Plan of Action

The « plan of action » concept allows you to plan an action or a series of actions for a patient. In this way your patient can benefit from a prevention schema which helps you with the follow up of the patient.

To create a plan of action open a patients chart select the item you wish to plan for – right click on the item and press plan the action.

Enter the details as seen in the screen shot below.

When you press OK the action plan will be added to the action plan tab in the patients chart and the patient selector screen.

1. Planned date for the action : Here you can enter either the exact date you want the action to be done or a time interval when it should be done, say in 3 years time.

2. The **frequency** of the action to be carried out there after. You use this only if you wish to repeat the action at a given time interval into the future. You can also say here how many times you want to repeat the action into the future. HEALTH*one*™ will then automatically ask you do you want to carry on with the plan when the number is up.

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3. Whether you require a **reminder** to appear in the patient file when you open the record

4. Who is **responsible** for carrying out the plan

5. What **item name** you would like to use when you declare the action as being done.

These are all configurable

Now when you open the patient file all her planned actions are visible in a new tab next to the billing tab in the medical section of the file

When a planned action is done ?

Now you have a list of planned actions in the action plan tab for the entire population and also, possibly, a list of planned actions in each patients file, visible when you click the action plan tab.

When you actually carry out these plans, how do you manage the plan.

There are several ways of doing this. However, in Ireland we advise you to stick with the following protocol.

1. Individual patients :

If an action is planned, there will appear in the patient record, an additional tab called « action plan ». This tab contains a list of all the planned actions. You can click on one of the buttons at the top of the action plan tab, or right click on the action plan to get a list of possible

actions. One of these is to « set the action as done »
Setting the plan as « done » will remove the plan from the list in the patient file and also from the population list. An item will be inserted in the medical section to say the action is done. What item you use will depend on the options you set in the tools\options\action plan\

menu. By default the item name will be « done » and the content will be the name of the action :

You will also, of course, have to enter the result in the normal manner. For example, if a smear comes back, you will enter the item « cervical smear » with the result as the content.

In the case of a lab test you will enter the item name and the result, unless the result is imported electronically when it will be added in the same way - haemoglobin A1 --- 7.8

NOTE : If you do not set the plan as done it will continue to appear in the list of planned actions and will soon make the list worthless.

You can also indicate if an action plan will never be done

Or Delete an action plan