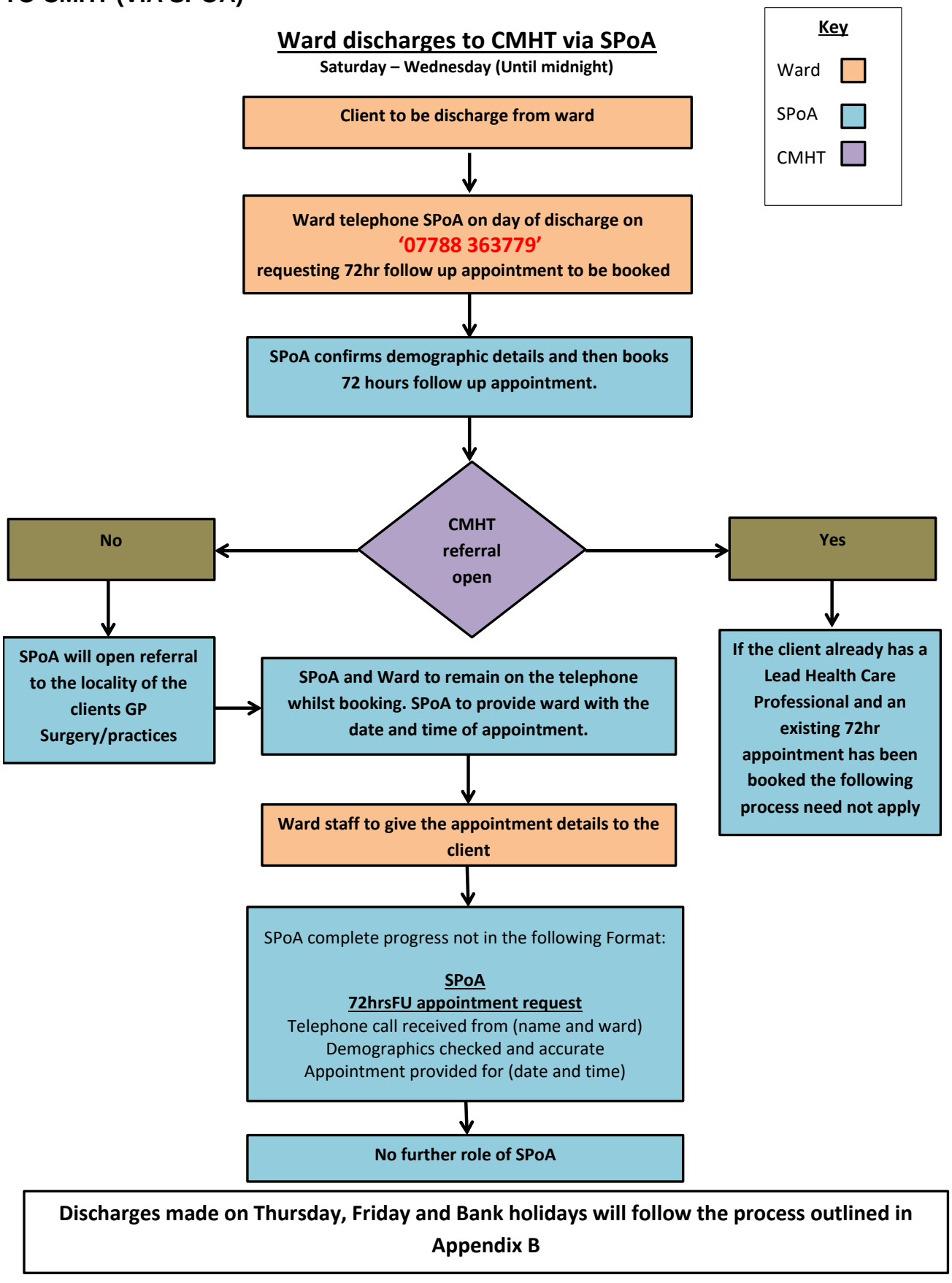
What will be monitored	How will it be monitored	Who will monitor	Frequency	Evidence to demonstrate monitoring	Action to be taken in event of non-compliance
Follow up appointment contacts	Review of performance report and action taken where needed	Performance Team	Weekly	Weekly emails to Service Managers/Team leaders. Team providing exception narrative when follow up has not been completed.	Escalation to Performance Team /Locality Managers/Deputy Chief Operating Officer/Heads of Service
72 hours Breaches	Review of performance report	Performance Team	Weekly	Weekly emails to Service Managers/Team leaders. Logging narratives or outcomed appointments on a monitoring spreadsheet	Escalation to Locality Manager/Deputy Chief Operating Officer/Heads of Service

