

Health&Care Information Model: nl.zorg.MedicatieGebruik

Final

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Content

1. nl.zorg.MedicatieGebruik-v3.0	3
1.1 Revision History	3
1.2 Concept	3
1.3 Mindmap	3
1.4 Purpose	3
1.5 Patient Population	4
1.6 Evidence Base	4
1.7 Information Model	4
1.8 Example Instances	9
1.9 Instructions	9
1.10 Interpretation	9
1.11 Care Process	9
1.12 Example of the Instrument	9
1.13 Constraints	9
1.14 Issues	9
1.15 References	10
1.16 Functional Model	10
1.17 Traceability to other Standards	10
1.18 Disclaimer	10
1.19 Terms of Use	10
1.20 Copyrights	10

1. nl.zorg.MedicatieGebruik-v3.0

DCM::CoderList	Kerngroep Registratie aan de Bron
DCM::ContactInformation.Address	
DCM::ContactInformation.Name	*
DCM::ContactInformation.Telecom	
DCM::ContentAuthorList	Projectgroep Generieke Overdrachtsgegevens & Kerngroep Registratie aan de Bron
DCM::CreationDate	19-12-2013
DCM::DeprecatedDate	
DCM::DescriptionLanguage	nl
DCM::EndorsingAuthority.Address	
DCM::EndorsingAuthority.Name	PM
DCM::EndorsingAuthority.Telecom	
DCM::Id	2.16.840.1.113883.2.4.3.11.60.40.3.9.2
DCM::KeywordList	Medicatie, Feitelijk Gebruik, Gebruik
DCM::LifecycleStatus	Final
DCM::ModelerList	Kerngroep Registratie aan de Bron
DCM::Name	nl.zorg.MedicatieGebruik
DCM::PublicationDate	1-5-2016
DCM::PublicationStatus	Published
DCM::ReviewerList	Projectgroep Generieke Overdrachtsgegevens & Kerngroep Registratie aan de Bron
DCM::RevisionDate	22-5-2015
DCM::Superseeds	nl.nfu.MedicatieGebruik-v1.0.1
DCM::Version	3.0

1.1 Revision History

Publicatieversie 1.0 (01-04-2015)

Bevat: ZIB-56, ZIB-308.

Incl. algemene wijzigingsverzoeken:

ZIB-94, ZIB-154, ZIB-200, ZIB-201, ZIB-309, ZIB-324, ZIB-326.

Publicatieversie 1.0.1 (22-05-2015)

Bevat: ZIB-381.

Publicatieversie 3.0 (01-05-2016)

Bevat: ZIB-453

1.2 Concept

MedicationUse describes taking or administering the medication, often in relation to a prescription, but also on the person's own initiative. This describes the pattern of medication use, as reported by the patient themselves, a caregiver or healthcare provider. Documenting medication use provides insight into the use of prescribed medication as well as the use of medication at home.

