10b. Behaviour & Social History - Requirements Specification

Introduction

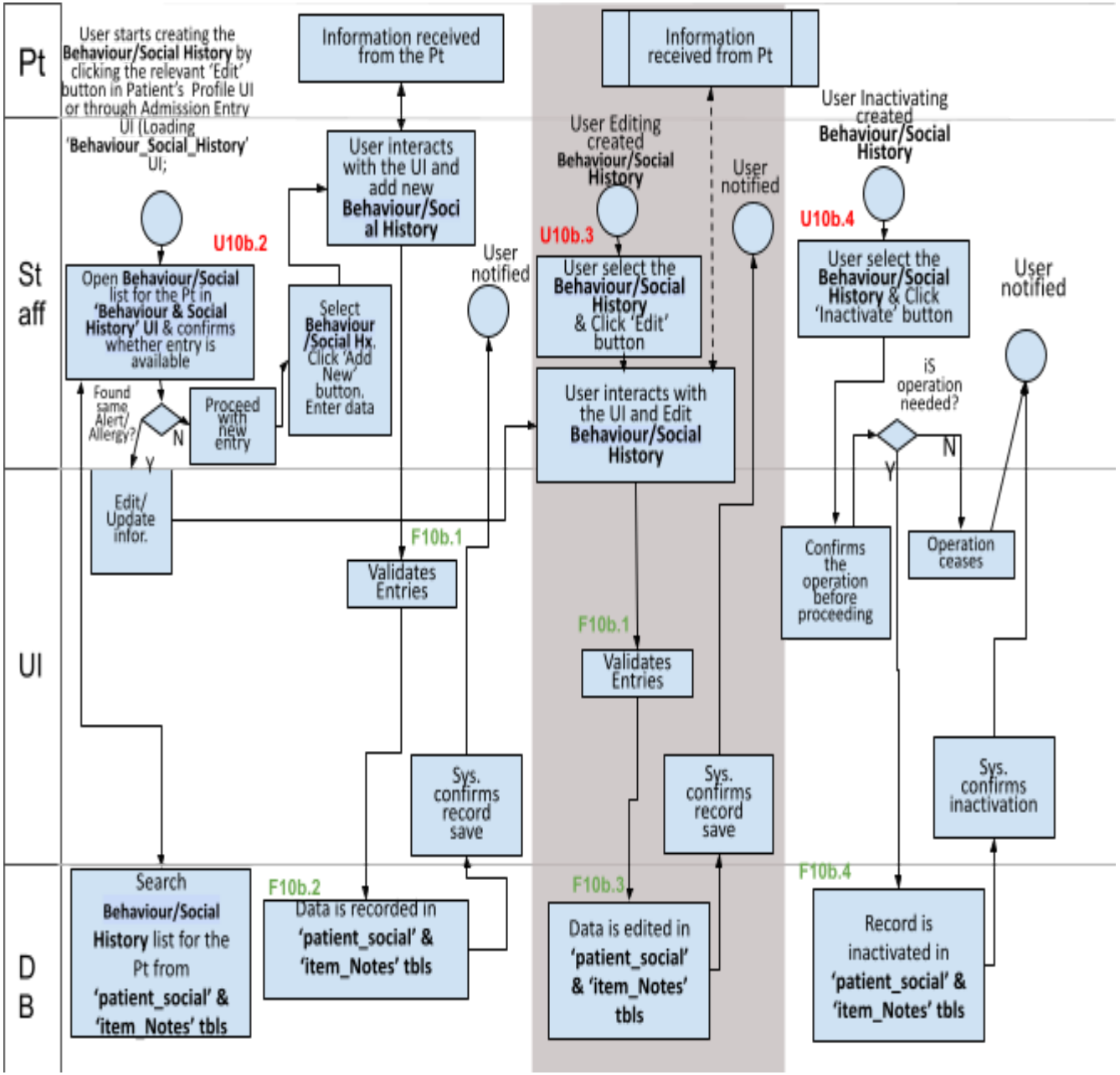
This information is captured during the admission process, inward care, ED, or outpatient department. Sometimes also flagged by the community and GPs. This is important in the decision-making process in care and to include in the discharge communication to the community/GPs. These are entered at the admission, inward stay, outpatient direct patient communication, or as per GPs/community inputs by the clinical staff.

