Standard Operating Procedure (SOP): Preparation and Completion of Discharge Summary Documentation

Purpose

This SOP details the **preparation and completion of discharge summary documentation**, covering the accurate collection of patient information, documentation of diagnosis and treatment, medication reconciliation, follow-up care instructions, and communication with primary care providers. The goal is to ensure comprehensive, clear, and timely discharge summaries that support continuity of care and enhance patient safety post-discharge.

Scope

This SOP applies to all healthcare staff involved in the preparation, review, and completion of patient discharge summaries.

Responsibilities

- **Physicians:** Complete and approve the discharge summary.
- **Nurses:** Provide relevant nursing notes and assist in medication reconciliation.
- **Pharmacists:** Support with medication reconciliation as needed.
- **Administrative Staff:** Ensure timely forwarding of the completed summary to appropriate recipients.

Procedure

1. **Preparation**
    - Obtain the patient's medical records and ensure accuracy of demographic and admission data.
2. **Collection of Patient Information**
    - Document patient identification details (name, MRN, DOB, contact info).
    - Record admission and discharge dates.
3. **Documentation of Hospital Course**
    - Summarize reasons for admission, significant diagnoses, and any complications.
    - Provide a concise overview of treatment provided, including procedures and interventions.
4. **Medication Reconciliation**
    - List medications at admission, during hospitalization, and upon discharge.
    - Highlight any changes in therapy, including additions, discontinuations, or dosage adjustments, with reasons.
5. **Discharge & Follow-Up Instructions**
    - Include clear instructions for continued care, medication regimen, activity restrictions, and warning signs to monitor.
    - Schedule and document follow-up appointments as appropriate.
6. **Communication**
    - Ensure copy of discharge summary is sent promptly to the patient's primary care provider and/or referring clinician.
    - Provide patient with a copy of the summary and educate them on its contents.
7. **Review & Completion**
    - Physician reviews and finalizes the discharge summary, signing and dating as required.
    - Administrative staff files the summary in the patient's record system.

Documentation Requirements

- All entries must be legible, accurate, and completed within 24 hours of patient discharge.
- Use standardized forms/templates where available.
- Correct all identified discrepancies prior to summary completion and transmission.

References

- Hospital Policy on Documentation Standards
- Regulatory standards (e.g., Joint Commission, local health authorities)
- Best practice guidelines for discharge processes

Revision History

Version	Date	Description	Reviewed By
1.0	2024-06-12	Initial SOP template created.	SOP Committee