OpenEHS  
Systems and Software Requirements Specification

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Preface

The purpose of this document is to define the functional and non-functional requirements associated with the details and behavior of the proposed software system. It will explain the processing and performance of the system as well as help in refining requirements as requested by stakeholders and potential users.

Version History

|  |  |  |
| --- | --- | --- |
| **Date** | **Description** | **Author(s)** |
| *8-Jan-2011* | Initial manual merge of the two SSRS documents. | JD Russell |
| *9-Jan-2011* | Added some formatting and table of contents. | Matthew Kimber |
| *16-Jan-2011* | Made changes to glossary and use cases | Austyn Mahoney |
| *19-Jan-2011* | Added and edited use cases | Austyn Mahoney |

Introduction

Korle Bu Teaching Hospital is a large medical facility in Ghana, Africa. The hospital campus is comprised of several buildings spread across a large campus. Currently, their medical records are tracked using logbooks and paper charts, which are stored in a central records facility.

The Martin Luther King Memorial Clinic is a small medical practice located in Ghana, Africa. The staff there is currently using paper to process and manage all their information. They are currently storing and tracking all of their medical and administrative information in paper formats as well.

In both cases the current system leads to many inefficiencies and errors. In many cases this affects the quality of patient care that both facilities are able to offer. For this reason a software system has been commissioned help improve the efficiency and accuracy of the staff and raise the quality of service for patients in both facilities. The goal of this project is to develop a solution that can be used in both facilities and possibly other facilities in the future. The proposed Electronic Healthcare System (EHS) will be composed of the functional and non-functional requirements specified within this document. Requirements for the EHS have been derived from the initial customer request and may require further expansion as more requirements of the system are discovered.

In order to accommodate the transition that must take place from a paper record to an EHS, there are two parts of the proposed system—1. A system that will allow for more efficient tracking of existing paper records, and 2. A system that will allow for the capture of basic health information such as vital statistics. The system will also be capable of generating reports that provide the government with statistical data relating to hospital operations. Both facilities can benefit from an increase in operational efficiency, which will allow staff to focus more on the care of patients and less on the manual work involved in keeping physical records.

System Requirements Specification

Functional Requirements

1. The system shall provide a user interface for physicians, nurses, and other staff members.
2. The system shall allow new patients to be added to the system.
3. The system shall allow a patient’s personal information to be edited.
4. The system shall allow a patient to be removed from the system only by a physician.
5. The system shall permit the receptionist to print a new patient information sheet for the patient to fill out personal information and previous medical history.
6. The system shall allow data entry of the information given to the receptionist by the patient via the patient information sheet.
7. The system shall permit the receptionist to check-in a patient upon arrival to a specific department.
8. The system shall permit the receptionist to maintain patient information at check in.
9. The system shall allow nurses to record the vitals of a patient.
10. The system shall have the ability to record a patient’s medical history.
11. The system shall allow a physician to review a patient’s medical history.
12. The system shall allow a physician to add information to a patient’s medical history.
13. The system shall allow a physician to edit information in a patient’s medical history.
14. The system shall allow a physician to remove information from a patient’s medical history.
15. The system shall allow physicians to record diagnoses of patients.
16. The system shall allow physicians to record notes regarding a patient.
17. The system shall allow physicians to prescribe medication for a patient.
18. The system shall allow the staff to pull up prescription orders for a patient.
19. The system shall allow a staff member to accept payments for services provided to a patient.
20. The system shall allow a staff member to accept payments for medication sold to a patient.
21. The system shall allow a staff member to accept payments for supplies (i.e. bandages, etc.).
22. The system shall track pharmacy inventory.
23. The system shall track supply inventory.
24. The system shall have the ability to generate and print reports on pharmacy inventory.
25. The system shall have the ability to generate and print reports on supplies inventory.
26. The system shall have the ability to automatically generate weekly pharmacy inventory reports.
27. The system shall have the ability to automatically generate weekly clinical supply inventory reports.
28. The system shall allow for the generation of clinical activity reports.
29. The system shall allow for the generation of clinical income reports.
30. The system shall have the ability to automatically generate weekly activity reports.
31. The system shall have the ability to automatically generate weekly income reports.
32. The system shall have the ability to check patient records out to a specific location.
33. A staff member merges two patient records.

Non-Functional Requirements

1. The system shall support different security roles and permissions for the physicians, nurses, and clerical staff.
2. The system shall be designed as an *n-tier* architecture for scalability.
3. The system shall have a *database* that will be used for information storage.
4. The system shall provide a server used to store *binaries* and related data.
5. The system shall be reliable; crashes and critical errors will be rare or non-existent.
6. The system shall be easy for non-technical users to learn and use.
7. The system shall respond quickly, without *lag*.
8. The system shall have measures for ensuring data integrity in the case of *environmental* or *hardware failures*.
9. The system shall be designed to work in a networked environment of at least two computers.
10. The system shall have the ability to scale up to at least 10 *client computers*.
11. The system shall be compatible with an *operating system* of Windows XP or greater.
12. The system shall create a *backup* each day.
13. The system shall be capable of retrieving data via laser scanner.

**Glossary of Terms**

.Net: a set of programming languages

AIDS: Autoimmune Deficiency Syndrome, a disease of the human immune system

ASP.NET: a programming language

C#: a programming language

ColdFusion: a programming language

CS3750, CS4750: Computer science class in which we work on this project

CSS: a programming language for page layout in HTML

Database: A software system for efficient data management on a computer

Electronic form: a series of fields displayed on the screen for user input

Field: a section of the electronic form for entering data by typing or selecting

HTML: a programming language for designing web pages

Java: a programming language

JavaScript: a programming language

jQuery: a programming library built in javascript

N-Tier: A system for developing software that divides up the aspects of the system among: data access, server processing, and presentation

NICU: Neonatal Intensive Care Unit, the hospital ward where infants with serious illness are treated

Oracle: A database application

Perl: a programming language

PHP: a programming language

RAPIDS: Record And Patient Identification Data System, the computer software and database structure that Kaizen Consulting is delivering to the Korle-Bu Hospital

Server: a computer that stores data and performs computing over a networked connection

Sickle Cell: an abnormal red blood cell having an elongated, crescent like shape due to the presence of abnormal hemoglobin.

Software: computer programs that perform a specific function

SQL: a programming language for databases

System: see RAPIDS

UML: unified modeling language, a collection of diagrams that permit specific description of a software system to improve communication among stakeholders

Web page: A web page or webpage is a document or resource of information that is suitable for the World Wide Web and can be accessed through a web browser and displayed on a monitor or mobile device.