- There is a dedicated interface for this; '**Behaviour & Social History**' UI (**Behaviour_Social_History**) which has the **'patient_social'** as the main backend table. **'Item_notes'** tbl is used to save notes related to an item (Behaviour/Social History). \
- To list Family history items → **'PatientFacts_ItemList'** tbl is used
  (SQL: "SELECT * FROM **PatientFacts_ItemList WHERE** UI_ID=**'10d' AND GROUP BY item_name"**)
- Description labels also taken from **'PatientFacts_ItemList'** tbl
- DropdownList for Descriptions is taken from the **'PatientFacts_ComboItems'** tbl
- This should be used by all clinical and ward clerks/admin staff (Accessibility is available in the 'Group_Permission' tbl link to DB Schema ; goto 'Group_Permission' sheet)

Needed additional functions

- This should be captured into the patient profile with the date (not into the episode) as special information related to the patient.
- Should be validated during entries (drop-down lists) and free text should also be allowed
- Should be used in decision-making in other modules (Special care for patients with ischemic heart disease and smoking behaviour).
- May need communication/integration with already available clinical systems and MHR
- The interface should facilitate entry of new behaviours/Social history of the Pt, if there is already an entered same behaviours/Social factor for the same Pt that should be flagged to the user.
- Auto-filling, dropdown menus should be provided to validate entries and improve user-friendliness.
- This data might be received from other care providers or MHR electronically. In that case, that data should be obtained from different sources through an API/direct entry.
- Once executing user actions (U10b.1 - U10b.4) always should check for the accessibility and privileges of the user (User Access Level) (Accessibility is available in the 'Group_Permission' tbl link to DB Schema ; goto 'Group_Permission' sheet)
- Any change in the data (through F10b.2- F10b.4) of the main table (**'patient_social'**) should be recorded in the system log with Date, Time, User Name, Table, Field & Change
- Consumer entered Patient Behaviours/Social factors should be shown in this UI. Consumer data recorded in **'patient_social_CI'** tbl (which has more or less the same fields as per 'Patient_social' tbl).
- Further, consumer should be able to validate provider entered Behaviours/Social History data and flagged into this UI (as 'Confirmed' or marked as 'Wrong')
- Further, correction of these entries as per consumer validation should be enabled. Consumer App gets provider data from the **'patient_social'** tbl to be checked by the consumer.
- In this comparison another field in the **'patient_social'** ('Consumer_Checked' field) captures whether the consumer marks the record as 'Wrong' or 'Confirmed' as correct. Last Update date of the both consumer and provider entries should be taken into account in flagging mismatch.

Application Process - Create/Edit/Inactivate Behaviour & Social History of a patient



