Standard Operating Procedure (SOP): Arrangement of Transportation and Post-Discharge Support Services

This SOP details the **arrangement of transportation and post-discharge support services**, encompassing the coordination of patient transport logistics, ensuring timely and safe transfers, organizing follow-up care, providing necessary support for recovery at home, and facilitating communication between healthcare providers and patients. The objective is to enhance patient experience and continuity of care by delivering efficient transportation solutions and comprehensive post-discharge assistance.

1. Scope

This SOP applies to all healthcare staff involved in discharge planning, transportation coordination, and post-discharge care provision.

2. Roles and Responsibilities

- **Discharge Coordinator:** Initiates and manages discharge process, coordinates with transport and support services.
- **Nursing Staff:** Communicates patient needs, educates patient and family, documents post-discharge plans.
- **Transport Coordinator:** Arranges and confirms transportation, ensures timely pickup and drop-off.
- **Home Care/Support Services:** Provides necessary home-based care, follow-up visits, and patient support.
- **Patient/Family:** Collaborates with staff, provides updated contact and accessibility information.

3. Procedure

1. **Assessment and Planning**
    - Review patient's clinical status and needs for transportation and home support.
    - Assess patient mobility, need for special transport (e.g., ambulance, wheelchair-access vehicle).
    - Identify necessary post-discharge support services (e.g., nursing, physiotherapy, medical equipment).
    - Record and update discharge plan in patient records.
2. **Transportation Coordination**
    - Contact approved transportation providers to book necessary transport.
    - Verify patient's address, contact information, and special requirements.
    - Communicate pickup time and transport details to patient/family.
    - Confirm with transport provider prior to discharge.
3. **Post-Discharge Support Arrangement**
    - Organize necessary home care services according to patient's recovery needs.
    - Set up follow-up appointments (in-person/telehealth) as needed.
    - Coordinate delivery or setup of home medical equipment and supplies.
    - Ensure clear documentation and handover to post-discharge care team.
4. **Patient & Family Education**
    - Provide written and verbal information about post-discharge care plan.
    - Explain transportation process and contact information for service provider.
    - Review emergency contact procedures.
5. **Communication & Handover**
    - Inform primary care provider and relevant specialists of discharge and support plans.
    - Ensure two-way feedback between community/home care teams and hospital staff.
6. **Documentation**
    - Record all transportation bookings, patient preferences, support services arranged, and instructions provided in patient records.
7. **Follow-Up**
    - Confirm safe arrival of patient at home/residence.
    - Monitor patient progress and adapt support plan as needed.

4. Quality and Safety Considerations

- Ensure all providers are accredited and comply with health and safety regulations.
- Maintain patient confidentiality throughout the process.
- Review incident reports and patient feedback for quality improvement.

5. References & Related Documents

- Patient Discharge Policy
- Transportation Provider List
- Home Care Coordination Guidelines
- Patient Education Materials (Discharge & Home Care)

Note: Review and update this SOP annually or whenever new transportation or support service providers are added.