Website: A group of web pages stored on a common server with a common purpose

System Architecture



## Use Cases

**UC-01 - Create New Patient**  
When a new patient arrives a staff member must first register the patient with the system before he or she can be seen. A staff member gathers all required personal information and enters it into the system.  
  
<< diagram here >>

|  |  |
| --- | --- |
| Identifier | UC-01 |
| Description | Process to register a new patient. |
| Actor(s) | Staff |
| Preconditions | Patient does not have an electronic record in the system. (Verified by performing search of existing records in system.) |
| Flow of Events | 1. The staff selects option to register new patient.  2. The staff asks the patient for all required information.  3. The patient presents all required information to the receptionist. 4. The receptionist inputs all information into the system and saves record. |
| Post Conditions | The patient has a record in the system. |

**UC-02 - Create Patient ID Card**  
During the create of a new patient an identification card is generated from the given information and presented to the patient. This card serves as an identifier for quick look-up of patient information and speeds up the process of check-in.  
  
<< diagram here >>

|  |  |
| --- | --- |
| Identifier | UC-02 |
| Description | Process to create a patient ID card. |
| Actor(s) | Staff |
| Preconditions | Patient does not have current ID card. (Either patient is newly registered or patient lost ID card.) |
| Flow of Events | 1. The staff member selects print patient ID card.  2. The card is printed.  3. The staff member gives the patient the new ID card. |
| Post Conditions | Patient now has ID card. |

**UC-03 - Generate Physical Patient Record**  
For certain purposes the facility would like to keep a physical copy of the patient’s chart or record. A receptionist, nurse, or physician can produce this record while viewing the patient’s information.  
  
<< diagram here >>

|  |  |
| --- | --- |
| Identifier | UC-03 |
| Description | Process to generate a physical copy of a patient record |
| Actor(s) | Receptionist, Nurse, Physician |
| Preconditions | A digital record exists in the system for the patient |
| Flow of Events | 1. The user searches for an existing patient record. 2. The user selects to print a physical copy of the record. 3. A physical copy is printed with a date/time stamp to identify how recent the physical copy is. |
| Post Conditions | A physical copy of the patient record is created. |

**UC-04 - Edit Patient**  
A staff member desires to modify the patient in question and can do so saving their updates to the system.  
  
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| --- | --- |
| Identifier | UC-04 |
| Description | A staff member modifies existing patient data or adds new patient data to the system. |
| Actor(s) | Staff, Nurse, Physician |
| Preconditions | The patient has a record in the system. |
| Flow of Events | 1. Staff member retrieves the patient’s record by completing UC-06. 2. Staff member modifies information as necessary. |
| Post Conditions | The system is up to date with current patient information. |

**UC-05 - Delete Patient**  
An administrator or physician has decided to remove an individual patient from the system. This removal process is a *soft delete.*  
  
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| --- | --- |
| Identifier | UC-05 |
| Description | An administrative user removes/deactivates a patient from the system |
| Actor(s) | Administrator, Physician |
| Preconditions | The patient has a record in the system |
| Flow of Events | 1. The user searches for an existing patient record. 2. The user selects to delete/deactivate the patient record from the system 3. The user is prompted to make sure they really want to remove the patient 4. If Yes is selected then the patient is marked as inactive. If No is selected then the user remains unchanged. (Deactivated records are recoverable and can be marked as ‘Active’ again) |
| Post Conditions | The user is removed from the active list of patients |

**UC-06 – Look-up Patient Record**  
The receptionist or another staff member needs to search the system for a particular patient. This can be done using various data provided by a potentially existent patient.  
  
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| --- | --- |
| Identifier | UC-06 |
| Description | A staff member searches for a patient based on previously provided demographic information. |
| Actor(s) | Receptionist, Nurse, Physician |
| Preconditions | N/A |
| Flow of Events | 1. Staff member enters search criteria into the system. 2. Staff member is returned a set of results based on search criteria.  3. Staff member identifies correct result from result set. |
| Alternate Flow | 1a. Staff member scans patient’s bar code. |
| Post Conditions | The system will provide the user with zero to many results based on the search criteria. |

**UC-07 - Admit Patient**  
This is the process by which a patient is admitted to the facility for care.  
  
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| --- | --- |
| Identifier | UC-07 |
| Description | Collect and enter information about a patient being checked into the facility for care. |
| Actor(s) | Receptionist |
| Preconditions | N/A |
| Flow of Events | 1. Staff member completes UC-06 to find patient record.  2. Staff member records information about specific encounter. |
| Alternative Flow | 1a. Staff member completes UC-01 to create a new patient record. |
| Post Conditions | Patient is admitted and has an encounter associated with admission. |

**UC-08 - Discharge Patient**  
Care has been provided and the patient is to leave the facility.  
  
<< diagram here >>

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| --- | --- |
| Identifier | UC-08 |
| Description | Patient is checked out of the facility. |
| Actor(s) | Physician, Nurse |
| Preconditions | Patient has been checked in. |
| Flow of Events | 1. Staff uses UC-06 to look up patient.  2. Staff records discharge information. |
| Post Conditions | Patient encounter is closed and discharge information is recorded. |

**UC-09 - Record Patient Vitals**  
During a patient’s stay at the facility a staff member will record their vitals initially and then on a regular basis.  
  
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| Identifier | UC-09 |
| Description | Process to take patient’s vitals. |
| Actor(s) | Nurse, Physician |
| Preconditions | Patient is checked in. |
| Flow of Events | 1. Nurse takes all required vitals from the patient.  2. Nurse records vitals into the patient’s record. |
| Post Conditions | Patient’s vitals are associated with encounter. |

**UC-10 - Create New Encounter**  
Each time the physician performs a significant visit with the patient he or she will create an encounter to record their impressions, take notes, perform diagnoses, and issue orders for the nursing staff.  
  
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| --- | --- |
| Identifier | UC-10 |
| Description | Process for adding an encounter with a patient |
| Actor(s) | Physician |
| Preconditions | The patient must have a record in the system. |
| Flow of Events | 1. User searches for the patient’s record 2. User selects option to add an encounter for the patient 3. User fills out information about the encounter and saves the record |
| Post Conditions | The patient record now reflects the details from the newly inserted encounter |

**UC-11 - Add Notes to Patient Record**  
During an encounter between either a physician or a nurse and a patient notes may be taken in free form.  
  
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| --- | --- |
| Identifier | UC-11 |
| Description | Process to view and input clinical information into patient record. |
| Actor(s) | Physician, Nurse |
| Preconditions | Patient has been checked in. |
| Flow of Events | 1. Physician/nurse selects patient using UC-06. 2. Physician/nurse inputs clinical notes in free text form. 3. Physician/nurse saves clinical note. |
| Post Conditions | Patient record has clinical note associated with patient encounter. |

**UC-12 - View Patient History**  
A physician or nurse may view the patient’s recorded medical history. This information would include past encounters and related notes, vital signs, and possibly symptoms.  
  
