SOP Template: Discharge Planning and Patient Transfer Protocols

This SOP defines the **discharge planning and patient transfer protocols**, detailing coordinated steps for effective patient discharge and safe transfer between healthcare settings. It covers assessment of patient needs, communication among multidisciplinary teams, documentation requirements, patient and family education, and the use of transfer tools to ensure continuity of care, minimize risks, and enhance patient outcomes. The goal is to streamline transitions, prevent readmissions, and promote patient safety throughout the discharge and transfer process.

1. Purpose

To establish standardized procedures for discharge planning and patient transfer, ensuring patient safety, continuity of care, and optimal health outcomes.

2. Scope

This SOP applies to all clinical staff involved in discharge planning and patient transfers within and between health care facilities.

3. Responsibilities

- **Physicians:** Assess discharge eligibility, determine post-discharge needs, and authorize discharge/transfer.
- **Nurses:** Coordinate with multidisciplinary teams, provide patient and family education, prepare discharge/transfer documentation.
- **Case Managers/Social Workers:** Assess psychosocial needs and coordinate post-discharge resources/support.
- **Allied Health Professionals:** Contribute to the multidisciplinary assessment and care planning.

4. Procedure

4.1 Assessment of Patient Needs

1. Initiate discharge planning on admission or as early as possible.
2. Conduct a comprehensive assessment covering medical, social, functional, and psychological needs.
3. Identify potential barriers or risks post-discharge (e.g., mobility, medication management, home environment).

4.2 Multidisciplinary Team Communication

1. Convene regular multidisciplinary meetings for discharge planning.
2. Clearly assign responsibilities for each aspect of the discharge/transfer process.
3. Document decisions and action items in the patient's medical record.

4.3 Patient and Family Education

1. Educate patient and caregivers regarding post-discharge plan, medication regimen, follow-up appointments, and warning signs.
2. Provide printed/written materials and contact information for questions or emergencies.
3. Verify understanding using teach-back methods.

4.4 Documentation Requirements

1. Complete and update discharge/transfer summary in the medical record.
2. Include diagnosis, treatments, pending test results, medication list, and follow-up instructions.
3. Document all communications with patients, families, and other care providers.

4.5 Patient Transfer Protocol

1. Notify receiving facility/unit in advance and share relevant medical records and care plans.
2. Utilize standardized transfer tools (e.g., SBAR, transfer forms).
3. Arrange safe transport and necessary medical equipment.
4. Confirm patient identification and perform handoff communication upon arrival.

5. Transfer Tools and Checklists

- Patient Transfer Form (including medical history, allergies, current medications)
- SBAR (Situation, Background, Assessment, Recommendation) Communication Tool
- Discharge Checklist
- Patient Education Materials

6. Quality Assurance and Review

1. Audit discharge and transfer documentation for completeness and accuracy.
2. Monitor readmission and adverse event rates related to discharge/transfer.
3. Conduct regular reviews and update SOP as necessary.

7. References

- National/State Health Policies on Patient Transfers
- Hospital Discharge Planning Guidelines
- Accreditation Standards for Continuity of Care

8. Appendix

Document	Description
Discharge Summary Template	Standardized format to record discharge details.
Patient Transfer Checklist	Step-by-step list to ensure safe and complete transfer.
Patient Education Leaflet	Information sheet for patients/caregivers about post-discharge care.