1.3 Mindmap

1.4 Purpose

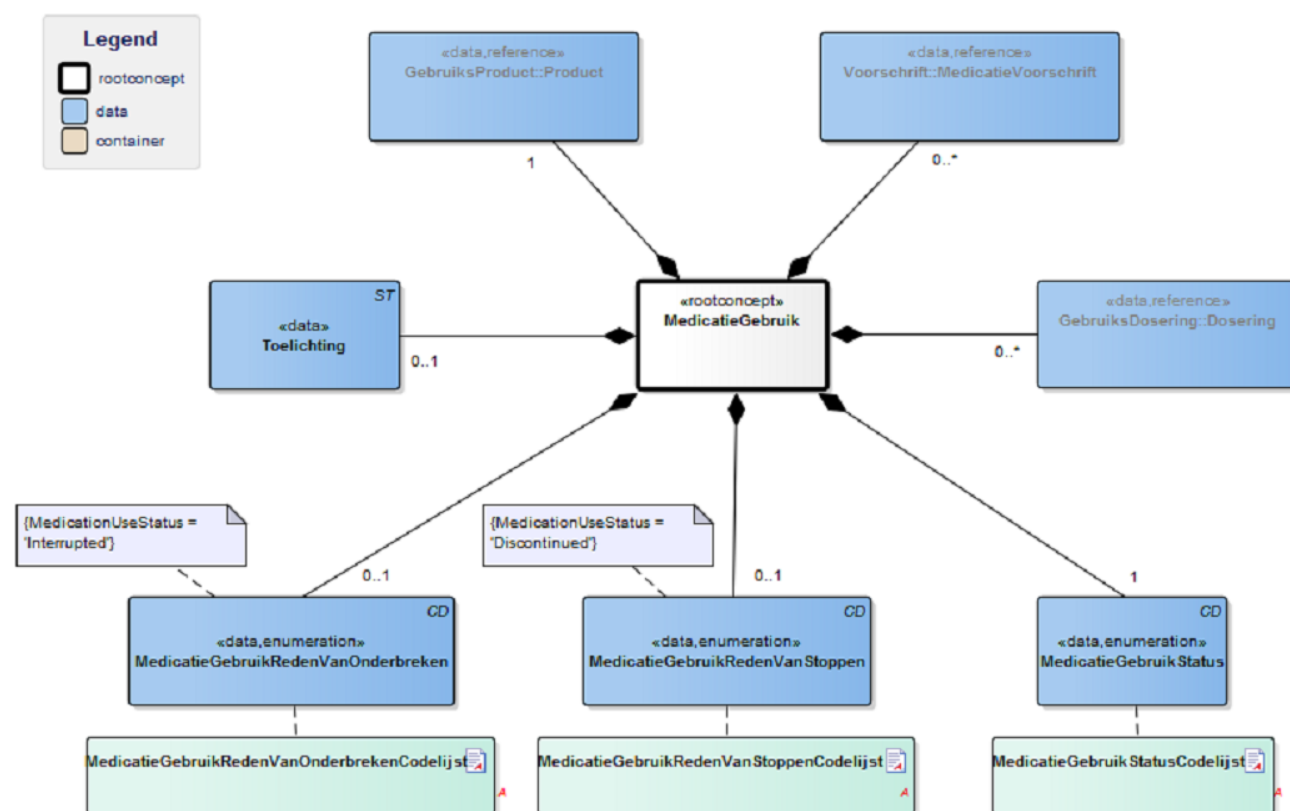
Recording medication information is a very important part of continuity in healthcare. It concerns the core of patient safety. Healthcare professionals in the collaborative branch must always have access to an up-to-date medication overview. Applying the information model will usually involve:

- Recording the patient’s intake of self-medication or ‘drugs’.
- Recording the medication used during a patient’s stay at the hospital.
- Medication verification: recording the active medication profile.

1.5 Patient Population

1.6 Evidence Base

1.7 Information Model



«rootconcept»	MedicatieGebruik
Alias	Gebruik, medicatie EN: Use, medication
Definition	Root concept of the MedicationUse information model. This root concept contains all data elements of the MedicationUse information model.
Datatype	
DCM::DefinitionCode	NL-CM:9.2.1
Options	

«data»	GebruiksProduct::Product
Alias	EN: ProductUsed::Product
Definition	The product used. This is usually medication. Food, blood products, aids

	and bandages do not strictly fall under the category of medication, but can be recorded as well.	
	In principle, this will be the prescribed product, but the product used may differ from the prescribed product.	
Datatype		
DCM::DefinitionCode	NL-CM:9.2.2	
DCM::ReferencedDefinitionCode	NL-CM:9.5.6	Dit is een verwijzing naar concept Product in information model MedicatieVoorschrift.
Options		

