

Organisation name Site or unit		PLAN Discharge plan: written, agreed and passed on	
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Owner		Approved by	
Signature			

Plan · AFT-PLN-001 · Version 0.1 · Draft for local review

Supports: 42.1

At a glance

- Every patient leaving a ward, unit or clinic has a written discharge plan, agreed with the patient, and started before the day of discharge.
- The plan covers the diagnosis, treatment given, medicines, follow-up, warning signs, social needs and who to contact.
- The plan is sent to the next provider, the GP or community team on the day of discharge, with the patient's agreement.
- Patients who cannot go home safely are not discharged until the safe plan is in place.
- Stop and check if: a plan is missing, not agreed with the patient, or has not reached the next provider.

1. 1. Purpose

To make sure every patient leaves with a written discharge plan that they understand and agree with, and that the plan reaches the people who will care for them next, so that care continues without a gap (42.1).

2. 2. Scope

Item	Coverage
Applies to	Doctors, nurses, allied health staff, social workers and discharge coordinators
Patients	All patients discharged from inpatient, day-case, emergency and outpatient care, including transfers to another facility or to home
Documents	The discharge plan, the summary sent to the next provider, and the patient's copy

3. 3. Definitions

Term	Meaning in this SOP
Discharge plan	A written plan that sets out the patient's condition at discharge, the care they need after it, who will provide it, and how to get help
Next provider	The GP, community team, care home, another facility or the family member responsible for the next stage of care
Teach-back	A check that the patient understands the plan, by asking them to say back the key points in their own words

4. 4. Background

Poor discharge is one of the most common causes of readmission and harm after hospital care. Plans that are written late, that do not reach the next provider, or that the patient does not understand are a frequent cause of avoidable problems. Starting planning early, and agreeing the plan with the patient, improves outcomes.

5. 5. Responsibilities

Role	Responsibility
Responsible clinician	Confirms the patient is fit for discharge, agrees the plan, and signs the discharge summary
Ward nurse	Gives the patient the written plan and warning signs, does the teach-back, and confirms the medicines
Discharge coordinator or social worker	Arranges the services, transport and support needed, and confirms they are in place
Service manager	Keeps the template, the transfer route and the audit in place

6. 6. Procedure

6.1 Starting the plan

1. Start discharge planning on admission, and record the expected discharge date and the likely needs.
2. Identify early any patient who may need support at home, a care package or a transfer, and inform the discharge coordinator within 24 hours of admission.
3. Review the planned date at each ward round, and update the plan when it changes.

6.2 Writing the plan

1. Write the plan with the patient, using plain language, in the language the patient uses.
2. Include: diagnosis and treatment given; medicines at discharge with any changes; follow-up appointments with dates; tests still awaited, with who will act on them; warning signs and who to call; activity, diet and self-care advice; social and carer needs and services in place; and the contact number of the ward.
3. Record the patient's agreement, or the reason it could not be agreed.

6.3 Passing it on

1. Send the discharge summary and the plan to the next provider on the day of discharge, by the agreed secure route.
2. Give the patient their copy, and send one to the GP with the patient's agreement.
3. Record the date and the route sent, and the name of the person who received it where known.

6.4 Teach-back and confirmation

1. Before discharge, ask the patient and their carer to explain the key points of the plan in their own words.
2. Correct any misunderstanding and repeat the check until the key points are correct.
3. Record the teach-back result on the plan.

7. 7. Decision points

Situation	Action
Patient is not safe to go home	Do not discharge until a safe plan is in place. Inform the senior clinician and the discharge coordinator the same day
Next provider does not accept the plan	Inform the responsible clinician, who contacts the provider directly before discharge
Patient does not agree with the plan	Discuss the reasons, offer a second conversation with the senior clinician, and record the outcome, including the patient's decision and any risks they have accepted
Patient does not speak the language	Use a professional interpreter for the plan and teach-back

8. 8. Escalation

- Plan not sent by the end of the day of discharge: the ward manager is informed the same day.

- Readmission within 28 days linked to a planning gap: the discharge review is carried out within 14 days, and the case is reported to the governance meeting.
- Harm after discharge linked to the plan: report under INC-SOP-001 within 24 hours.

9. 9. Monitoring

The ward manager audits 20 discharges each month for the existence of the plan, the agreement, the teach-back, and the time it was sent. Results are reported to the quality committee each quarter.

Measure	Target
Discharges with a written plan agreed with the patient	100 percent
Plans sent to the next provider on the day of discharge	At least 95 percent
Teach-back recorded	At least 95 percent
Readmissions within 28 days with a planning gap found on review	Reviewed each quarter

10. 10. Records

- Discharge plan, signed by the patient and the clinician.
- Discharge summary.
- Teach-back record.
- Record of transmission to the next provider.

11. 11. Training

All staff who prepare or agree discharge plans complete training on the template, teach-back and safe transfer at induction and every two years.

12. 12. Related documents

Code	Document
AFT-FRM-001	Follow-up booking before discharge
AFT-FRM-002	Warning signs and urgent help record
AFT-SOP-001	High-risk patient contact after discharge
AFT-SOP-002	Written warning signs and urgent help route
SHO-SOP-001	Safe handover procedure

13. 13. Evidence

This SOP is based on the reference sources listed below and on the requirement of criterion 42.1 of the ASF standards. The template and the transmission route must be confirmed against the national transfer-of-care requirements at each review.

14. References

1. NHS England. Transfer of care from hospital to primary care (transfer of care standard). Current edition (check the current publication before use).
2. NICE. NG27: Transition between inpatient hospital settings and community or care home settings. 2015.
3. Facility discharge template and transfer route (to be inserted by the facility at adoption).

15. Change history

Version	Date	Change
0.1	2026-10-26	First draft for review. Not yet approved by the ASF Expert Committee.

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- Related standard**
- [Standard 42: Aftercare, Follow-Up and Post-Discharge Safety](#)