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| Identifier | UC-12 |
| Description | Process by which medical staff views patient’s historical clinical information. |
| Actor(s) | Physician, Nurse |
| Preconditions | Patient has record.  Patient has medical history. |
| Flow of Events | 1. Physician/nurse selects patient using UC-06. 2. Physician/nurse is shown list of previous medical information including its date and type.  3. Physician/nurse selects which information they wish to view.  4. Physician/nurse is shown clinical information. |
| Post Conditions | N/A |

**UC-13 - Issue a Prescription**  
If the physician sees fit to issue a prescription to the current patient then they may do so via the system’s user interface. The prescription will be printed out and given to the patient. This prescription will be attached to the patient’s medical history.  
  
<< diagram here >>

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| --- | --- |
| Identifier | UC-13 |
| Description | Process to issue a prescription. |
| Actor(s) | Physician |
| Preconditions | The physician has seen the patient. |
| Flow of Events | 1. Physician inputs patient details.  2. Physician validates prescription to patient.  3. Physician submits prescription into system.  4. Physician prints a paper copy of the prescription. |
| Post Conditions | Patient can pick up prescription. |

**UC-14 - Add Patient Allergy**  
During the first encounter, and possibly subsequent encounters, a staff member will interview the patient asking if there are any allergies to be concerned about. If there are allergies they will be recorded and attached to the patients medical record.  
  
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| --- | --- |
| Identifier | UC-14 |
| Description | Process to add an allergy to the patient’s record |
| Actor(s) | Receptionist, Nurse, Physician |
| Preconditions | Patient has been checked in. |
| Flow of Events | 1. Open the patient record 2. Identify any allergies the patient has 3. Ensure that the allergy is not already listed on the patient record 4. Verify if other existing allergies are still relevant to the patient 5. Add new allergies to the patient record by selecting option and entering information about the patient’s allergy |
| Post Conditions | The patient’s allergies are linked to the patient record |

**UC-15 - Add Item/Service to Patient Bill**  
As items and services are provided to patient they will be recorded against the patient’s account.   
  
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| --- | --- |
| Identifier | UC-15 |
| Description | Process to charge a patient for services. |
| Actor(s) | Staff, Nurse, Physician |
| Preconditions | Patient is checked in. |
| Flow of Events | 1. Staff/Nurse/Physician selects patient using UC-06.  2. Staff/Nurse/Physician searches for supply or service in database.  3. Staff/Nurse/Physician selects service or supply to add to patient’s bill.  4. Staff/Nurse/Physician enters quantity to apply to patient’s bill.  5. Staff/Nurse/Physician saves transaction. |
| Post Conditions | Item or service is recorded on patient’s bill. |

**UC-16 - Bill Patient**  
Once services have been provided to a patient an invoice will be generated. The invoice will include line items with charges for various supplies, medicines, and care.  
  
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| --- | --- |
| Identifier | UC-15 |
| Description | Process to charge a patient for services. |
| Actor(s) | Staff |
| Preconditions | Patient has valid medical record. |
| Flow of Events | 1. Staff member looks up patient using UC-06.  2. Staff member generates invoice. |
| Post Conditions | N/A |

**UC-17 - Record Payment**  
The patient may make periodic payments which he or she will make to the facility. These payments will be recorded and applied to a certain invoice.  
  
<< diagram here >>

|  |  |
| --- | --- |
| Identifier | UC-16 |
| Description | Process to record payment to patient’s account. |
| Actor(s) | Staff |
| Preconditions | Patient has balance owing on account. |
| Flow of Events | 1. Staff member looks up patient using UC-06.  2. Staff member receives payment.  3. Staff member records payment amount and type.  4. Staff member prints receipt. |
| Post Conditions | Amount paid is credited to the patient’s account. |

**UC-18 - Add Item to Inventory**  
The facility staff will occasionally add new items such as supplies or medicines to the inventory. These items will track quantity as well as any pertinent information.  
  
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| --- | --- |
| Identifier | UC-17 |
| Description | Process to add a new item to inventory. |
| Actor(s) | Staff |
| Preconditions | N/A |
| Flow of Events | 1. Staff member selects option to add new item to inventory.  2. Staff member inputs information about item.  3. Staff member saves item. |
| Post Conditions | Inventory is updated to reflect new supply, availability, and cost. |

**UC-19 - Remove Item from Inventory**  
On occasion an item will need to be removed from the inventory because it is no longer being produced or simply cannot be obtained.  
  
<< diagram here >>

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| --- | --- |
| Identifier | UC-18 |
| Description | Process to remove an item for inventory. |
| Actor(s) | Staff |
| Preconditions | Item is currently in inventory.  Quantity available must be zero. |
| Flow of Events | 1. Staff member selects item from current inventory.  2. Staff member selects option to delete item. |
| Post Conditions | Item is no longer available to update in inventory or to bill to a patient. |

**UC-20 - Update Item in Inventory**  
When new purchases are made by facility staff the quantities and possibly other information will need to be updated to reflect the current inventory.  
  
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| --- | --- |
| Identifier | UC-19 |
| Description | Process to update item details in inventory. |
| Actor(s) | Staff |
| Preconditions | Item exists in inventory. |
| Flow of Events | 1. Staff selects item from inventory.  2. Staff updates information. 3. Staff saves updated information. |
| Post Conditions | Item’s status in inventory is now up-to-date and accurate to be billed against. |

System Models

Registering a Patient



Record Patient’s Vitals



Visit with Physician



*GUC01 - Search Patient Records*

The staff member receives any or all of patient name, address, date of birth, or patient id. Then they enter patient data as search criteria into the system to attempt to locate the patient in the system.

*GUC02 - Scan barcode*

The staff member takes the physical medical record and uses the laser scanner to transfer the data contained in the barcode to the system so the location of the physical medical record can be updated.

*GUC03 - View patient record*

The staff member views a screen that has information about the patient in general as well as information that is relevant to a specific department of the hospital. The staff member will then be able to make decisions on how to proceed.

*GUC04 - Update patient record*

The staff member modifies existing patient data or adds new patient data to the system.

*GUC05 - Create Patient*

The staff member creates a new patient. If this is the Records Desk, a physical record is created and a Patient ID is assigned.

*GUC06 - View patient visits*

The staff member views a screen that provides a list of previous and current visits for a given patient.

*GUC07 - Generate report*

The staff member generates a report that can be related to general hospital operations or that is specific to a certain department.