9 EXCEPTIONS

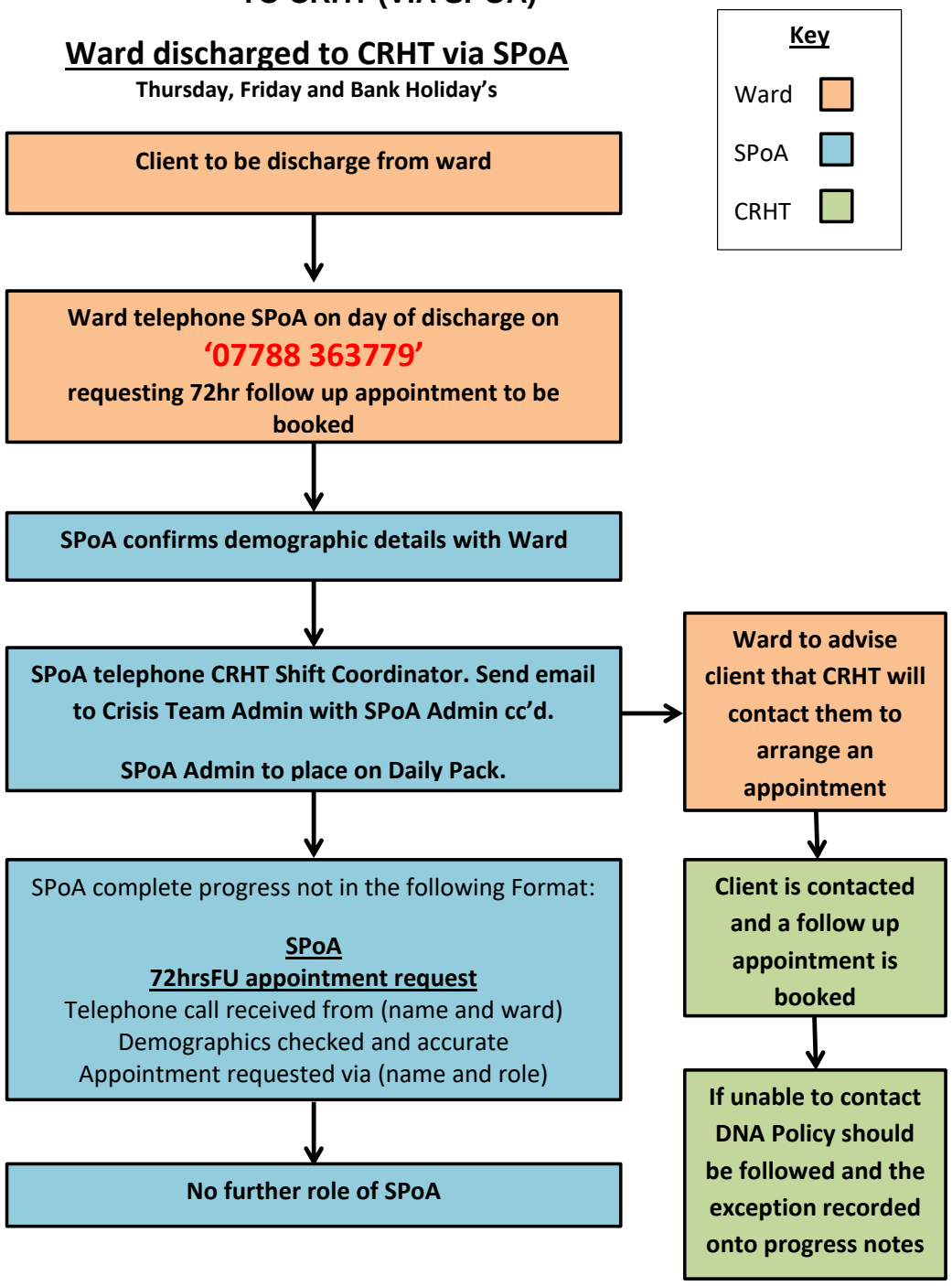
Situation	Exclusion	Justification
Where legal precedence has forced the removal of a client from the country	Local Exclusion	It is not currently possible to identify this cohort in the MHSDS but is a rare occurrence
Clients who have died within 72hrs of discharge	Exclusion	If a client has died within 72hrs of discharge it would not be possible to complete a follow up
Clients transferred to NHS psychiatric Inpatient ward	Exclusion	This would be classed as a transfer of care and not a discharge
Clients transferred to a non-NHS hospital	Exclusion	This would be classed as a transfer of care and not a discharge
Clients discharged to prison	Exclusion	Health and Justice services are commissioned by specialised commissioning and therefore are outside the scope of this CQUIN
Clients from outside of England. E.g. Scotland and Wales	Exclusion	This protocol covers CCG commissioned activity only

