Standard Operating Procedure (SOP)

Patient Eligibility Assessment and Discharge Readiness Confirmation

This SOP details the process for **patient eligibility assessment and discharge readiness confirmation**, including criteria for evaluating patient medical status, functional abilities, and psychosocial factors. It ensures comprehensive assessment protocols are followed to determine eligibility for discharge, coordinate multidisciplinary team input, plan for post-discharge care, and confirm patient and family understanding of discharge instructions. The goal is to facilitate safe, timely, and appropriate transitions from healthcare facilities to home or other care settings.

1. Purpose

To establish standardized procedures for assessing patient eligibility for discharge and confirming readiness, ensuring all necessary criteria are met for a safe transition of care.

2. Scope

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

3. Responsibilities

- **Attending Physician:** Medical assessment and final discharge authorization.
- **Nursing Staff:** Ongoing patient evaluation, education, and discharge preparation.
- **Allied Health Professionals (e.g., therapists, social workers):** Functional, psychosocial, and home care planning assessments.
- **Case Manager/Discharge Planner:** Coordination of discharge processes and documentation.

4. Procedure

1. **Initiation of Discharge Planning**
    - Begin discharge planning at admission or as soon as medically appropriate.

2. **Eligibility Assessment Criteria**
    - Medical Status:
        - Clinical stability (vitals within normal range)
        - Completion, modification, or transition of acute medical treatments
        - Clear diagnosis and prognosis
        - No outstanding critical investigations or procedures
    - Functional Abilities:
        - Ability to perform activities of daily living (ADLs) independently or with support
        - Mobility assessment (ambulatory status, need for mobility aids)
    - Psychosocial Factors:
        - Adequate home support system (family, caregivers, community resources)
        - Mental health and cognitive assessment
        - Access to necessary post-discharge medical supplies and medications

3. **Multidisciplinary Team Review**
    - Case discussion involving physician, nursing, allied health, and case manager/discharge planner
    - Documentation of team consensus and recommendations

4. **Patient and Family Education**
    - Confirm understanding of discharge instructions (medications, appointments, wound care, red flags)
    - Written and verbal instructions provided; documentation of understanding obtained

5. **Discharge Readiness Confirmation**
    - Final checklist completion by nurse/case manager
    - Review and approval by attending physician

6. **Discharge Execution**
    - Prepare discharge summary and prescriptions
    - Arrange transportation if needed

- Notify relevant post-care providers (e.g., home care, primary physician)

7. **Documentation**
   - All assessment findings, instructions given, and authorizations must be documented in the patient record

5. References

- Hospital Discharge Policies
- National Guidelines for Safe Patient Transitions
- Relevant Accreditation Standards (e.g., Joint Commission)

6. Forms & Checklists

Form/Checklist	Description
Discharge Eligibility Assessment Form	Checklist/table to record assessment findings against eligibility criteria
Discharge Instructions Form	Template for written discharge instructions for patient and family
Discharge Summary Template	Standardized template for documenting patient discharge summary

7. Revision/Approval

Version: 1.0
Date: [Insert Date]
Approved by: [Name/Title]