*GUC08 - Record Payment.*

Staff or accounting personnel record payment for hospital visit.

*NICU01 - Admit Patient*

Collect and enter information about a child checking into the Newborn Intensive Care Unit.

*NICU02 - Discharge Patient*

Patient is checking out of the hospital.

*HUC01 - Admit Patient*

Additional information is added to patient record for admission to hospital ward.

*HUC02 - Discharge Patient*

Patient is checking out of the hospital.

**Detailed Use Cases**

|  |  |
| --- | --- |
| **Identifier** | GUC01 |
| **Name** | Search Patient Records |
| **Description** | The staff member receives any or all of patient name, address, date of birth, or patient id. Then they enter patient data as search criteria into the system to attempt to locate the patient in the system. |
| **Actor(s)** | *Staff* |
| **Preconditions** | N/A |
| **Post Conditions** | The system will provide the user with zero to many results based on the search criteria |
| **Assumptions** | The user will be provided patient data that the system can use as search criteria. |
| **Normal Flow** | 1. Staff member enters search criteria into system. 2. Staff member is returned a set of results based on search criteria. 3. Staff member identifies the correct result from the result set. |
| **Alternate Flow** | 2a. There are no results after the search the staff member executes the patient creation use case. |

|  |  |
| --- | --- |
| **Identifier** | GUC02 |
| **Name** | Scan barcode |
| **Description** | The staff member takes the physical medical record and uses the laser scanner to transfer the data contained in the barcode to the system so the location of the physical medical record can be updated. |
| **Actor(s)** | *Staff* |
| **Preconditions** | N/A |
| **Post Conditions** | The location of the physical medical record is updated and available for all users. |
| **Assumptions** | Laser scanner is operational, the physical medical record is in hand, and the barcode label is not damaged. |
| **Normal Flow** | 1. Staff member initiates update record location in the system. 2. Staff member scans the barcode with the laser scanner and the data is sent to the system. |
| **Alternate Flow** | 2a. The data is not sent to the system due to an error with the laser scanner or the barcode is damaged. The staff member troubleshoots the laser scanner by trying to scan in another record. If that is successful the barcode on the original record is replaced. If more than one barcode can not be scanned in the laser scanner is replaced. |

|  |  |
| --- | --- |
| **Identifier** | GUC03 |
| **Name** | View patient record |
| **Description** | The staff member views a screen that has information about the patient in general as well as information that is relevant to a specific department of the hospital. The staff member will then be able to make decisions on how to proceed. |
| **Actor(s)** | *Staff* |
| **Preconditions** | N/A |
| **Post Conditions** | The staff member has the ability to make informed decisions about patient care. |
| **Assumptions** | N/A |
| **Normal Flow** | 1. Staff member executes the search patient records use case (GUC01). 2. Staff member selects view patient record. 3. Staff member views patient data based on permission level. |
| **Alternate Flow** | N/A |

|  |  |
| --- | --- |
| **Identifier** | GUC04 |
| **Name** | Update patient record |
| **Description** | The staff member modifies existing patient data or adds new patient data to the system. |
| **Actor(s)** | *Staff* |
| **Preconditions** | N/A |
| **Post Conditions** | The patient data in the system is up to date and available for users of the system. |
| **Assumptions** | N/A |
| **Normal Flow** | 1. Staff member executes the view patient record use case. 2. Staff member selects edit record and modifies or adds new patient data to the system. |
| **Alternate Flow** | N/A |

|  |  |
| --- | --- |
| **Identifier** | GUC05 |
| **Name** | Create Patient |
| **Description** | The staff member creates a new patient. If this is the Records Desk, a physical record is created and a Patient ID is assigned. |
| **Actor(s)** | *Staff* |
| **Preconditions** | A search has been performed to ensure the patient does not already have a record. |
| **Post Conditions** | The patient has a record in the system that may be linked with visit records. |
| **Assumptions** | N/A |
| **Normal Flow** | 1. Staff selects option to create a new patient 2. Staff enters patient’s name. 3. Staff enters patient’s date of birth. 4. Staff enters patient’s gender. 5. Staff enters patient’s address. 6. Staff marks checkbox for AIDS, cardiac, sickle cell, etc. if applicable. 7. Patient is referred to Patient Creation Desk for a physical record |
| **Alternate Flow** | 6a. This is the patient creation desk: staff obtains a new physical record for the patient and inputs the Patient ID Number.  7a. System prints a barcode label for the clerk to affix to the physical record. |

|  |  |
| --- | --- |
| **Identifier** | GUC06 |
| **Name** | View patient visits |
| **Description** | The staff member views a screen that provides a list of previous and current visits for a given patient. |
| **Actor(s)** | *Staff* |
| **Preconditions** | N/A |
| **Post Conditions** | The staff member can make informed decisions based on the history of visits for a given patient. |
| **Assumptions** | N/A |
| **Normal Flow** | 1. Staff member executes the view patient record use case. 2. Staff member selects view patient visit history option from the system. 3. Staff member makes decisions for patient care based on the history of the patient’s visits. |
| **Alternate Flow** | N/A |

|  |  |
| --- | --- |
| **Identifier** | GUC07 |
| **Name** | Generate report |
| **Description** | The staff member generates a report that can be related to general hospital operations or that is specific to a certain department. |
| **Actor(s)** | *Staff* |
| **Preconditions** | N/A |
| **Post Conditions** | Reports are available for hospital administration and government officials to review various aspects of hospital operations. |
| **Assumptions** | Data required to generate the report is stored in the system. |
| **Normal Flow** | 1. Staff member initiates report generation section of system. 2. Staff member selects from a list of reports that are available for generation based on the staff member’s privilege level. 3. Staff member views the report on screen and has the option to print a physical copy. |
| **Alternate Flow** | N/A |

|  |  |
| --- | --- |
| **Identifier** | GUC08 |
| **Name** | Record Payment. |
| **Description** | Staff or accounting personnel record payment for hospital visit. |
| **Actor(s)** | *Staff/Accounting* |
| **Preconditions** | Patient already has a record and has been admitted. |
| **Post Conditions** | Payment is recorded on patient’s record. |
| **Assumptions** | N/A |
| **Normal Flow** | 1. Staff looks up the patient record by Patient Number or name. 2. Staff records the amount billed. 3. Staff records the amount paid. 4. Staff records the receipt number. |
| **Alternate Flow** | N/A |