It is important to note that compliance with the 72hr period is measured in days, not hours and starts the day after the person is discharged from hospital e.g. If someone was discharged on the 1st of January, they could be followed up on the 2nd, 3rd or 4th January to comply with the 72hr time-period

APPENDIX A: FLOWCHART – POST DISCHARGE FOLLOW UP PROCESS FROM WARD TO CMHT (VIA SPOA)

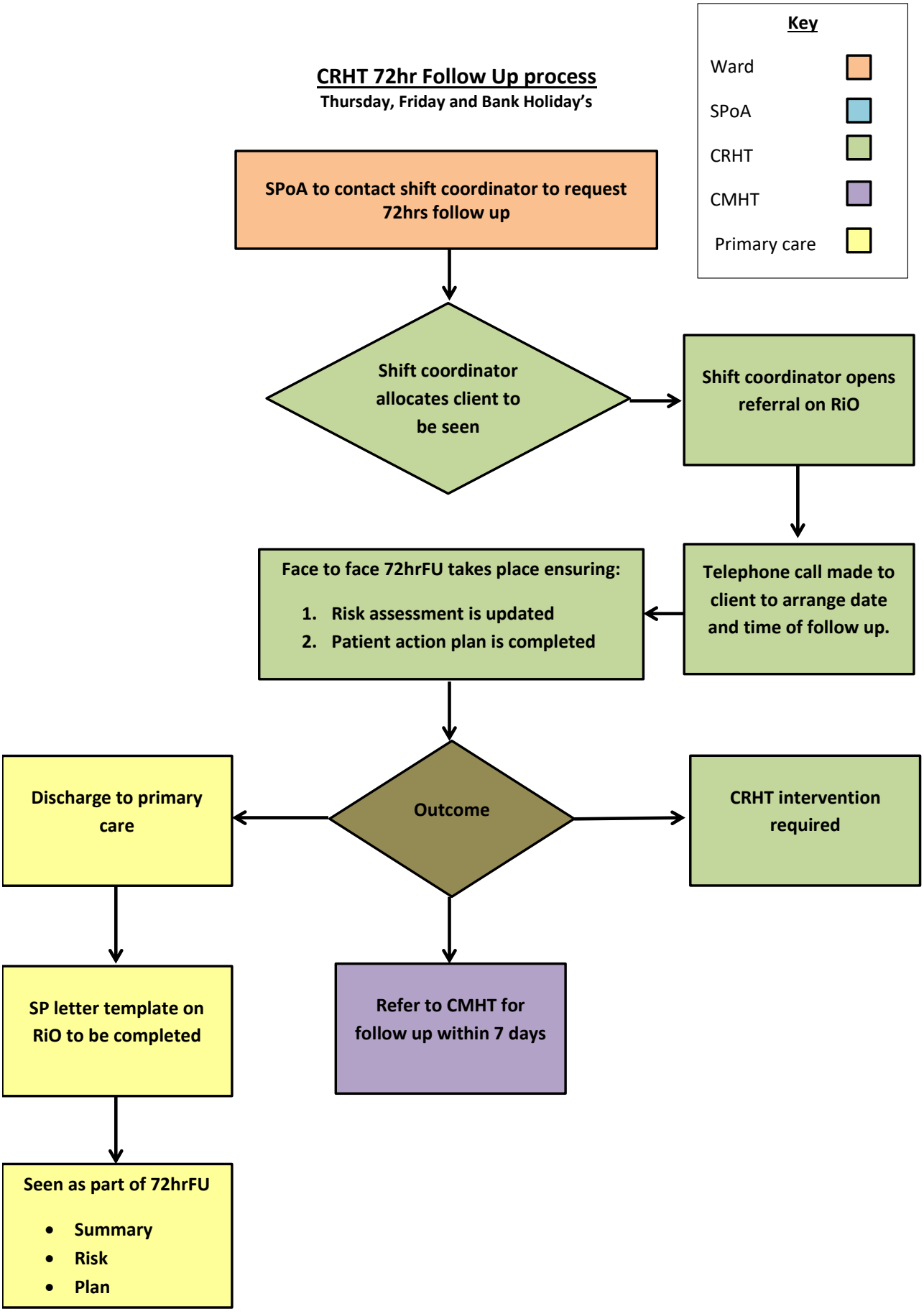


APPENDIX B FLOWCHART – POST DISCHARGE FOLLOW UP PROCESS FROM WARD TO CRHT (VIA SPOA)