User Functions

U10b.1 - Loading - **Behaviour_Social_History**

U10b.2 - Create the new **Behaviour/Social History**

U10b.3 - Edit **Behaviour/Social History**

U10b.4 - Inactivate **Behaviour/Social History**

System/DB Functions

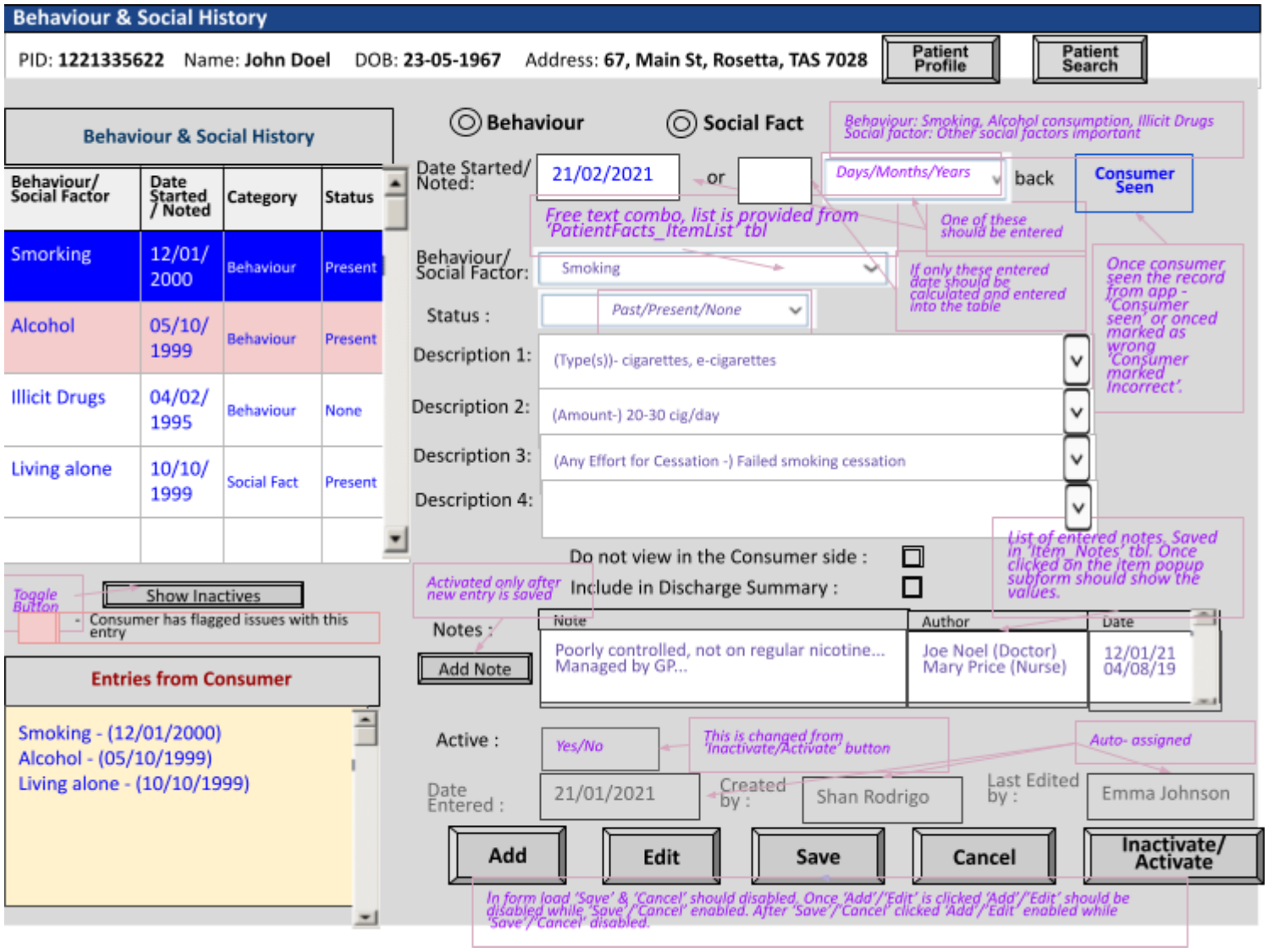
F10b.1 - Validating entries in creating a **Behaviour/Social History**

F10b.2 - Creating a **Behaviour/Social History**

F10b.3 - Edit **Behaviour/Social History**

F10b.4 - Inactivate **Behaviour/Social History**

Suggested UI Improvements (Name: Behaviour & Social History - 'Behaviour_Social_History')