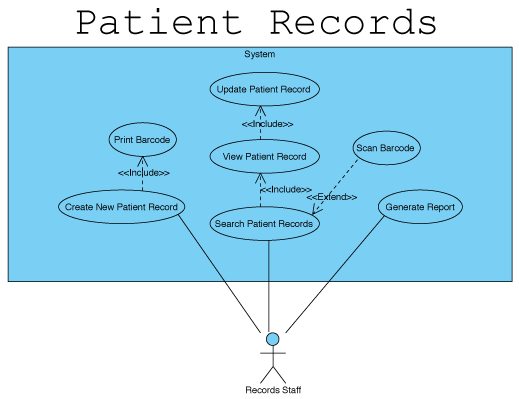
|  |  |
| --- | --- |
| **Identifier** | NICU01 |
| **Name** | Admit Patient |
| **Description** | Collect and enter information about a child checking into the Newborn Intensive Care Unit. |
| **Actor(s)** | *Staff* |
| **Preconditions** | N/A |
| **Post Conditions** | A log record has been created for the child, and linked to physical record. |
| **Assumptions** | The child was born at this hospital and already has a physical record. |
| **Normal Flow** | 1. Staff looks up patient record by Patient Number or name. 2. Staff records mother’s name (first, middle, last). 3. Staff records the patient’s birth weight in kilograms. 4. Staff records the patient’s time of birth. 5. Staff records the patient’s time of admission. 6. Staff records the patient’s referral (midwife, born in home, hospital). 7. Staff records the location of the patient’s mother in the hospital if applicable. 8. Staff records the patient’s maturity (gestation period in weeks). 9. Staff records the patient’s mode of delivery (SVD, breach, C-section) 10. Staff records the patient’s parity (number of previous miscarriages the mother had). 11. Staff records the mother’s age. 12. Staff records the cubical the patient is in. 13. Staff records the patient’s entry diagnosis. |
| **Alternate Flow** | Cause: The child does not have a physical record.  1a. Staff cannot find patient record when searching by Patient Number or name.  2a. Use Case GUC05  3a. Continue with step 2 of normal flow. |

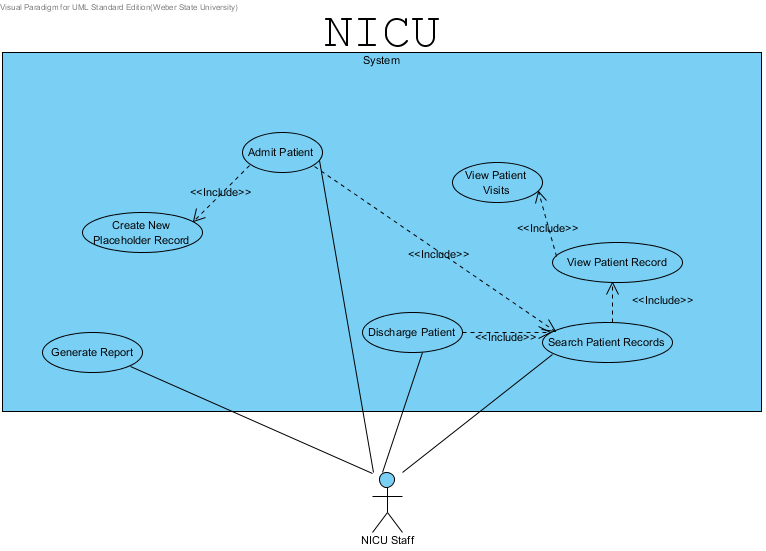
|  |  |
| --- | --- |
| **Identifier** | NICU02 |
| **Name** | Discharge Patient |
| **Description** | Patient is checking out of the hospital. |
| **Actor(s)** | *Staff* |
| **Preconditions** | Patient has been checked in |
| **Post Conditions** | Patient discharge information is recorded. |
| **Assumptions** | Patient will check with Staff before leaving. |
| **Normal Flow** | 1. Staff looks up the patient record by Patient Number or name. 2. Staff records the patient’s final diagnosis. 3. Staff records the patient’s discharge weight. 4. Staff records the patient’s discharge date. 5. Staff records the patient’s special treatments list (bililights, etc). |
| **Alternate Flow** | N/A |

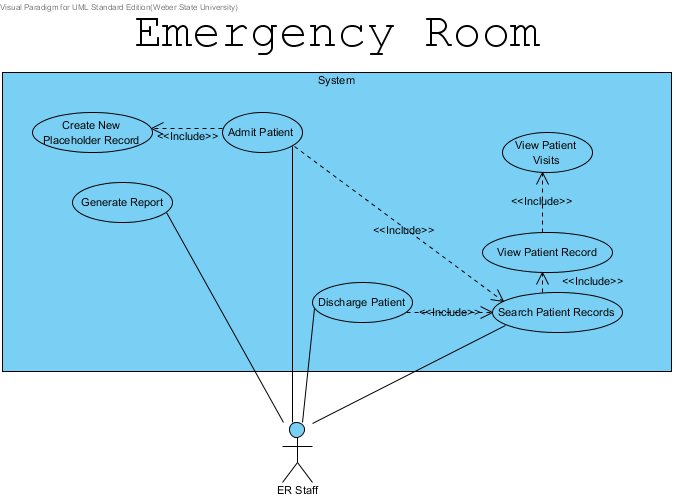
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| --- | --- |
| **Identifier** | HUC01 |
| **Name** | Admit Patient |
| **Description** | Additional information is added to patient record for admission to hospital ward. |
| **Actor(s)** | *Inpatient Staff* |
| **Preconditions** | A patient record must exist. |
| **Post Conditions** | A record has been created that is associated with the patient’s main record. It contains data pertinent to inpatient records. |
| **Assumptions** | The patient already has a record created and will be admitted to one of the wards. |
| **Normal Flow** | 1. Staff searches for record by ID or patient name. 2. Staff selects Admit Patient option. 3. Staff selects patient’s Current Occupation. 4. Staff enters Principal Diagnosis. 5. Staff selects ward the patient will be admitted to. 6. Staff reviews summary view of patient information to insure correctness. 7. Staff submits form to admit patient or cancels process. |
| **Alternate Flow** | Cause: The patient does not have a record created   1. Staff cannot find patient record when searching by Patient Number or name. 2. Use Case GUC05 3. Continue with step 2 of normal flow. |