«data»	Voorschrift::MedicatieVoorschrift	
Alias	EN: Prescription	
Definition	The agreement or order for the use of medication.	
Datatype		
DCM::DefinitionCode	NL-CM:9.2.3	
DCM::ReferencedDefinitionCode	NL-CM:9.5.1	Dit is een verwijzing naar concept MedicatieVoorschrift in information model MedicatieVoorschrift.
Options		

«data»	GebruiksDosering::Dosering	
Alias	EN: UsedDosage::Dosage	
Definition	<p>When taking stock of medication use, the dosage describes the amount and the pattern of use as reported by the patient or a healthcare provider.</p> <p>The used dosage is the reported dose used by the patient. The used dosage may differ in terms of the administering schedule of the prescribed dosage in the event that the patient makes different decisions on their use of the product and reports as such.</p>	
Datatype		
DCM::DefinitionCode	NL-CM:9.2.4	
DCM::ExampleValue	4x/dag 1 tablet via de mond voor de maaltijd en voor het slapen gaan.	
DCM::ReferencedDefinitionCode	NL-CM:9.5.4	Dit is een verwijzing naar concept Dosering in information model MedicatieVoorschrift.
Options		

«data»	MedicatieGebruikStatus	
Alias	EN: status	
Definition	<p>The status or status code is important in indicating the use schedule. This attribute indicates whether the prescription is actively used, temporarily interrupted, or by now discontinued. Interrupting (home) use often occurs in the event of admittance to a healthcare facility, prior to a procedure and in response to monitoring (mirroring provisions, effect measurements, etc.).</p> <p>When documenting this, the following interpretations are used:</p> <ul style="list-style-type: none"> • Active: The product is used. • Interrupted: Use has (temporarily) been interrupted, because of a surgical procedure, for example. Later, the patient and/or doctor can 	

	decide whether or not to resume or discontinue use. <ul style="list-style-type: none"> Discontinued: Use has been stopped for a specific reason. Completed: Use has now been completed (according to the plan, prescription or agreement).] Not started: The product was never used. 	
Datatype	CD	
DCM::DefinitionCode	NL-CM:9.2.5	
DCM::ExampleValue	Actief	
DCM::ValueSet	MedicatieGebruikStatusCode lijst	OID: 2.16.840.1.113883.2.4.3.11.60.40.2.9.2.1
Options		

«data»	MedicatieGebruikRedenVanStoppen	
Alias	EN: MedicationUseReasonForDiscontinuation	
Definition	Reason why the use of a certain medicine was discontinued.	
Datatype	CD	
DCM::DefinitionCode	NL-CM:9.2.6	
DCM::ValueSet	MedicatieGebruikRedenVanS toppenCodelijst	OID: 2.16.840.1.113883.2.4.3.11.60.40.2.9.2.2
Options		

«data»	MedicatieGebruikRedenVanOnderbreken	
Alias	EN: MedicationUseReasonForInterruption	
Definition	Reason why the use of a certain medicine was interrupted. Here, you can choose to enter text or one of the codes.	
Datatype	CD	
DCM::DefinitionCode	NL-CM:9.2.7	
DCM::ValueSet	MedicatieGebruikRedenVan OnderbrekenCodelijst	OID: 2.16.840.1.113883.2.4.3.11.60.40.2.9.2.3
Options		

«data»	Toelichting	
Alias	EN: Explanation	
Definition	Comments on the medication use.	
Datatype	ST	
DCM::DefinitionCode	NL-CM:9.2.8	
Options		

«document»	MedicatieGebruikStatusCodelijst	
Alias		
Definition		
Datatype		
Options		

MedicatieGebruikStatusCodelijst		OID: 2.16.840.1.113883.2.4.3.11.60.40.2.9.2.1		
Concept Name	Concept Code	Code System Name	Code System OID	Description
Active	active	ActStatus	2.16.840.1.113883	Actief

			.5.14	
Suspended	suspended	ActStatus	2.16.840.1.113883.5.14	Onderbroken
Aborted	aborted	ActStatus	2.16.840.1.113883.5.14	Afgebroken
Completed	completed	ActStatus	2.16.840.1.113883.5.14	Voltooid
Cancelled	cancelled	ActStatus	2.16.840.1.113883.5.14	Niet gestart