Getting values of the Behaviour/Social Factor

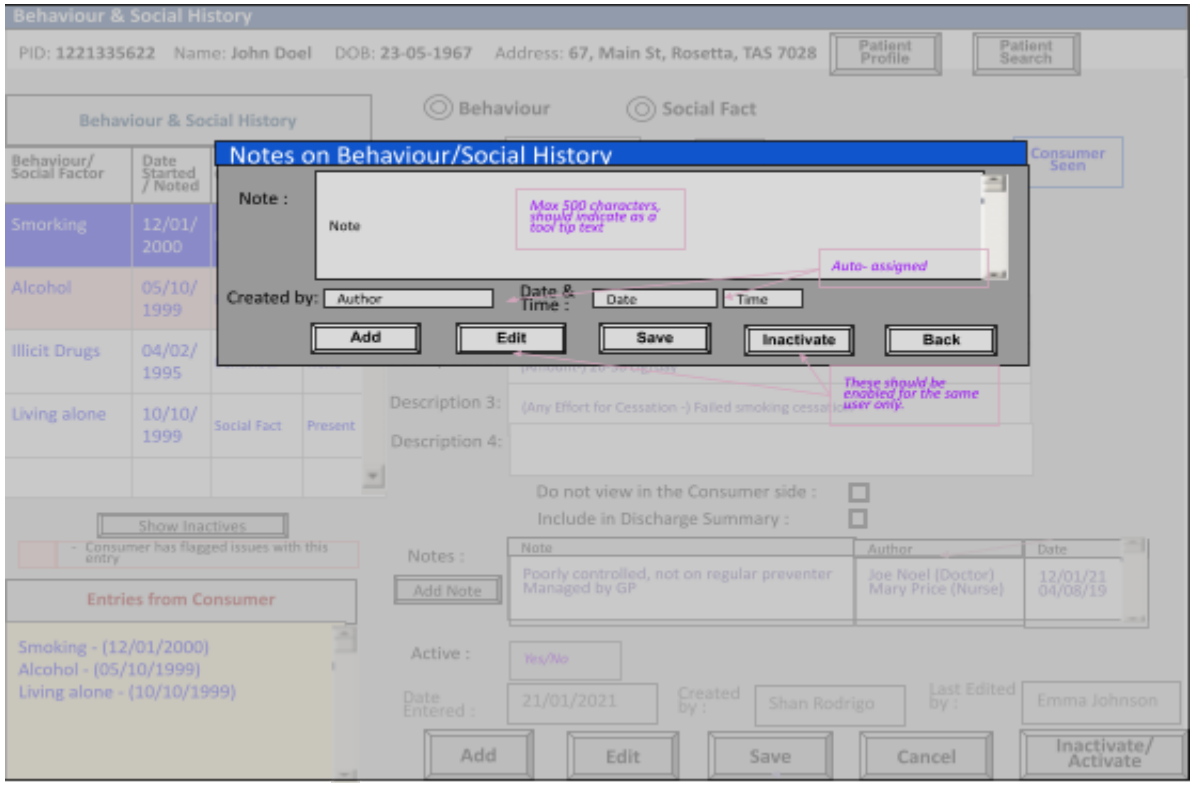
- Once the History item is clicked; its values should be viewed in the textboxes.
- 4 X Descriptions should show values according to the data of the **'patient_social' tbl (see below)** (Description1_Label→ label name for Desc. 1, Description1_value→ value for that description)
- **'PatientFacts_ItemList' tbl (see below)** data is used to check whether a relevant description text box is needed or not. Ex: if Description4_Label is blank, visibility of both Description 4 label and the relevant textbox should be false.
- Some values can be auto populated from the 'patient' tbl. This should be triggered by indicating the field name in the 'Get_Value_From' field of the 'PatientFacts_ItemList' tbl (ex: Occupation can be auto-populated from the 'Patient' tbl and indicate in the relevant description text box once 'Add New' is clicked. This function is triggered by indicating 'patient.Occupation' in 'Get_Value_From' field)
- Description combos dropdown lists may get items from 'PatientFacts_ComboItems' tbl (see below). These list items should grow as per free text entries of the users.