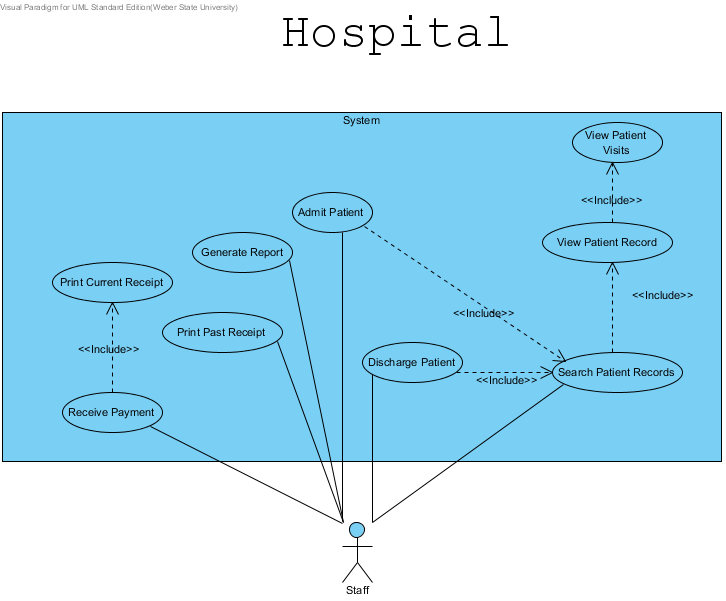
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| --- | --- |
| **Identifier** | HUC02 |
| **Name** | Discharge Patient |
| **Description** | Patient is checking out of the hospital. |
| **Actor(s)** | *Staff* |
| **Preconditions** | Patient has been admitted to the hospital and has a patient record. |
| **Post Conditions** | Patient discharge information is recorded. |
| **Assumptions** | Patient will have paid any fees. |
| **Normal Flow** | 1. Staff selects patient from currently admitted list. 2. Staff updates any diagnosis. 3. Staff updates any treatments necessary. 4. Staff checks summary screen to insure all patient data is correct and makes any necessary updates. 5. Staff submits discharge form or cancels. |
| **Alternate Flow** | N/A |

**7.0 Use Case Diagrams**



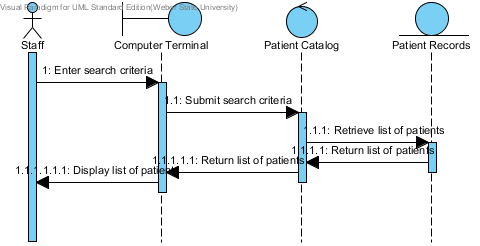




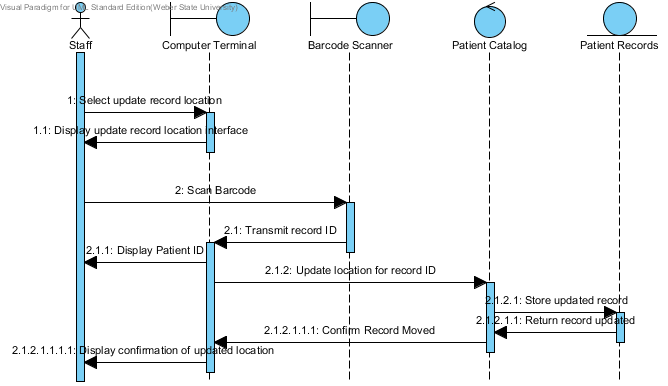


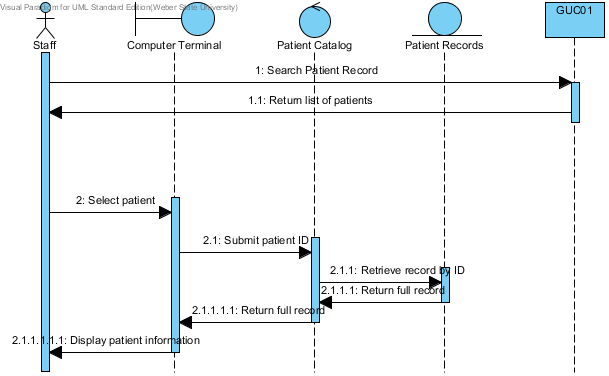
**8.0 Sequence Diagrams**

GUC01

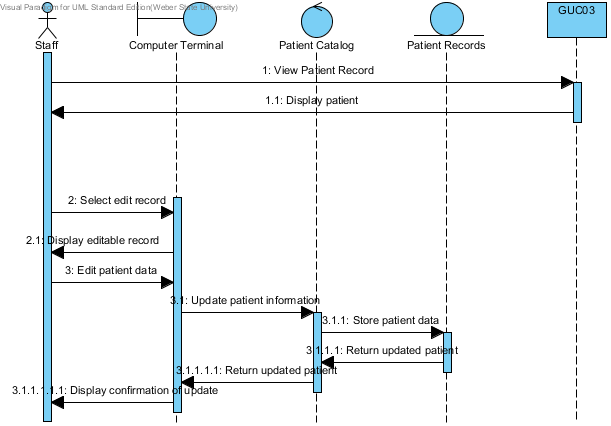


GUC02

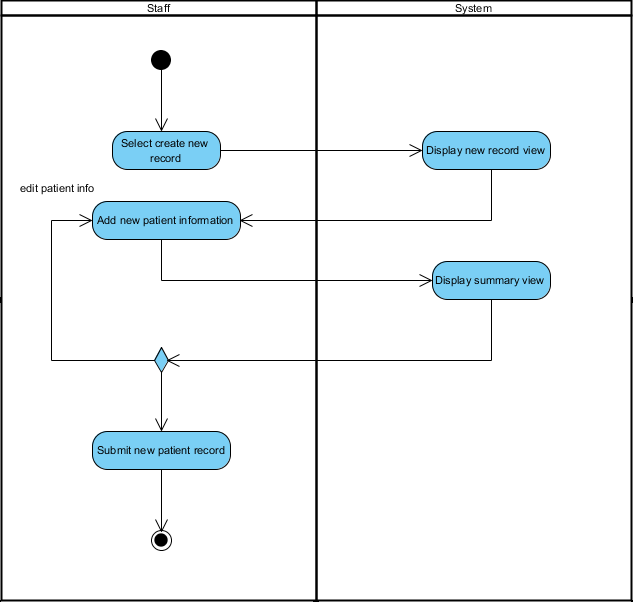
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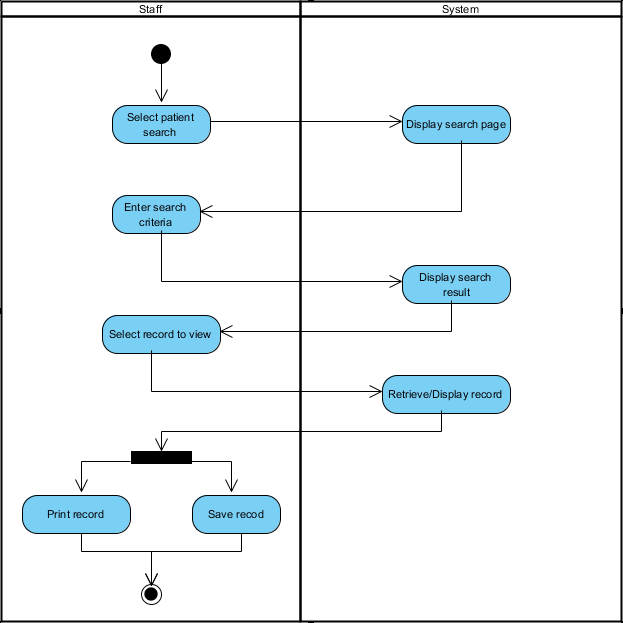
GUC03****