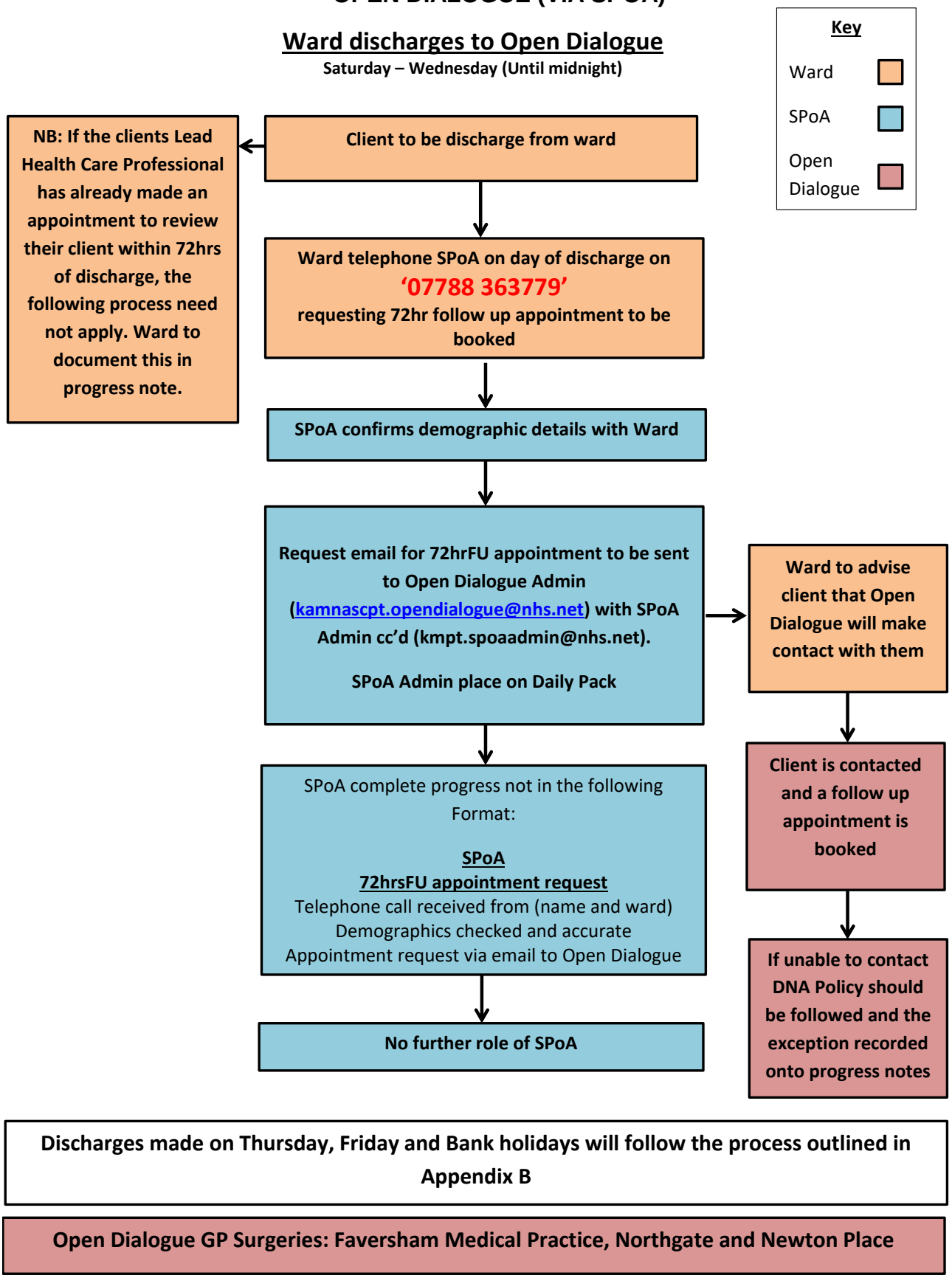


SPoA Admin Email kmpt.spoaadmin@nhs.net **Crisis Team Contact Details** Medway & Swale CRHT 07796938048 kmpt.medwayandswalecrhtt@nhs.net **North Kent CRHT** 07795642344 kmpt.dgscrhtt@nhs.net	**West Kent CRHT** 07788360069 kmpt.westkentcrht@nhs.net **North East Kent** 07788360149 kmpt.nekcrhtt.stmartins@nhs.net **South East Kent** 07788360115 kmpt.sekcrhtt@nhs.net