Highlighting Items with Pink when issues with the entry notice by consumer

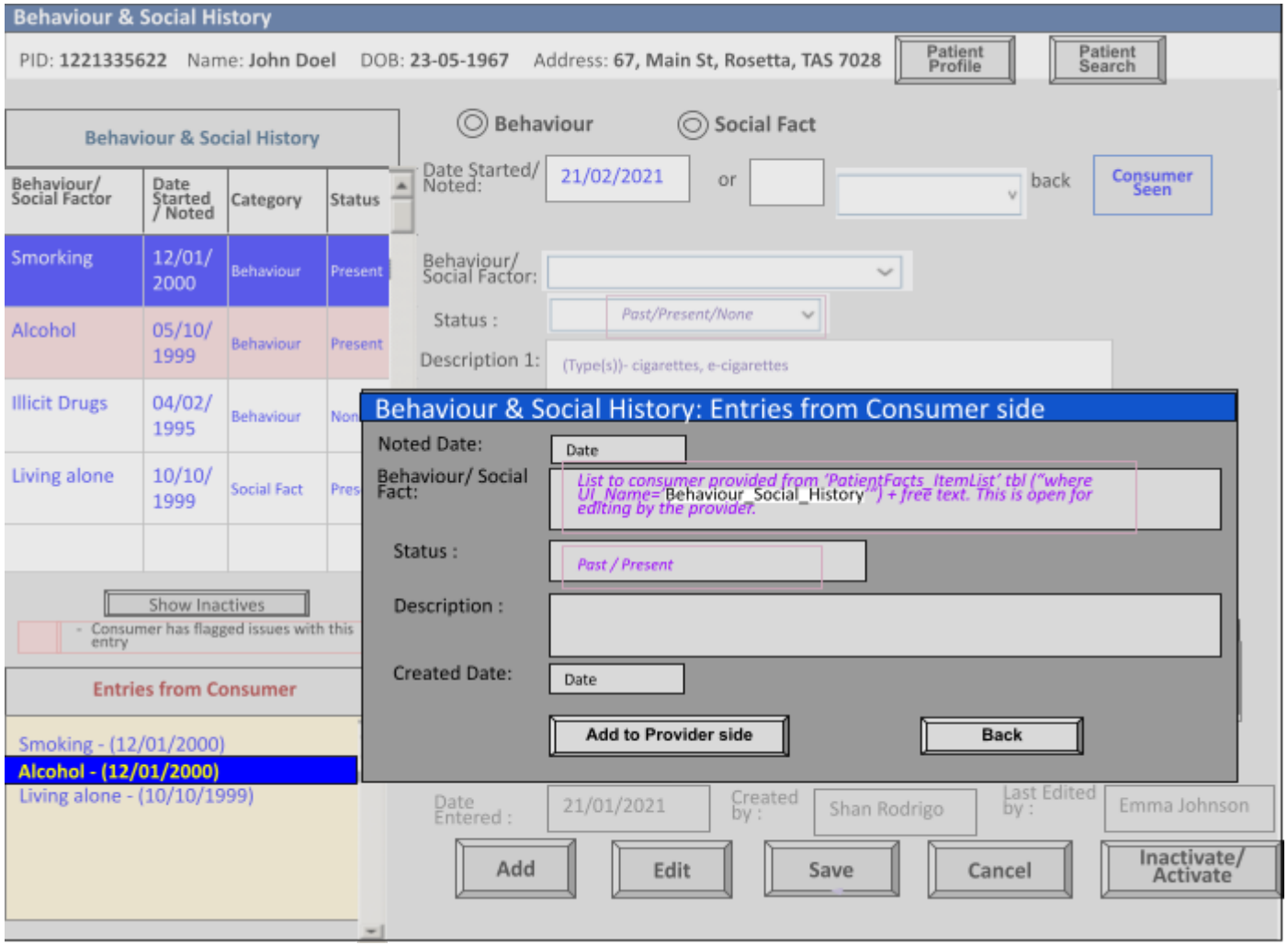
- When a Social History item is marked as 'Wrong' by the consumer (as per text 'Wrong' in the 'Consumer_Checked' field for the record in 'patient_social' tbl) should be highlighted in 'pink' in this list.
- Moving the cursor over the item should show the comment from the consumer ('Consumer_Comment' field for the past medical issue (record) in 'patient_social' tbl).