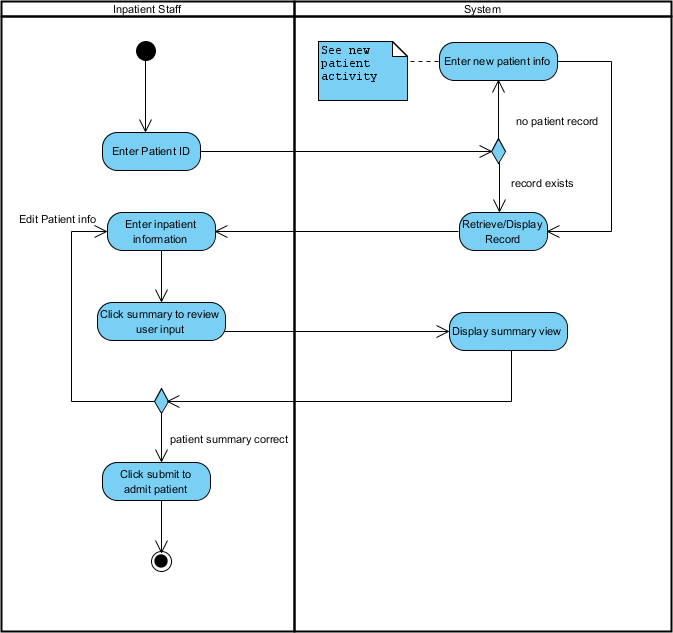
GUC04

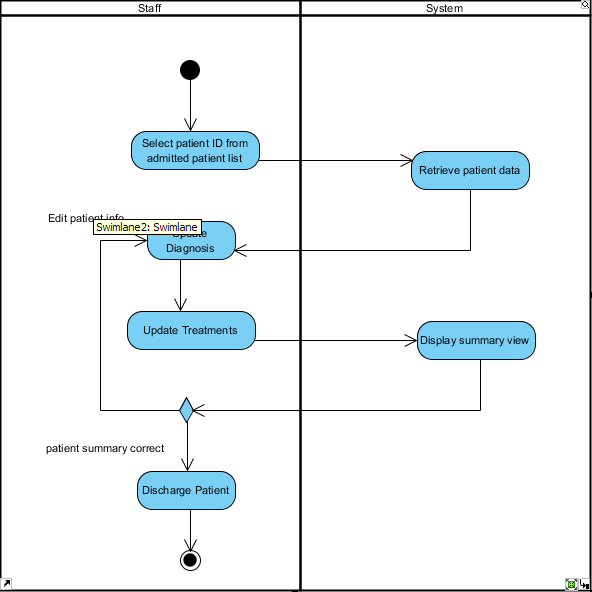
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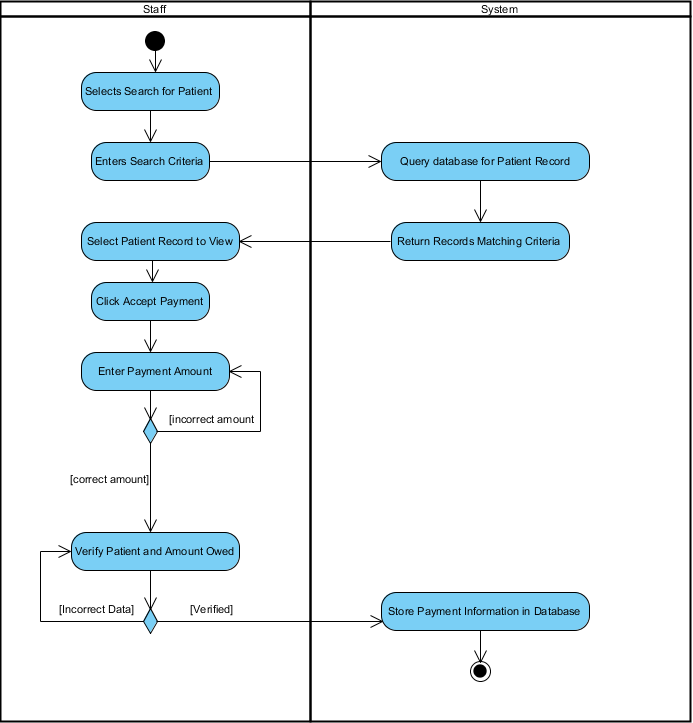
**9.0 Activity Diagrams**











User Interface Mockups

Add Patient to System



1. From the Front Desk Home Page, click the “Add/Edit” tab on the top of the screen.



1. Click on “Add New Patient”.



1. Fill out all the patient information.
2. Click “Create Patient” to finish adding a new patient.

Search for Patient



1. Click the “Find” tab to reach the Find Patient screen.
2. Enter a card ID number OR enter a first or last name.
3. Click “Search” to bring up matching results.
4. Highlight a patient by clicking the corresponding row.
5. Click “Select Patient” to select the patient.



1. The current patient is now set to the user’s selection. All system tasks, when performed, will be applied to the current patient listed on the upper portion of the screen.
2. If the wrong patient was selected, click “Go Back” to return to the “Find Patient” screen.

Fulfill an Appointment



1. Click the “Appts” tab to reach the Appointments screen.
2. Click “View Appointments”.



1. Today’s unfulfilled (to be seen) appointments are automatically displayed. To view another day’s appointments, enter the date and click “Show”.
2. Click on a patient and then click “Select Patient” to take the patient off the unfulfilled appointments list. This also sets the current patient for other tasks to apply to.

Take Patient Vitals



1. Click the “Vitals” tab to reach the Take Vitals screen.
2. Enter all the vital statistics, pressing Tab or clicking to reach the next field.
3. Enter a brief description of the reason for the patients visit if necessary.
4. Click “Submit” to save the information, which the physician may see now from his computer.

Issue Medications



1. Click the “Meds” tab to reach the Medications screen.
2. A list of medications prescribed by the physician will be listed.
3. Click on a medication to highlight it, then click “Issue and add selected to bill” after medication has been filled. This takes the quantity of drugs out from the inventory, and also adds the cost of the drugs to the patient’s bill to be paid.
4. Or click “Issue and add all medications to bill”.

