**APPLICATION: CREATING A FLOWCHART**

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INTRODUCTION

Hospitals, like any other institution in the society, has employees and clients who interact on a daily basis. The medical staff gets to share their expertise in giving service to the patients. Every process in the hospital requires logical steps that are guided to ensure compliance with professional ethical regulations and efficiency of the facility in assisting the sick to get well. This paper looks at the algorithmic steps that are taken at the hospital when a patient enters the hospital to the time they leave for recuperation.

**Step 1: Reception**

Proper registration is supposed to take place at the hospital once a new patient checks in. This process is conducted at the front desk by the hospital admission staff, who provide information regarding the geography of the area to the patient. This direction is meant to help the patients to get the right direction to the sections of the hospital that are relevant to their conditions. The patient will be formally registered with the hospital, and if the patient has regularly been treated at the facility, his or her files shall be prepared for the doctor’s review.

Registration and admission is done digitally, through the hospital intranet-served system, which lets people with access codes review the patient’s history at will. The hospital policy allows the admission staff to issue receipts with a unique access number for each patient in a way that is encoded for privacy reasons.

In order to admit a patient, the admission staff need to determine if the patient is a regular or a new one. In either case, personal information is crucial, including patient history, which may be given by the patient or caregiver.

**Step 2: Evaluation of condition of the patient and diagnosis**

The reception nurses will evaluate the state of the patient; whether they need emergency treatment, otherwise, they will be directed to proceed with standard hospital procedure, such as queuing for a service, if necessary. However, whenever an emergency is encountered, the patients are sent to the emergency rooms where quicker and more delicate attention can be given to them.  The hospital holds a policy to measure the blood group, count, pressure, and sugar levels, and BMI for every patient at the time of admission. This information is stored in the hospital database, as fed from the universal digital health kiosk. This information is mandatory before any person can be put under any sort of medication.

For the regular patients who have reported for emergencies, their files containing their medical history shall be supplied to the attending practitioners; the doctors and nurses for evaluation of and stabilization shall be conducted in the swiftest manner possible. The nurses shall provide the necessary support to the patient, such as putting them on the drip, preparation for surgery if one is due, or injecting them with tranquilizers if need be.

While the stabilization process continues for the people with emergencies, the laboratory staff should be allowed access to assess and give their opinion about any diagnosis that may help to avoid deterioration of the condition. This process should allow the doctors to understand any possible medical concerns that may hinder or counter recovery of the patient. Relatives could be contacted, if the patient is unconscious to give any history of allergies. This part is especially important for patients who have been brought to the hospital for the first time, and no medical records are traceable (Huser, Rasmussen, Oberg, & Starren, 2011).

On the other hand, those patients whose cases are regular and need normal medical attention; i.e. with no emergencies will be directed to the laboratory for tests after they are allowed access to the doctor for examination. If they are first-time patients, they will be registered a medical file opened for them.  The examination by the doctor will help to narrow down on the disease, so that it is less costly and for the patient, and saves time in carrying out only mandatory diagnoses at the laboratory.

The lab technician should prepare the reports in an appropriate manner that is by the accepted standards. They should be uploaded to the patient’s file and a hard copy given to the patient containing the results along with a reference number for his or her file for the doctor’s access digitally. The code is more convenient than the supply of a physical file since it eliminates the chances of misread or misinterpretation of the results since every detail is clear; both in appearance and jargon. Also, it is accessible instantly across two places that are a distance apart. For instance, in the case of emergencies, the medical report can be accessed by the doctors and nurses almost as soon as they are supplied. For practical purposes, every person knows their national identification number. It means that the hospital will need not to force the patients to attend hospital with any documents. The system has to be air gapped to prevent unauthorized access from any quarters outside of the facility’s premises.

**Step 3: Treatment**

After the doctor has been supplied with the medical information, he or she should conduct further cross-examination, if possible, and prescribe the most suitable medication for the patient. All the details about the treatment should be updated to the patient’s medical file for recording purposes, and a prescription given to the pharmacist with the consent of the patient, who will collect the prescriptions at the end of the chain as indicated by the flow diagram. After treatment, the patients should be discharged and let to recuperate either in the wards or at home, depending on their conditions.

To prescribe treatment, the hospital regulations allow the doctor to use the e-prescription or traditional form, depending on whichever is convenient. However, e-prescription is favored more. In the case of the use of traditional prescription, the doctor has to append the information about the medicine to the patient’s file for future reference (Nøhr, 2010).

The Information Technology department is charged with the responsibility of maintaining and training the medical staff on the usage of the intranet system that is in place in the hospital facility. The hospital would like to implement a fully digital way of filing and access to patient records. However, the policies leave some allowance for the late adopters, in the areas of prescription and a few others.

SUCCESS METRICS

The intranet is designed to bar hackers and other people who may have ulterior motives for accessing any of the reports. The confidentiality and privacy of the patients is highly regarded. This process is beneficial to the hospital since it reduces the workload off a patient in that the digital system stores and disseminates information on demand (Health IT, 2016). In this way, it boosts their confidence that their information is available to the medical practitioners, and they can visit the facility at any time for treatment or check-up without having to look for books or files regarding their medical history (healthit.ahrq.gov, 2016). Also, they are not required to remember any names of the medicines to which they have been prescribed. Medical jargon and other information about their conditions are recorded once and only simple cross-examination to determine progress is necessary. Therefore, this method of operation is effective.

IMPROVEMENTS

The roles of the hospital staff have not been defined, and their level of access is still undefined. This situation creates a possibility of malicious access. People who need certain information from the hospital regarding a particular patient may obtain it by bribing any medical staff. The access protocols need to be sufficiently designated to avoid this kind of breach.

It is crucial for the hospital staff to know the flow process of activities that are supposed to take place. Advancing technology means that communication on paper will soon be obsolete, and it will be mandatory them to keep standards as high as ever. Due to the high efficiency of this method of flow of information, understanding the protocol will make it easier for service delivery and hence, reduced casualties.

SUMMARY

Predictable steps in a hospital are essential in that they enable medical institution to instill organizational cultures and code of ethics within their operation. For such organizations, the most important routine job is handling of patients from reception to discharge. In-between, there are numerous processes that take place, including admission, diagnosis, disease monitoring and control, and issuance of a prescription of a regimen. After a patient is received in a hospital, they are evaluated for the next course of action, after which they are stabilized and diagnosed, then treated. They happen in a specific way, and because each hospital has its way of handling operations, it is prudent to automate the processes to avoid missing of certain steps. The use of technology is essential as it hastens processes, such as obtaining and sharing information. This paper also discusses the rules and regulations, and improvements to current systems that are in place.