	Entries from Consumer • Data from 'patient_social_CI' tbl. • Once clicked on an item, should show a pop-up menu with the details of the entry and button to copy consumer entry into this provider view (see below).

Adding/Viewing Notes

- When the 'Add Note' button is clicked this should appear with blank input for add new.
- When a Note from the note list is clicked it should view the whole note as below and the provision for the user who entered the note should be able to edit/inactivate (Thus user name should be checked when trying to edit/update; except for Sys. Admin.).
- Once saved the Note should be recorded in 'Item_Notes' table filling fields as follows; Note_ID (auto increment), NPID (Pt ID), Item_ID (ALERGYID, PATHISTORYID, etc.), Table_ID (tbl of the items), UI_ID, Note_Body, CreateDate, CreateUser, CreateTime, LastUpDate, Active
- 

Consumer side entry



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Once the entry from the consumer is clicked details should appear in subform like this.

Table: patient_social, table ID: 74 (New table) **Blue - Using old fields** | **Red - New field** | **Black- Not using fields**

Table_ID	Table_Name	Field_Name	Field_ID	Type	Type_Txt	Size	Null	Key	Default	Extra	Comment
74	patient_social	PATSOCIALID	74_1	int(11)	int	11	NO	PRI	NULL	auto_increment	
74	patient_social	NPID	74_2	varchar(20)	varchar	20	YES		NULL		Patient Hospital ID
74	patient_social	Behaviour_Social_Type	74_3	varchar(50)	varchar	50	No		NULL		Behaviour/Social Fact
74	patient_social	Behaviour_Social_Name	74_4	varchar(200)	varchar	200	No		NULL		Behaviour/Social Fact Name
74	patient_social	Noticed_Date	74_5	Date			YES		NILL		Date Started/Noted
74	patient_social	Description1_Label	74_6	varchar(50)	varchar	50	YES		NULL		Description 1 label
74	patient_social	Description1_Value	74_7	varchar(500)	varchar	500	YES		NULL		Description 1 value
74	patient_social	Description2_Label	74_8	varchar(50)	varchar	50	YES		NULL		Description 2 label
74	patient_social	Description2_Value	74_9	varchar(500)	varchar	500	YES		NULL		Description 2 value
74	patient_social	Description3_Label	74_10	varchar(50)	varchar	50	YES		NULL		Description 3 label
74	patient_social	Description3_Value	74_11	varchar(500)	varchar	500	YES		NULL		Description 3 value
74	patient_social	Description4_Label	74_12	varchar(50)	varchar	50	YES		NULL		Description 4 label
74	patient_social	Description4_Value	74_13	varchar(500)	varchar	500	YES		NULL		Description 4 value
74	patient_social	Status	74_14	varchar(10)	varchar	10	NO		'Present'		Past/Present/ None (Do not have that behaviour)
74	patient_social	CreateDate	74_15	datetime	datetime		YES		NULL		
74	patient_social	CreateUser	74_16	varchar(200)	varchar	200	YES		NULL		
74	patient_social	LastUpDate	74_17	datetime	datetime		YES		NULL		
74	patient_social	LastUpDateUser	74_18	varchar(200)	varchar	200	YES		NULL		
74	patient_social	Active	74_19	tinyint(1)	tinyint	1	YES		1		
74	patient_social	Not_view_consumer	74_20	tinyint(1)	tinyint	1	YES		NULL		Whether enable view by the consumer
74	patient_social	Consumer_Checked	74_21	varchar(10)	varchar	10	YES		NULL		Consumer check noted, marking 'Wrong' by consumer is captured
74	patient_social	Consumer_Check_Date	74_22	datetime	datetime		YES		NULL		Consumer marked date
74	patient_social	Consumer_comment	74_23	varchar(250)	varchar	250	YES		NULL		Comment from consumer
74	patient_social	Include_Discharge_Summary	74_24	tinyint(1)	tinyint	1	YES		NULL		Include in discharge summary

