**Use Case Template Document**

**Use Case Name:**

Import Patient Record for Acute Care Admissions (including medication reconciliation)

**Brief Description:**

Upon admission to or attendance at Newcastle upon Tyne Hospitals NHS Trust it is necessary to record the patient’s current medications, allergies, diagnosis and conditions on the local clinical system (CERER).

**Use Case Justification:**

Clinical and Administration:

* Access to accurate information at the point of care reducing the opportunity for errors to occur.
* Reduction in transcription between systems and paper to IT, leading to a reduction in prescribing errors.
* Reduction in clinical time wasted, away from the patient, collecting and collating information.
* Reduction in clinical time wasted, away from the patient, manually updating IT systems.
* Reducing the paper flow through departments by utilising the systems workflow to manage tasks using staff time efficiently.

Patient Focused:

* Security of patient information is maintained and improved through the reduction of paper-based “Patient Identifiable Documents” in use within departments.
* Increased patient / clinician time due to reduction in clinician time spent collecting and transcribing information away from the patient.
* Increased patient safety due to the reduction in manual transcription errors.
* Better patient experience as they are not being asked for information which should already be available to the clinician.

Cost Reduction:

* Reduction in printing supplies.

**Primary Actors:**

Clinician.

CERNER (EPR)

GP Connect.

GP Clinical System.

**Secondary Actors:**

Patient

**Triggers:**

Patient is admitted to, or attends hospital for treatment.

**Pre-Conditions:**

* The patient’s details have been verified and entered on CERNER upon admission / attendance.
* Hospital staff have the correct / appropriate system access rights.
* The patient’s GP has agreed to share patient information via GP Connect.
* The patient allows this shared information to be viewed / used by hospital staff.
* Electronic Interactions between Hospital System(s) / GP Connect / GP Clinical System have been correctly configured.

**Post Conditions:**

* **On Success:**
* **Guaranteed:**
  + A full history of medications, allergies, diagnosis and conditions is recorded on CERNER

**Basic Flow with Alternative and Exception Flows:**

*{The basic flow is the best-case scenario (i.e. the happy path) of what should happen in the use case if all the conditions are met. Describe other allowed variations of the basic flow. Are the any alternate routes that can be taken? Describe Error Conditions or what happens when a failure occurs in the flow}*

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| Step 1 | Patient attends/admitted to hospital. |
| Step 2 | Clinician identifies need to establish the patient’s medication history. |
| Step 3 | Clinician accesses the CERNER system to retrieve GP patient record history. CERNER requests the GP patient record from GP Connect. |
| Step 4 | GP Connect requests GP patient record from the GP Clinical System. |
| Step 5 | GP Clinical System provides the GP patient record to GP Connect.  This GP patient record will include:   * Medications * Allergies * Diagnosis * Conditions |
| Step 6 | GP Connect presents the GP patient record to CERNER. |
| Step 7 | CERNER saves a copy of the GP patients   * Medications * Allergies * Diagnosis * Conditions |
| Step 8 | CERNER presents an integrated view of GP patient record to the clinician for review with the patient. |
| Step 9 | Clinician reviews and updates GP patient record with Patient / Patient Proxy. |