TICKET HOME OVERVIEW

DISCHARGE PLANNING FROM THE TIME OF ADMISSION

The method used to remodel the discharge process was based on LEAN principles that identified the current state, mapped each step of the process, identified areas of waste (either in time, motion, supplies), testing and refinement of the new process. Participants included stakeholders from the various nursing units and the LEAN Manager. The program was tested first in a critical care nursing unit as a tool to help guide the patient, family and care team through discharge planning, and subsequently implemented by all nursing units.

The new discharge process is called "Ticket Home" and begins at the time of admission. The patient is given a personalized folder with the ticket form and other pertinent information such as education, list of personal belongings, discharge instructions, etc. The folder is kept close to the patient for easy reference, and the folder is used as a tool for shift reporting and multidisciplinary meetings. It prompts each shift for appropriate communications with the patient and family and helps discern if patient is ready for discharge and needed processes complete (catheter, oxygen, IV, medications, etc.)

The program requires all staff to be active in asking the physician for anticipated date of discharge (subject to change). The anticipated discharge date is written on an oversized, laminated "ticket home" posted on the corkboard in each patient's room. Ideally, this is done at the time of admission but no later than 24 hours after admission, as many patients are discharged within that timeframe.

Feedback on the Ticket Home project has been universally good. Patients and family like the simplicity and visibility, and the healthcare providers find that it is an easy yet effective method for consistent discharge planning. JCAHO has requested the program materials for Best Practice development.

One of the most important learnings was the need to continue working diligently on home medication accuracy and awareness. A strong emphasis on possible side effects of discharge medications, including signs and symptoms, is a vital element to a smooth transition. All patients are encouraged to use the medication cards provided in the Ticket Home folder.

In addition, several nursing units are now making a phone call to the patient within 24 hours post-discharge. This provides an excellent opportunity to answer any patient questions and/or prevent readmission by early identification and management of any problems that may have developed.

Efficiency and effectiveness of discharge are included in the hospital's ongoing patient surveys, and we are hopeful that the diligence, planning, and preparedness of Ticket Home will be reflected positively through an improvement in satisfaction levels. The cost of this project is minimal.