Patient Facts Item list (Table : 'PatientFacts_ItemList') table ID: 76 (This data is used to show description labels and their combos in patient facts UIs)

item_id	UI_ID	UI_Name	type	item_name	Description1_Label	Description2_Label	Description3_Label	Description4_Label	Get_Value_From	Explained_Term
1	10b	Behaviour_Social_History	Behaviour	Smoke	Type(s)	Amount	Any effort for Cessation	Other Remarks		
2	10b	Behaviour_Social_History	Behaviour	Alcohol	Amount (Lite/Moderate/Heavy)	Any effort for Cessation	Other Remarks			Amount (Lite/Moderate/Heavy)
3	10b	Behaviour_Social_History	Behaviour	Illicit Drugs	Type(s)	Amount	Any effort for Cessation	Other Remarks		Recreational drugs
4	10b	Behaviour_Social_History	Behaviour	Exercise	Frequency (per week)	Other Remarks				
5	10b	Behaviour_Social_History	Behaviour	Travels	Where	Duration	Other Remarks			Recent travels important for healthcare
6	10b	Behaviour_Social_History	Social Fact	Occupation	Other Remarks				patient.Occupation	Profession/Routine job
7	10b	Behaviour_Social_History	Social Fact	Living alone	Other Remarks					
8	10b	Behaviour_Social_History	Social Fact	Social Support	Services	Other Remarks				Support services
9	10b	Behaviour_Social_History	Social Fact	Financial issues	Other Remarks					
10	10b	Behaviour_Social_History	Social Fact	Cultural issues	Other Remarks					
11	10b	Behaviour_Social_History	Social Fact	Language issues	Other Remarks					
12	10b	Behaviour_Social_History	Social Fact	Religious issues	Other Remarks					
13	10b	Behaviour_Social_History	Social Fact	Not for Transfusion	Yes/No	Other Remarks				Not for transfusion of blood or blood products
14	10b	Behaviour_Social_History	Social Fact	Female Care Providers Requested	Yes/No	Other Remarks				

Combo list items for Patient Facts (Table : 'PatientFacts_ComboItems') table ID: 77(This data is used to fill the dropdown lists of description combos. In addition to available these combo items the list should grow as per inputs of the user; adding user entries for relevant descriptions into this table. Thus every new entry will be available in the relevant description combo for subsequent entries)

Combo_Item_id	UI_ID	item_name	Description	Description_Label	Combo_Item
1	10b	Smoke	Description1	Type(s)	Cigarette
2	10b	Smoke	Description1	Type(s)	Cigar
3	10b	Smoke	Description1	Type(s)	e-Cigarette
4	10b	Smoke	Description1	Type(s)	Cigarette, e-Cigarette
5	10b	Smoke	Description2	Amount	<5
6	10b	Smoke	Description2	Amount	5-10
7	10b	Smoke	Description2	Amount	10-20
8	10b	Smoke	Description2	Amount	20-40
9	10b	Smoke	Description2	Amount	>40
10	10b	Smoke	Description3	Any effort for Cessation	None
11	10b	Smoke	Description3	Any effort for Cessation	Used, but failed
12	10b	Smoke	Description3	Any effort for Cessation	On nicotine patches/inhalers
13	10b	Alcohol	Description1	Amount	Lite
14	10b	Alcohol	Description1	Amount	Moderate
15	10b	Alcohol	Description1	Amount	Heavy
16	10b	Alcohol	Description2	Any effort for Cessation	None
17	10b	Alcohol	Description2	Any effort for Cessation	Was in a programme, but failed
18	10b	Alcohol	Description2	Any effort for Cessation	Currently in a programme
19	10b	Illicit Drugs	Description1	Type(s)	Cannabis
20	10b	Illicit Drugs	Description1	Type(s)	Methamphetamine
21	10b	Illicit Drugs	Description1	Type(s)	Heroin
22	10b	Illicit Drugs	Description1	Type(s)	Cannabis, Methamphetamine
23	10b	Illicit Drugs	Description1	Type(s)	Cannabis, Methamphetamine, Heroin
24	10b	Illicit Drugs	Description2	Amount	Small
25	10b	Illicit Drugs	Description2	Amount	Moderate
26	10b	Illicit Drugs	Description2	Amount	Heavy