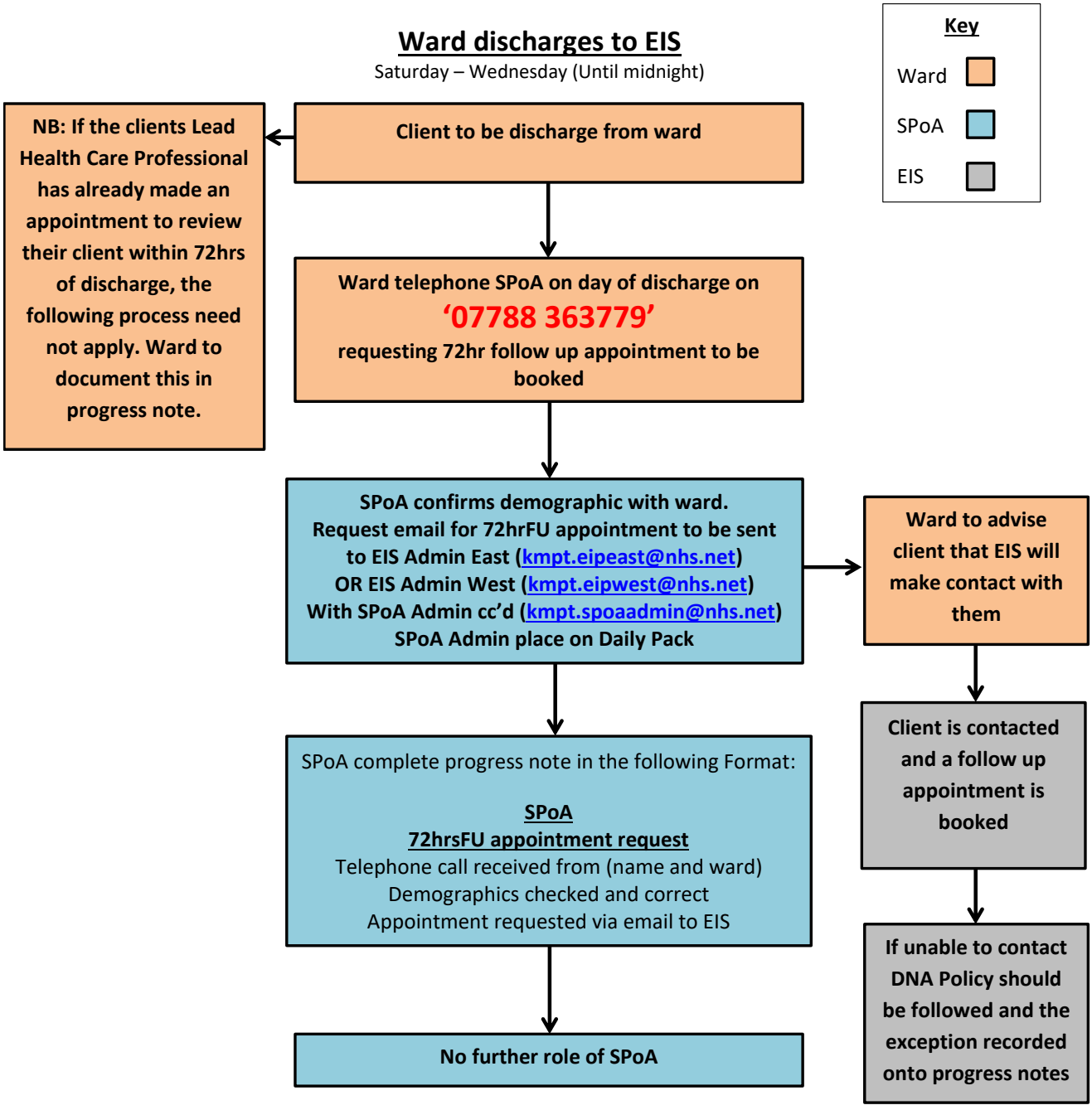
APPENDIX C: FLOWCHART – CRHT FOLLOW UP PROCESS



APPENDIX D: FLOWCHART – POST DISCHARGE FOLLOW UP PROCESS FROM WARD TO OPEN DIALOGUE (VIA SPOA)



APPENDIX E: FLOWCHART – POST DISCHARGE FOLLOW UP PROCESS FROM WARD TO EARLY INTERVENTION SERVICE (VIA SPOA)