Bill Patient



1. Click the “Billing” tab to reach the Billing screen.
2. Click “Pay Full Amount” if the patient has the money to pay the total bill.
3. Or enter an amount for partial payment, and click “Pay Partial”.

View Pharmacy Inventory Report



1. Click the “Reports” tab to reach the Reports screen.
2. Choose “Pharmacy Inventory Report” from the drop down list.
3. Choose a desired export option.
4. Click “Create Report”.

The report generated will be in the following form.



View Pharmacy Sales Report



1. Click the “Reports” tab to reach the Reports screen.
2. Choose “Pharmacy Sales Report” from the drop down list.
3. Choose a desired export option.
4. Click “Create Report”.

The report generated will be in the following form.



View Clinic Income Report



1. Click the “Reports” tab to reach the Reports screen.
2. Choose “Clinic Income Report” from the drop down list.
3. Choose a desired export option.
4. Click “Create Report”.

The report generated will be in the following form.



Select Patient to See



1. From the Physician Home Page, click the “Select Patient” tab on the top of the screen.



1. The patient waiting the longest amount of time will be shown and selected automatically on the top of the list.
2. Another patient may be highlighted for selection by clicking the row corresponding to their name.

Click “Select Patient” to select the highlighted patient, and begin using other system functions on them as the Current Patient.

View/Add Patient Records



1. Click the “Patient Records” tab to reach the Patient Records screen.
2. Click the record to view from the list of dates.
3. To add a new record, click “Add New Record”.
4. Enter notes for each section of the patient record.
5. Click “Save Record” to add a new record on today’s date for the patient.

View/Make Diagnosis



1. Click the “Diagnosis” tab to reach the Diagnosis screen.
2. Any previous diagnosis can be removed, or toggled between cured and not cured with the two lower buttons.
3. To select a new diagnosis, choose a condition or disease from the list, or type the name of the condition or disease if it is not in the list.
4. Click “Add” to add the selected diagnosis to the patient’s record.

Prescribe Medicine



1. Click the “Rx” tab to reach the Prescriptions screen.
2. Select a medicine to prescribe from the clinic inventory by clicking In the drop down list.
3. Choose a quantity of the medicine to prescribe.
4. Select a refill date for the prescription.
5. Click “Issue Prescription” to issue the prescription to the patient. The front desk will now be able to see this prescription when the patient comes to receive it.

**User Interface Mockups**







User Effort Estimation

Search for Patient

Navigation events to data entry events ratio is **1:3**.

1. **NAVIGATION:** total 1 mouse click, as follows
   1. Click the “Find” tab.
2. **DATA ENTRY:** total 2 mouse clicks and 1 keyboard field entry, as follows
   1. Type in Patient Card Number (or Tab to name and type name).
   2. Click “Search” (or press Enter).
   3. Click “Select Patient”.

NOTE: The above process of finding and selecting a patient can be circumvented by using the barcode scanner to simply scan the patient’s ID card.

Add Patient to System

Navigation events to data entry events ratio is **2:16.**

1. **NAVIGATION:** total 2 mouse clicks, as follows
   1. Click the “Add/Edit” tab.
   2. Click “Add New Patient”.
2. **DATA ENTRY:** total 2 mouse clicks, 7 Tabs to next field, and 7 keyboard field entries, as follows
   1. Click “Sex: Male or Female”.
   2. Tab and enter first name.
   3. Tab and enter last name.
   4. Tab and enter date of birth.
   5. Tab and enter phone number.
   6. Tab and enter house number.
   7. Tab and enter area.
   8. Tab and enter city.
   9. Click “Create Patient”.

Take Vitals

Navigation events to data entry events ratio is **1:14**

1. **NAVIGATION:** total 1 mouse click, as follows
   1. Click the “Vitals” tab.
2. **DATA ENTRY:** total 1 mouse click, 6 Tabs to next field, and 7 keyboard field entries, as follows
   1. Enter height.
   2. Tab and enter weight.
   3. Tab and enter blood pressure.
   4. Tab and enter heart rate.
   5. Tab and enter respiratory rate.
   6. Tab and enter temperature.
   7. Tab and enter the reason for visit.
   8. Click “Submit”.

Bill a Patient

Navigation events to data entry events ratio is either **1:1** or **1:3**, depending on the flow of events.

1. **NAVIGATION:** total 1 mouse click, as follows
   1. Click the “Billing” tab.
2. **DATA ENTRY:** total 1-2 mouse clicks, and 0-1 keyboard field entries, as follows
   1. Click “Pay Full Amount”.
   2. Or, if partial payment is allowed, type in the amount to pay.
   3. Click “Pay Partial”.

Select Patient to See

Navigation events to data entry events ratio is **1:1** or **1:2**, depending on the flow of events.

1. **NAVIGATION:** total 1 mouse click, as follows
   1. Click the “Select Patient” tab.
2. **DATA ENTRY:** total 1-2 mouse clicks, as follows
   1. The patient waiting the longest is automatically highlighted at the top of the list. If the physician wishes to see another patient first however, then click on that patient.
   2. Click “Select Patient” button.

Add a Patient Record

Navigation events to data entry events ratio is **2:8.**

1. **NAVIGATION:** total 2 mouse clicks, as follows
   1. Click the “Patient Records” tab.
   2. Click “Add New Record”.
2. **DATA ENTRY:** total 1 mouse click, 3 Tabs to next field, and 4 keyboard field entries, as follows
   1. Enter patient notes.
   2. Tab and enter treatment description.
   3. Tab and enter prescription.
   4. Tab and enter follow up notes.
   5. Click “Save”.

View/Make Diagnosis

Navigation events to data entry events ratio is **1:3.**

1. **NAVIGATION:** total 1 mouse click, as follows
   1. Click the “Diagnosis” tab (Diagnosis history is shown for viewing).
2. **DATA ENTRY:** total 3 mouse clicks, as follows
   1. Click on “New Diagnosis” drop down list.
   2. Click a condition or disease to select it or type in a new one.
   3. Click “Add”.

Prescribe Medicine

Navigation events to data entry events ratio is **1:8.**

1. **NAVIGATION:** total 1 mouse click, as follows
   1. Click “Rx” tab.
2. **DATA ENTRY:** total 3 mouse clicks, 2 Tabs to next field, and 3 keyboard field entries, as follows
   1. Click on “Prescribe” drop down list.
   2. Click a listed drug to select it.
   3. Tab and enter quantity.
   4. Tab and enter refill date.
   5. Click “Issue Prescription”.