Requirements Document for UM-BBD/PPS

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Part I

User Requirements

0.0.0.0.1 UR001

Statement *MHC-PMS shall generate monthly management reports showing the cost of drugs prescribed by each clinic during that month.*

Priority *A*

¡¡¡¡¡¡¡ HEAD

0.0.0.0.2 MonthlyReport The MHC-PMS shall generate monthly management reports showing the cost of drugs prescribed by each clinic during that month. =======

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Part II

System Requirements

Chapter 1

Non-Functional Requirements

1.1 Product Requirements

1.1.1 Usability Requirements

1.1.2 Efficiency Requirements

1.1.2.1 Performance Requirements

1.1.2.2 Space Requirements

1.1.3 Dependability Requirements

1.1.3.0.1 NFR001

Statement *The MHC-PMS shall be available to all clinics during normal working hours (MonFri, 08.3017.30). Downtime within normal working hours shall not exceed five seconds in any one day.*

Priority *A*

1.1.4 Security Requirements

1.2 Organziational Requirements

1.2.1 Environmental Requirements

1.2.1.0.2 NFR002

Statement *Users of the MHC-PMS system shall authenticate themselves using their health authority identity card.*

Priority A

1.2.2 Operational Requirements

1.2.3 Development Requirements

1.3 External Requirements

1.3.1 Regulatory Requirements

1.3.2 Ethical Requirements

1.3.3 Legislative Requirements

1.3.3.1 Accounting Requirements

1.3.3.2 Safety / Security Requirements

1.3.3.2.1 NFR003

Statement *The system shall implement patient privacy provisions as set out in HStan-03-2006-priv.*

Priority *A*

Chapter 2

Functional Requirements

2.0.3.2.2 FR001

Statement *On the last working day of each month, a summary of the drugs prescribed, their cost, and the prescribing clinics shall be generated. (see user requirement UR001)*

Priority *A*

2.0.3.2.3 FR002

Statement *The system shall automatically generate the report for printing after 17.30 on the last working day of the month. (see user requirement UR001)*

Prioriy *A*

2.0.3.2.4 FR003

Statement *A report shall be created for each clinic and shall list the individual drug names, the total number of prescriptions, the number of doses prescribed, and the total cost of the prescribed drugs. (see user requirement UR001)*

Priority *A*

2.0.3.2.5 FR004

Statement *If drugs are available in different dose units (e.g., 10 mg, 20 mg) separate reports shall be created for each dose unit. (see user requirement UR001)*

Priority *A*

2.0.3.2.6 FR005

Statement *Access to all cost reports shall be restricted to authorized users listed on a management access control list. (see user requirement UR001)*

Priority *A*

Chapter 3

Scenarios

3.1 Scenario for collecting medical history

INITIAL ASSUMPTION: *The patient has seen a medical receptionist who has created a record in the system and collected the patients personal information (name, address, age, etc.). A nurse is logged on to the system and is collecting medical history.*

NORMAL: *The nurse searches for the patient by family name. If there is more than one patient with the same surname, the given name (first name in English) and date of birth are used to identify the patient.*
The nurse chooses the menu option to add medical history.
The nurse then follows a series of prompts from the system to enter information about consultations elsewhere on mental health problems (free text input), existing medical conditions (nurse selects conditions from menu), medication currently taken (selected from menu), allergies (free text), and home life (form).

WHAT CAN GO WRONG: *The patients record does not exist or cannot be found. The nurse should create a new record and record personal information.*
Patient conditions or medication are not entered in the menu. The nurse should choose the other option and enter free text describing the condition/medication.
Patient cannot/will not provide information on medical history. The nurse should enter free text recording the patients inability/unwillingness to provide information. The system should print the standard exclusion form stating that the lack of information may mean that treatment will be limited or delayed. This should be signed and handed to the patient.

OTHER ACTIVITIES: *Record may be consulted but not edited by other staff while information is being entered.*

SYSTEM STATE ON COMPLETION: *User is logged on. The patient record including medical history is entered in the database.*