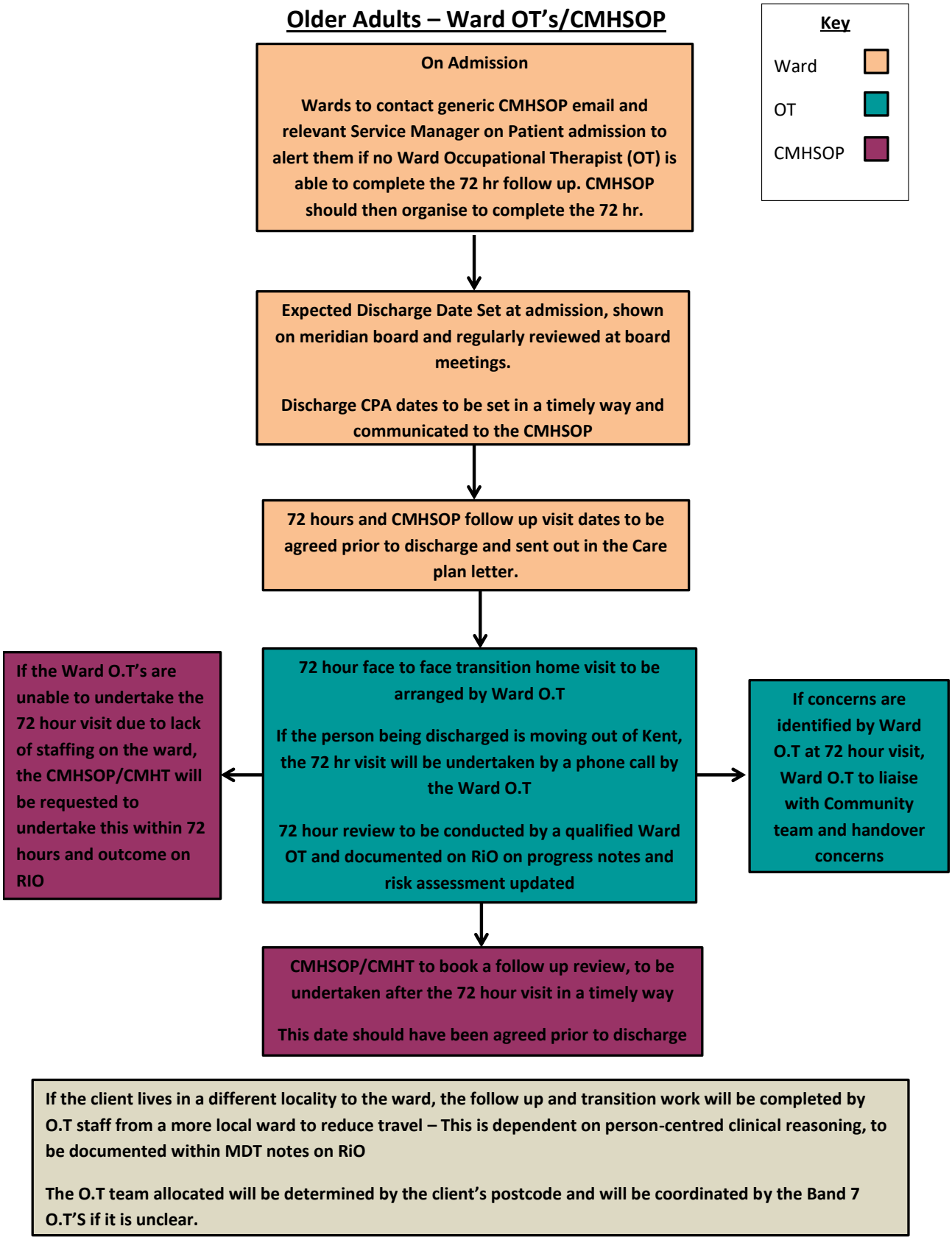
Discharges made on Thursday, Friday and Bank holidays will follow the process outlined in Appendix B

EIP Contact Telephone Numbers:

