**Use Case Template Document**

**Use Case Name:**

Admission of patient to the Yorkshire Eating Disorders Clinic

**Brief Description:**

Upon admission to the clinic all available information about the patient is gathered for review. This information covers the entire life of the patient from their birth to the present day. Any of the data recovered that might be relevant to the patient’s eating disorder is recorded on the PARIS system.

**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 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.

**Primary Actors:**

Clinician.

PARIS Health and Care System.

GP Connect.

GP Clinical System.

**Secondary Actors:**

Patient

**Triggers:**

Patient is admitted to the Yorkshire Eating Disorders Clinic.

**Pre-Conditions:**

* The patient’s details have been verified and entered on the hospital system.
* 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:**
  + All the relevant available information on the patient’s medical history has been recorded on the PARIS system.

**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 | Patients are referred to the service by:   * + Directly by their GP   + Through the SPA (Single Point of Access)   + For patients outside Leeds by their Local Mental Health Care Coordinator   The referral may or may not include some patient medical details such as bloods, BMI, etc. |
| Step 2 | There is a weekly referral meeting where the team decide where the patient can best be treated. This determines if they are admitted as an inpatient. |
| Step 3 | The patient attends a pre-admission visit / consultation. The patient is advised as to what treatment they may expect as an inpatient. |
| Step 4 | The ward administrators gather all the information they can about the patient from the records they have available.  This will include a request for the patient’s entire medical record from the patient’s GP practice. |
| Step 5 | The PARIS system will request the patient’s entire medical record held in the GP Practice system via the GP Connect service |
| Step 6 | GP Connect and the GP Practice system will check that the Yorkshire Eating Disorders Clinic is allowed access to the data and that the patient has not objected to their data being shared. |
| Step 7 | GP Clinical System provides the entire patient record.  This will include:   * Social History   + Demographic (name, age, address)   + Family history and background   + Education   + Safeguarding   + Child Protection   + Dependants * Medical History (from birth to present)   + Medication     - Current and historic     - Reasons for being giving medication   + Allergies and intolerances     - to ensure it is not related to the patient’s mental illness   + Significant Conditions   + Historic Conditions   + GP consultation notes     - GP may be the only clinician currently seeing the patient.   + Previous admissions     - Surgery     - Psychiatric     - Consultation notes     - Discharge summaries   + Previous mental assessments the patient has received   + Future Appointments / Referrals     - Depending on circumstance they may help the patient attend or cancel the appointment   + Physical Health Checks   + Outpatient letters     - Contains information on outpatient assessments   + Child development (including historic records for adults)   + Children’s ‘red book’ which includes all patient’s early immunisations and health checks   + Any other medical contacts |
| Step 8 | PARIS imports the entire patient record supplied from the GP practice. This data is now available for clinicians to review and maintain. |
| Step 9 | The medical data retrieved by the ward administrator from other sources is manually added to the PARIS system. |
| **Alternative Path** | |
| Step 6a | Where there are not the appropriate permissions to share the data, GP connect returns an error message saying the information cannot be returned.  The ward administrator will retrieve the information using the SCR and direct requests to the GP practice. They will then manually enter the data. |