27	10b	Illicit Drugs	Description3	Any effort for Cessation	None
28	10b	Illicit Drugs	Description3	Any effort for Cessation	Was in a programme, but failed
29	10b	Illicit Drugs	Description3	Any effort for Cessation	Currently in methadone programme
30	10b	Illicit Drugs	Description3	Any effort for Cessation	Currently in other programme
31	10b	Not for Transfusion	Description1	Yes/No	Yes
32	10b	Not for Transfusion	Description1	Yes/No	No
33	10b	Female Care Providers Requested	Description1	Yes/No	Yes
34	10b	Female Care Providers Requested	Description1	Yes/No	No

Table: patient_social_CI, table ID: 75 (New table) **Consumer end social/behavioural information table**

Table_ID	Table_Name	Field_Name	Field_ID	Type	Type_Txt	Size	Null	Key	Default	Extra	Comment
74	patient_social	PATSOCIALID	74_1	int(11)	int	11	NO	PRI		auto_increment	
74	patient_social	CI_ID	74_4	int(11)	int	11	NO				Consumer ID (system generated on registration)
74	patient_social	Behaviour_Social_Name	74_5	varchar(200)	varchar	200	No		NULL		Behaviour/Social Fact Name
74	patient_social	Noticed_Date	74_6	Date			YES		NILL		Date Started/Noted
74	patient_social	Description1_Label	74_7	varchar(50)	varchar	50	YES		NULL		Description 1 label
74	patient_social	Description1_Value	74_8	varchar(500)	varchar	500	YES		NULL		Description 1 value
74	patient_social	Description2_Label	74_9	varchar(50)	varchar	50	YES		NULL		Description 2 label
74	patient_social	Description2_Value	74_10	varchar(500)	varchar	500	YES		NULL		Description 2 value
74	patient_social	Description3_Label	74_11	varchar(50)	varchar	50	YES		NULL		Description 3 label
74	patient_social	Description3_Value	74_12	varchar(500)	varchar	500	YES		NULL		Description 3 value
74	patient_social	Description4_Label	74_13	varchar(50)	varchar	50	YES		NULL		Description 4 label
74	patient_social	Description4_Value	74_14	varchar(500)	varchar	500	YES		NULL		Description 4 value
74	patient_social	Status	74_15	varchar(10)	varchar	10	NO		'Present'		Past/Present/ None (Do not have that behaviour)
74	patient_social	CreateDate	74_16	datetime	datetime		YES		NULL		

74	patient_social	CreateUser	74_17	varchar(200)	varchar	200	YES		NULL		
74	patient_social	LastUpDate	74_18	datetime	datetime		YES		NULL		
74	patient_social	LastUpDateUser	74_19	varchar(200)	varchar	200	YES		NULL		
74	patient_social	Active	74_20	tinyint(1)	tinyint	1	YES		1		
74	patient_social	Share	74_21	tinyint(1)	tinyint	1	YES		NULL		Whether to share this information with the providers