**Use Case Template Document**

**Use Case Name:**

Medicines Reconciliation for Acute Care Admissions

**Brief Description:**

Upon admission to or attendance at hospital, the attending clinician is responsible for consolidating a list of the patient’s medications. Information on medications listed within the GP System (SCR) is gathered, in paper format and then discussed with the patient / patient proxy for validation. Amendments, where required, are annotated on the paper copies. The Clinician then manually transcribes all appropriate medications into the hospital Patient Administration System (PAS) / Electronic Patient Record (EPR) system and the patient’s paper drug chart before completing the admission / consultation Process.

**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.

PAS / 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 the hospitals PAS / EPR 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.
* An Electronic Prescribing & Medicines Administration (EPMA) system is in use and integrates with the PAS / EPR.

**Post Conditions:**

* **On Success:**
* **Guaranteed:**
  + A full history of medication used by the patient on admission / attendance:
    - Medication prescribed by the patient’s GP.
    - Medication prescribed in other care settings.
    - Medication obtained elsewhere, i.e. “Over the Counter”.
  + Patients receive the correct medications when admitted.

**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 hospital PAS / EPR system to retrieve GP medication history. PAS requests GP medication list from GP Connect. |
| Step 4 | GP Connect requests GP medication list from the GP Clinical System. |
| Step 5 | GP Clinical System provides the defined medication list to GP Connect.  This medication information will be the same as that provided in the SCR / SCR AI and will be subject to the same exclusion criteria:   * Acute Medications (with a prescribed date in the last 12 months)   + Prescribed date   + Medication Item   + Dosage Instructions (including day of administration where applicable)   + Quantity   + Source (the organisation that issued the prescription) * Current Repeat Medications (with an end date in the future)   + Last issued date   + Medication Item   + Dosage Instructions (including day of administration where applicable)   + Quantity   + Reason for medication   + Source (the organisation that issued the prescription) * Discontinued Repeat Medications (with an end date in the past and the last scripts prescribed date in the last six months)   + Last Issued   + Medication Item   + Dosage Instructions (including days of administration where applicable)   + Quantity   + Reason for Medication   + Date Discontinued   + Source (the organisation that issued the prescription) * For all three categories above:   + Include mixtures   + Includes medications recorded on the GP record that were prescribed by another organisation (example an hospital)   + Do not include medications where the script was cancelled before being prescribed (example entered in error) |
| Step 6 | GP Connect presents the GP medication list to the hospital PAS / EPR. |
| Step 7 | PAS / EPR saves a copy of the GP medications list directly to PAS / EPR. |
| Step 8 | PAS / EPR presents an integrated view of GP medications to the clinician for manipulation into the EPMA. |
| Step 9 | Clinician reviews and verifies GP medication list with Patient / Patient Proxy. |
| Step 10 | Clinician marks medication for ‘Inclusion As-Is’ into the PAS / EPR. |
| Step 11 | Medication is integrated into the PAS / EPR as “Medication on Arrival”. |
| Step 9a | This scenario details the situation where medications are identified in addition to those recorded within the GP Clinical System and are not present within the PAS / EPR Integrated View. This scenario includes items which may be ‘over the counter’ medications.  9A1. Clinician selects ‘Add New Medication’.  9A2. Clinician manually enters new medication details. |
| Step 9b | This scenario details the situation where discrepancies are identified with one or more items of the patient’s medications recorded within the GP Clinical System and are presented within the PAS / EPR Integrated View but the medication is still in use.  9B1. Clinician marks medication for ‘Inclusion with Amendment’ into the PAS / EPR.  9B2. Clinician amends medication details. |
| Step 9c | This scenario details the situation where discrepancies are identified with one or more items of the patient’s medications recorded within the GP Clinical System and are presented within the PAS / EPR Integrated View but the medication is no longer in use.  9C1. Clinician marks medication as ‘Stopped’.  9C2. Clinician adds the reason for the medication being stopped. |

**Original Use Case**

This use case is a reformatted version of the “Medicines Reconciliation Acute Care Admissions & Discharges” use case developed by North of England Commissioning Support. The original is attached here.

