Organisation name Site or unit		STANDARD OPERATING PROCEDURE Discharge and aftercare planning	
Document ID	HOS-SOP-010	**Version**	1.0
Status	Blank form, to adapt	**Issue date**	
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Owner		**Approved by**	
Signature			

Standards › **Standard S1** › **Standard operating procedures (SOPs)**

Standard operating procedure (SOP) · HOS-SOP-010 · Version 1.0 · Approved by the ASF Expert Committee

Supports: System S1 (Hospital), criterion S1.10

At a glance

- Write an aftercare plan for every discharged patient.
- Explain it and check understanding with the patient (teach-back).
- Send the plan to the next provider on the day of discharge.
- Give the patient a copy.
- Stop and get help straight away if: a patient leaves the hospital with no written aftercare plan.

1. 1. Purpose

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

2. 2. Scope

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

3. 3. Definitions

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

4. 4. Background

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. 5. Responsibilities

Role	Responsibility	Competence
Discharging clinician	Writes and explains the plan	Doctor or nurse
Ward clerk or nurse	Sends the plan to the next provider	Administrative

6. 6. Materials and equipment

Item	Requirement	Condition
Discharge aftercare plan (HOS-FRM-008)	Current	Printed on the ward

7. 7. Safety

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

8. 8. Before you start

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

9. 9. Procedure

Step 1. Write the plan.

- Write the diagnosis, the medicines, the follow-up and the warning signs.

Key point: The plan is written before the patient leaves.

Step 2. Explain.

- Explain the plan to the patient and any carer.
- Ask them to say back the key points (teach-back).

Key point: Teach-back shows understanding.

Step 3. Send.

- Send the plan to the next provider on the day.
- Record the date and the receiver.

Key point: The next provider needs it on day one.

10. 10. Decision points

- No decision points in this procedure.

11. 11. Special situations

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

12. 12. Escalation

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

13. 13. Monitoring

Measure	Target	Frequency	Owner	If not met
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

14. 14. Records

Record	Kept in	Retention
Record named in this document	Patient record or the area file	the period set by the facility's records policy years

15. 15. Training

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

16. 16. Related documents

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

17. 17. Evidence

Reference	Note
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.

18. 18. Change history

Version	Date	What changed	Approval
1.0	the date of approval	First version	set Expert Committee approval

No e-learning course is linked to this document yet.

19. References

- Accréditation Sans Frontières (2026). ASF Policy Framework v1.2. (E-006)
- Accréditation Sans Frontières (2026). ASF Expert Committee consensus on Standard 1. (E-009)
- World Health Organization (2007). Nine patient safety solutions, including correct patient identification. Geneva: WHO. **Open source** (E-007)

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Related standard

- **Standard 42: Aftercare, Follow-Up and Post-Discharge Safety**