

Discharge and aftercare planning

Standard operating procedure (SOP) | HOS-SOP-010

Document type	Standard operating procedure (SOP)
Title	Discharge and aftercare planning
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Prepared by	{{roles.quality_lead.name}}, Quality lead
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Replaces	None (new document)
Standards and criteria supported	System S1 (Hospital), criterion S1.10
Evidence basis	E-006, E-009
Status of this document	Recommended best-practice model. A hospital may adopt, adapt or replace it with an equivalent that meets the same criteria.

At a glance: what to do

1. Write an aftercare plan for every discharged patient.
2. Explain it and check understanding with the patient (teach-back).
3. Send the plan to the next provider on the day of discharge.
4. Give the patient a copy.

Stop and get help straight away if: a patient leaves the hospital with no written aftercare plan.

1. Purpose

To make sure every patient leaves with a clear, written plan that is understood and reaches the next provider (S1.10).

2. Scope

Applies to	Clinical and support staff in the hospital
Locations	All wards, clinics and departments of {{facility.legal_name}}
When	Whenever the activity described is carried out
Does not apply to	Activities covered by another document listed in section 15

3. Definitions and abbreviations

Term	Meaning in this SOP
Clinical lead	The doctor or nurse in charge of the area at the time

4. Background and rationale

Patients who leave without a written plan often return or harm themselves. A written, explained plan sent to the next provider keeps the care going.

5. Responsibilities

Role	Duties in this SOP	Competence needed
Discharging clinician	Writes and explains the plan	Doctor or nurse
Ward clerk or nurse	Sends the plan to the next provider	Administrative

6. Equipment, materials and resources

Item	Specification or standard	Check before use
Discharge aftercare plan (HOS-FRM-008)	Current	Printed on the ward

7. Safety and infection prevention

- Stop and call for help if a patient is at immediate risk. Do not delay urgent care to complete paperwork.

8. Before you start

- Confirm the forms and equipment named in this document are available and current.

9. Procedure

Follow the steps in order. Where a step says "If", take the action for the case that applies. Do not skip a step. If a step cannot be done, use section 11 and section 12.

Step	Action	How to do it	Key point
1	Write the plan.	Write the diagnosis, the medicines, the follow-up and the warning signs.	The plan is written before the patient leaves.
2	Explain.	- Explain the plan to the patient and any carer. - Ask them to say back the key points (teach-back).	Teach-back shows understanding.
3	Send.	- Send the plan to the next provider on the day. - Record the date and the receiver.	The next provider needs it on day one.

Decision points

- No decision points in this procedure.

10. Special situations

Situation	What to do
Out of hours	Follow the same steps. Use the on-call contact on the wall of the area.

11. Problems and escalation

- Any serious problem goes to the duty clinical lead at once and to the clinical director the same day.

12. Monitoring and compliance

What is checked	Target	How often	Who	If the target is missed
Discharges with written plan	100%	Monthly	Ward manager	Escalate to clinical director
Plans sent on the day	At least 70%	Monthly	Ward manager	Escalate to clinical director

13. Records

Record	Where it is kept	Kept for
Record named in this document	Patient record or the area file	{{facility.records_retention_years}} years

14. Training and competence

- Staff are trained in this document at induction and refreshed each year, with a recorded competency check.

15. Related documents

ID	Title	Relationship
HOS-FRM-008	Discharge aftercare plan	Plan form
HOS-SOP-011	Post-discharge follow-up	Follow-up after the plan

16. Evidence

ID	Source and status
E-007	WHO Nine patient safety solutions (2007): communication at transfers.
E-006	ASF Policy Framework v1.2. Adapted.
E-009	ASF Expert Committee consensus.

EC = ASF Expert Committee consensus. Items marked EC are reviewed by the Committee each year.

17. Change history

Version	Date	What changed	Approver and signature
1.0	{{document.effective_date}}	First version	Pending Expert Committee approval