SOP: Patient Discharge Planning and Education

This SOP details **patient discharge planning and education**, encompassing the coordination of discharge processes, patient and family education on post-discharge care, medication management, scheduling follow-up appointments, and ensuring clear communication among healthcare providers. The goal is to facilitate a smooth transition from hospital to home or other care settings, improve patient outcomes, and reduce readmission rates through comprehensive discharge preparation and patient empowerment.

1. Purpose

To establish standardized procedures for effective discharge planning and comprehensive patient and family education to support safe, coordinated transitions of care.

2. Scope

This SOP applies to all healthcare professionals involved in the discharge process in the hospital, including physicians, nurses, pharmacists, case managers, and allied health personnel.

3. Responsibilities

Role	Responsibility
Discharge Coordinator/Case Manager	Facilitates discharge planning; liaises between patient, family, and health team.
Physician	Confirms readiness for discharge; develops discharge orders; reviews instructions.
Nursing Staff	Provides education on care, medications, and follow-up; assists with coordination.
Pharmacist	Reviews and reconciles medications; counsels patient on medication management.
Allied Health (OT, PT, etc.)	Assesses need for equipment, home modifications, or further therapy.

4. Procedure

1. **Initiate Discharge Planning**
    - Begin planning upon admission or as early as possible.
    - Identify potential barriers to safe discharge (e.g., home environment, social support).

2. **Develop Discharge Plan**
    - Collaborate with multi-disciplinary team, patient, and family.
    - Document individualized discharge needs and solutions.

3. **Patient & Family Education**
    - Explain diagnosis, expected outcomes, warning signs, and when to seek advice.
    - Educate on wound care, mobility, nutrition, equipment, and safety as applicable.
    - Use teach-back method to confirm understanding.

4. **Medication Management**
    - Conduct medication reconciliation.
    - Provide written and verbal instructions on medications, dosing, side effects, and interactions.
    - Address questions or concerns about medications.

5. **Arrange Follow-Up Care**
    - Schedule follow-up appointments before discharge (primary care and specialists).
    - Provide contact information for community resources and home health agencies if needed.

6. **Documentation**
    - Document all discharge instructions, educational materials provided, and patient understanding.
    - Update discharge summary in the patient's medical record.

7. **Ensure Communication**
    - Communicate discharge plan and summary to patient, family, and next care provider (e.g., home health, primary doctor).
    - Send necessary documents to post-discharge providers as relevant.

5. Related Documents and Forms

- Discharge checklist
- Patient education materials
- Medication reconciliation form
- Discharge summary template

6. Review and Compliance

- SOP compliance will be monitored through regular discharge audits and patient feedback.
- This SOP should be reviewed and updated annually or as regulations and best practices evolve.

7. References

- Hospital Discharge Planning Policy
- National and Local Regulations/Guidelines
- Accreditation Standards (e.g., Joint Commission)