Use Cases: Consulting Register Project

1. Nurse records patient information (HP)

A nurse logs patient information in the register. If the patient does not exist in the register, this entails inputting a new patient with a new patient ID and patient information into the register. If the patient exists in the register, then this entails entering visit information for a patient.

2. Nurse searches for an existing patient

Nurse uses a patient ID, name and date of birth, or other information that the patient can provide to establish their identity. If the patient is found, then the nurse can look up information from past visits. If not, the nurse may input a new patient ID into the system, and enter the patient's basic information before their exam.

3. Nurse records patient visit

Nurse records information that is gleaned during the course of the examination, and logs it under a new visit in the system. This information will include patient reported symptoms, vital signs, and conclusions/diagnosis.

4. Create outpatient morbidity report

5. Refer a patient to another facility

The nurse records a recommendation in the register system, and sends the recommendation to another facility. This information should be recorded safely and discreetly so that the other facility can query the nurse or original facility if they need additional information or they lose the sent recommendation.

6. Update patient information

A patient has moved or other information has changed. Patient information can be updated/edited.

7. Nurse searches for patients associated with clinic ID

A nurse retrieves a list of patients associated with a clinic I. This list will provide basic information such as patient ID, name, DOB. This information will be helpful for creating the outpatient morbidity report.

8. Nurse enters principal diagnosis of a patient condition

When a nurse begins to enter the diagnosis of the patient, a code for the condition will appear using the international statistical classification of diseases and related health problems scheme.

Error Cases

Error case 1: Nurse enters patient identification information and it is lost. In this case a nurse would enter an item such as a patient ID number and the number would be lost, causing the patient to be lost in the system and not retrievable for future visits.

Error case 2: Nurse enters sensitive patient information into the system and it is exposed. In this case, the nurse enters information about a patient that is sensitive medical information such as a diagnosis, physical address, or other. This results in the patient's sensitive information being visible and insecure.

Error case 3: Nurse refers patient to another facility but the referral is lost. In this case, the nurse requires a specialist referral for the patient. The nurse makes the referral, but the referral is lost in the system. In this case, the patient would not be accepted by the referred provider, and would need to seek a repeat referral from the nurse.