**Healthcare Management Action Plan**

Dawnielle Williams

Columbia Southern University

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For a longer period, healthcare management of the patients in various healthcare institutions has attested to be indefinable. Several medical practitioners have been facing many challenges in offering quality services to their clients (patients). At times, summarizing all the relevant information regarding the patients cannot be obtained appropriately, making it challenging to manage patients' consistency. Most patients have raised more complaints about unethical and harsh questioning, usually when they go to any healthcare facility for medication. Consequently, most of them feel that the data regarded to be much classified can be leaked or shared with an unknown person who enters the hospital. These patients feel uneasy and displeased being questioned about themselves every time they go to the healthcare facility. Hence, the global health sector should enhance the record and the information profiling aspect of their patients.

With a clear and well-arranged record-keeping, healthcare facilities will adequately ensure that patients' information and treatment is achieved appropriately immediately they get into the healthcare facility. Also, medical practitioners should ensure that only the patient's relevant information is keyed into the healthcare system and that patients' information should remain confidential (Williams et al., 2016). Furthermore, all hospitals should adopt the electronic data recording system to effectively assist them in storing all data about the patients, such as diagnosis, name, age, gender, and medicine, prescribed, among others (Kerr, 2018). Hence, people should question themselves the meaning of the term hospital. If the hospital is unable to appropriately record and store relevant information about the patients, does it deserve to maintain its patients' well-being?

Indeed, health is a crucial part of human life. A productive country is a nation whose population is healthy, hence working. Thus, all the relevant health stakeholders worldwide should enhance how human health gets managed in every society to achieve accessibility and proper evaluation in the future (Kerr, 2018). As a senior nurse, I made frequent visits to certain healthcare facilities, and I found that taking care of patients is unethical and not pleasing. During my visits, some nurses would often ask their patients about their biological and medical information that would have been recorded on the first day of their visit to the clinic. At times, certain will get annoyed and never come back to the hospital due to poor services. These patients feel uncomfortable to keep on answering unending questions about them.

Therefore, there is a need to improve records and information profiling of patients in many health facilities. With a well-structured and organized record keeping, it will ensure that patients get the correct treatment every time they visit a hospital due to the effective data entered into the healthcare system. In conjunction with this, all healthcare facilities should develop an electronic data recording system that will help them store their patients' data, including the diagnosis, prescribed medicine, next check, and even their biological information. We need to ask ourselves the meaning of a healthcare facility. If a hospital cannot accurately record and store the data of its patient, is it worth maintaining the wellness of its patients?

Health is a very integral aspect of human life. A nation is productive because its population is healthy, thus working. Therefore, there is a need to improve how health is managed in our societies to ensure the eases of access and analysis in the future (Kerr, 2018). In my visits to some clinics, I realized that the handling of patients is, in a way, upsetting. The physician will keep on asking the patient details that would have just been taken the first day they come to the hospital. Occasionally, some patients will get upset and will never return to the clinic. They feel that the physicians are not keen on them just because they ask the same questions now and then. A lot has to be done to improve record-keeping (Williams et al., 2016). Thanks to being the 21st century, we can now make a database that the information can be recorded on and safely stored. But before this is achieved, some constraints are expected to be faced.

The first and obvious challenge is the high initial cost of purchasing electronic devices to enter the data. The whole system is managed with computers, meaning that every healthcare facility must be able to own computers. Newly trained personnel will also have to be employed who will run the system. This will mean an additional cost to be incurred by the management (Sell & Wong, 2015). Secondly, some information might be lost during the transition from the old system to the new system. Not all information will be transferred, and errors are bound to occur. The system might also require that collecting information from the patient be redone as some additional information may be required.

**Benefits of Electronic Healthcare Recording System**

Some patients feel ashamed to keep on repeating their illness details to different physicians they find in the facilities. With the introduction of the electronic healthcare recording, the facility will have well-detailed information about the patients. They will not have to be asked the same question if they find different personnel next time they come. It will also help improve the confidentiality of patient information (Sell & Wong, 2015). They will feel that their information is kept secret, and in the long run, their trust with the hospital is built.

Electronizing the patient's record will also ease the physicians' workload and will, in turn, increase the clinical performance (Williams et al., 2016). Efficiency is essential in every healthcare as it will ensure that patients are diagnosed correctly, and the prescription is correct. The outdated paperwork will be eradicated, relieving the institution of unnecessary expenses of buying papers for printing. The nurses will not have the usual long filing searching but will have to search for the patient's name on the computer. Unlike in the past, where patient's files were occasionally reported lost, the system will ensure proper and safe storage of the information.

Another reason to improve patient data recording in every health facility is to ensure access to patient information from any healthcare center. If a patient decides to go for treatment in a different hospital, the facility will just access the previous diagnosis to make their work easier (Sell & Wong, 2015). For example, a person may be involved in a car accident and, as a result, will have to be rushed to the nearest emergency wing. There will be no time to test for the patient blood group or any other important information due to the urgency. At this point, the electronic data recording will be handy as this information will easily be accessed from the patient profile in the system. This will also act as a solution to tiring calls for blood assistance that is unfruitful in most cases (Williams et al., 2016). If a person is identified to require a blood donation urgently, they will just such for a blood group match, and the person will then be pleaded to donate blood instead of appealing for assistance through the media.

Perfect healthcare is supposed to have information about its patients. The information ranges from their bloodline, genetic information, and previous medication. Some diseases are generic, and therefore the clinical officer can be required to look at the patient gene line to access which diseases are possible to have been inherited(Kerr, 1978). After all, what is the essence of a healthcare facility if it is not to provide the best of its services? The system will ensure the confidentiality of such information, which is key to maintaining a perfect patient’s relationship.

**Major Consequences of Electronic Data Recording**

If the program is not initiated, the healthcare providers will worsen the already weak patient relationship. They will continue with their upsetting procedure of handling customers, making patients lose complete trust in the institutions. Manual record-keeping is not efficient to effectively serve a large patient population. If this improvement is not made, healthcare management will still prove a very hard hurdle to overcome. Nurses might not get the perfect information about the patient, resulting in the wrong diagnosis and prescription.

The system can provide a quick link to access the customers who, at some point, might even have their checkups online with the help of a clinical support service. It makes it easy to get in touch with the patient because of the information that is profiled there, and in case there is an urgency, the management can get to the patient quickly. If the MAP is not adapted, this will never come to pass.

**Desired Outcomes and Implementation of Electronic Data Recording System**

My management action plan's desired outcome is to ensure that a good profiling system of patient information is done digitally. One should access information like the last diagnosis, last visit, and the medication proposed to the patient. A patient should always feel safe submitting their information to the medical practitioner, knowing that access to such information is limited. The patient should also be able to continue with their treatment schedule even away from their usual hospitals or clinic. This means that all health facilities can access the patient information without necessarily consulting their counterparts. Lastly, the old system of profiling using papers should be completely eradicated and replaced with computers.

To access the implementation, healthcare facilities should be visited to check which data recording system is being used. One can also lookup on the internet to check services like the hospital website or portal.

**References**

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