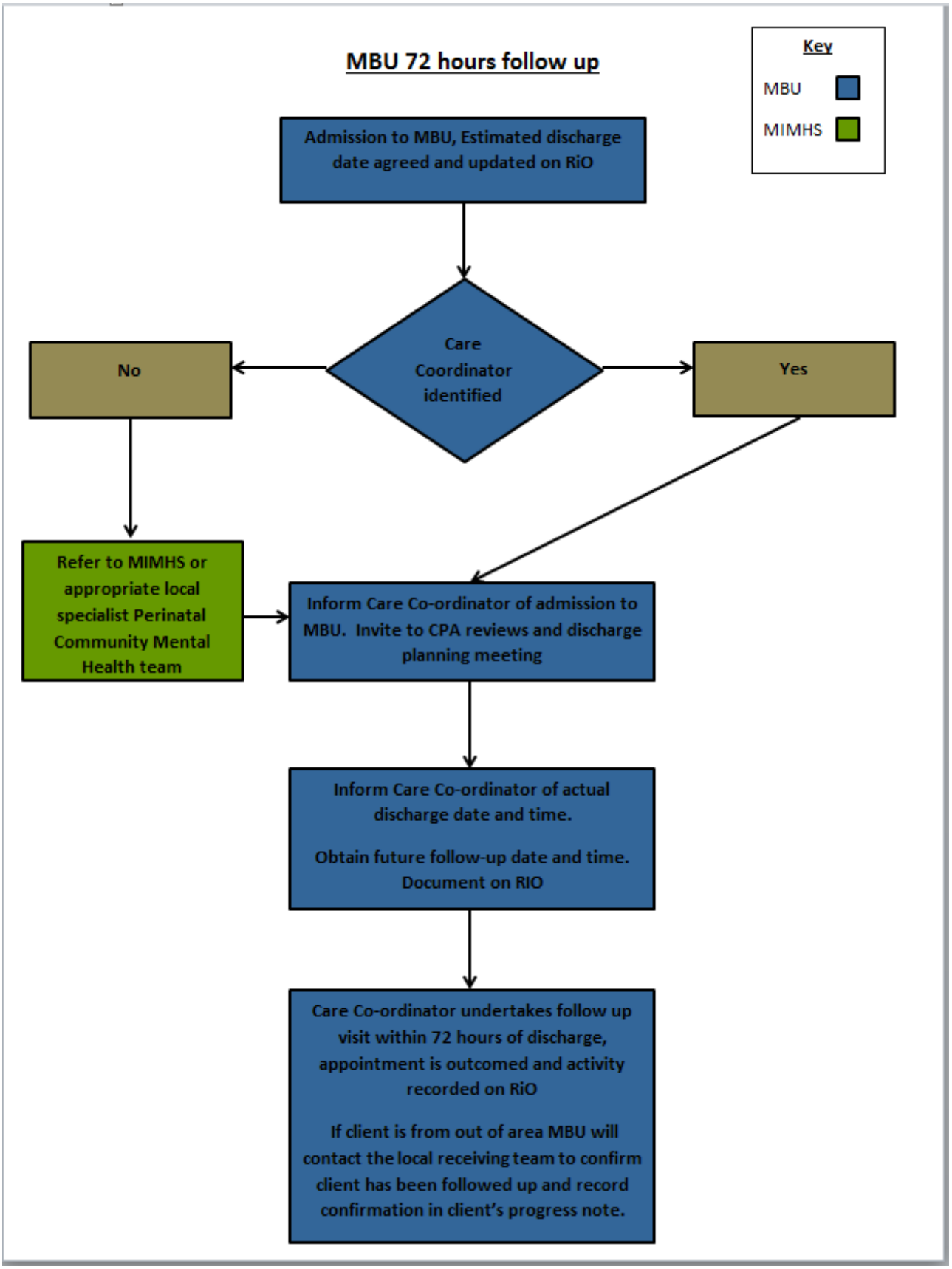
West Kent EIP 01634 854547

East Kent EIP 01227 812390

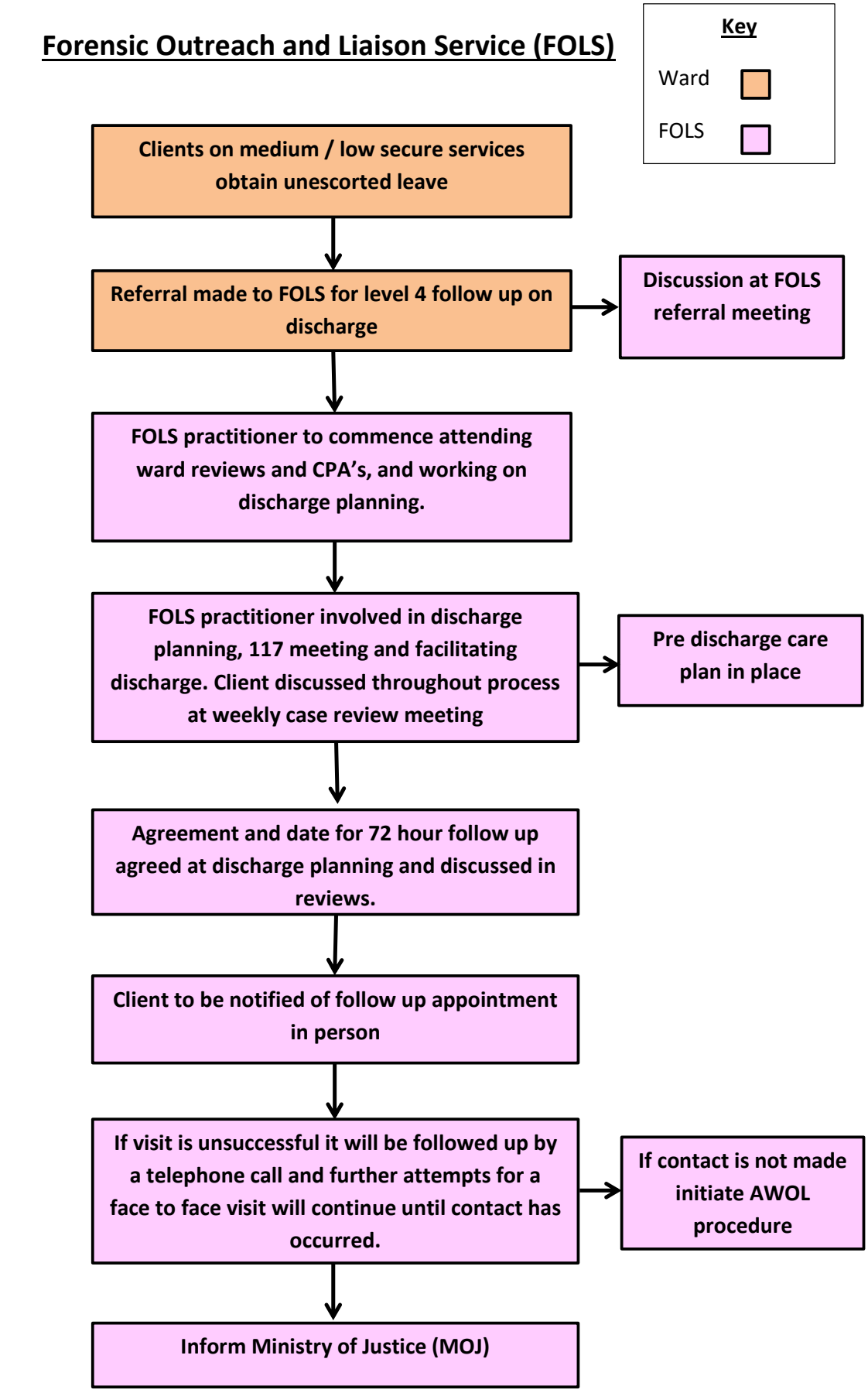
APPENDIX F: FLOWCHART – POST DISCHARGE FOLLOW UP PROCESS FOR OLDER ADULTS COMMUNITY



APPENDIX G: FLOWCHART – POST DISCHARGED FOLLOW UP PROCESS FOR MBU



APPENDIX H: FLOWCHART – POST DISCHARGE FOLLOW UP FOR FOLS



APPENDIX I: FLOWCHART – PROGRESS NOTE TEMPLATE

PROGRESS NOTE STANDARDS

Setting and purpose of visit
Who was present
Care planning
Mental health symptoms and presentation
Social and environmental issues
Actions taken during visit
Identified risks and needs
Plan

Setting and purpose of visit

e.g. Patient's home, CMHT building etc.

Medication review, Care coordinator review etc.

If this is a 72 hour follow up visit, include this as the purpose of the visit

Who was present

e.g. Care coordinator, patient attended with mother etc.

Care planning

e.g. Make reference to the care plan / Personal Care & Support Plan – each identified need/goal and what steps have been taken towards the achievement of these goals

Mental health symptoms and presentation

e.g. Low mood, suicidal thoughts, psychotic symptoms and then mental state exam, appearance, any evidence of thought disorder, any evidence of mood disorder, eye contact, insight etc.

Medication

e.g. What they are on? Compliance? Supply (if recently discharged is the person is receipt of the correct drugs)? Is it working? Side effects?

Social and environmental issues

e.g. Accommodation, occupation, relationships, stresses etc.

Actions taken during visit

e.g. Went for short walk as per graded exposure plan, discussed concerns re medication etc.

Identified risks and needs

e.g. Risk to self or others

Plan, including next appointment

e.g. What are the therapeutic options received or waiting for? Include proposed date / time frame for next appointment