

SOP: Preparation and Review of Patient Discharge Summary

This SOP details the **preparation and review of patient discharge summary**, outlining the process of compiling comprehensive and accurate patient information, including diagnosis, treatment provided, medications prescribed, follow-up instructions, and any necessary referrals. It emphasizes the importance of timely preparation, thorough review by healthcare professionals, and clear communication to ensure continuity of care and patient safety upon discharge.

1. Purpose

To ensure the accurate and timely preparation and review of patient discharge summaries, facilitating high-quality, safe, and coordinated patient care after hospital discharge.

2. Scope

This SOP applies to all healthcare professionals involved in the discharge process, including physicians, nurses, and administrative staff responsible for documenting, reviewing, and communicating patient discharge summaries.

3. Responsibilities

- **Attending Physician:** Prepares initial discharge summary and ensures completion of all sections.
- **Nurses:** Provide input regarding patient care and ensure accuracy of documented treatments and instructions.
- **Reviewing Clinician/Supervisor:** Reviews the discharge summary for completeness, accuracy, and clarity.
- **Administrative Staff:** Ensure timely delivery of the discharge summary to the patient and relevant care providers.

4. Procedure

Step	Description	Responsible Person
4.1	Collect all relevant patient information (diagnosis, investigations, treatment plan, procedures, outcomes).	Attending Physician
4.2	Document discharge medications, dosages, and instructions.	Attending Physician / Nurse
4.3	Summarize follow-up appointments and referrals to other care providers.	Attending Physician / Administrative Staff
4.4	Draft the discharge summary in the approved format/template.	Attending Physician
4.5	Review the summary for accuracy, completeness, legibility, and clarity.	Reviewing Clinician/Supervisor
4.6	Obtain signatures of all required healthcare staff.	Reviewing Clinician/Supervisor
4.7	Provide the discharge summary to the patient/family and ensure transmission to primary care physician or referring provider.	Administrative Staff
4.8	Document the completion and delivery of the summary in the patient medical record.	Administrative Staff

5. Documentation

- Completed discharge summary (retained in patient's health record)
- Copies for patient and referring/primary care provider
- Log of summary delivery (if separate tracking is required)

6. Quality Control & Review

- Regular audits of discharge summaries for completeness and accuracy
- Ongoing training for staff on the discharge process and documentation requirements
- Immediate correction of identified deficiencies, with feedback to responsible staff

7. References

- Relevant hospital discharge policies and guidelines
- National/regional standards for hospital discharge documentation
- Professional regulatory requirements

8. Revision History

Version	Date	Description of Change	Prepared By
1.0	2024-06-01	Initial SOP issued	SOP Committee