SOP Template: Completion of Discharge Documentation and Reporting

This SOP details the **completion of discharge documentation and reporting** process, covering accurate preparation of patient discharge summaries, verification of required information, coordination with healthcare teams, ensuring compliance with legal and regulatory standards, timely submission of reports, and proper archiving of discharge records. The goal is to facilitate seamless patient transitions, maintain comprehensive medical records, and support effective communication among healthcare providers.

1. Purpose

To outline standardized procedures for completing discharge documentation and reporting to facilitate seamless patient transitions and ensure regulatory compliance.

2. Scope

This SOP applies to all clinical and administrative staff involved in the discharge process within the healthcare facility.

3. Responsibilities

- **Attending Physician:** Prepares and reviews the discharge summary.
- **Nursing Staff:** Assists with data collection and verification.
- **Medical Records Department:** Archives discharge records and ensures timely submission.
- **Case Management:** Coordinates with healthcare teams for post-discharge planning.

4. Procedure

1. **Gather Documentation:** Collect all relevant patient information, including clinical notes, test results, and treatment summaries.
2. **Prepare Discharge Summary:** Complete the discharge summary form, including:
    - Patient identification details
    - Admission/discharge dates
    - Diagnosis at admission and discharge
    - Treatment provided
    - Medications on discharge
    - Follow-up care instructions
    - Attending physician's sign-off
3. **Verification:** Review the discharge summary for completeness and accuracy. Confirm that all required fields are filled and all necessary documents are attached.
4. **Coordination:** Communicate with the healthcare team regarding follow-up care and transfer arrangements as needed.
5. **Compliance Check:** Ensure that all legal and regulatory standards regarding discharge documentation are met.
6. **Submission:** Submit the finalized discharge summary to the relevant department(s) within the specified timeline (e.g., 24-48 hours after discharge).
7. **Archiving:** Send discharge documentation to the Medical Records department for secure archiving according to policy.

5. Documentation and Reporting

- All completed discharge summaries must be entered into the electronic medical record (EMR) system, if available.
- Physical records must be securely stored and accessible only to authorized personnel.
- Reports of discharge activity should be generated and submitted to management as per schedule (weekly/monthly).

6. Compliance

All discharge documentation must comply with institutional policies and relevant healthcare regulations, such as HIPAA

and local medical board standards.

7. Review and Revision

This SOP should be reviewed annually or as required to maintain alignment with best practices and regulatory updates.

8. References

- Institutional Discharge Policy and Procedures
- Relevant Healthcare Regulatory Guidelines
- Medical Records Management Policy