«document»		MedicatieGebruikRedenVanStoppenCodelijst		
Alias				
Definition				
Datatype				
Options				
MedicatieGebruikRedenVanStoppenCodelijst		OID: 2.16.840.1.113883.2.4.3.11.60.40.2.9.2.2		
Concept Name	Concept Code	Coding Syst. Name	Coding System OID	Description
Intolerance	SINTOL	ActReason	2.16.840.1.113883.5.8	Bijwerking, allergie of intolerantie
Condition alert	COND	ActCode	2.16.840.1.113883.5.4	Contra-indicatie
Drug interacts with another drug	SDDI	ActReason	2.16.840.1.113883.5.8	Interactie met ander medicament
Dose change	DOSECHG	ActReason	2.16.840.1.113883.5.8	Dosiswijziging
No longer required for treatment	NOREQ	ActReason	2.16.840.1.113883.5.8	Niet langer vereist voor de behandeling
Ineffective	INEFFECT	ActReason	2.16.840.1.113883.5.8	Niet effectief
Formulary policy	FP	ActReason	2.16.840.1.113883.5.8	Ander voorschrijfbeleid
Product discontinued	DISCONT	ActReason	2.16.840.1.113883.5.8	Product niet meer leverbaar
Not covered	NOTCOVER	ActReason	2.16.840.1.113883.5.8	Product wordt niet vergoed
Patient refuse	PREFUS	ActReason	2.16.840.1.113883.5.8	Patiënt heeft geweigerd

«document»		MedicatieGebruikRedenVanOnderbrekenCodelijst		
Alias				
Definition				
Datatype				
Options				
MedicatieGebruikRedenVanOnderbrekenCodelijst		OID: 2.16.840.1.113883.2.4.3.11.60.40.2.9.2.3		
Concept Name	Concept Code	Coding System Name	Coding System OID	Description

e	Code	em Name		
Drug level too high	DRUG HIGH	Act Rea son	2.16.84 0.1.113 883.5.8	Te hoge geneesmiddel spiegel
Lab interference issues	LABORATORY	Act Rea son	2.16.84 0.1.113 883.5.8	Interferentie met gepland labonderzoek
Patient is pregnant/breast feeding	PREGNANT	Act Rea son	2.16.84 0.1.113 883.5.8	Patiënt is zwangerschap of geeft borstvoeding
Patient not-availa ble	NO AVAIL	Act Rea son	2.16.84 0.1.113 883.5.8	Patiënt is niet beschikbaar
Response to monitoring	MONITORING	Act Rea son	2.16.84 0.1.113 883.5.8	Reactie op monitoring
Drug interacts with another drug	DRUG INTERACTION	Act Rea son	2.16.84 0.1.113 883.5.8	Interactie met ander medicament
Duplicate therapy	DUPLICATE THERAPY	Act Rea son	2.16.84 0.1.113 883.5.8	Een andere therapie maakt het gebruik tijdelijk overbodig
Patient scheduled for surgery	SCHEDULED SURGERY	Act Rea son	2.16.84 0.1.113 883.5.8	Patient is ingepland voor een ingreep
Waiting for old drug to wash	WAITING FOR OLD DRUG TO WASH	Act Rea son	2.16.84 0.1.113 883.5.8	Tijdelijk onderbreken tot ander geneesmiddel geen werking

out				meer uitoefent
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1.8 Example Instances

GebruiksProduct	GebruiksDoserings				MedicatieGebruikStatus	Voorschrift
ProductNaam	StartDatum	EindDatum	Keerdosis Toedieningsschema	ToedieningsWeg		Reden van Voorschrijven
						Probleem
Paracetamol tablet 500 mg	05-2012		Zo nodig 500mg (=1st), max. 4x/dag	Oraal	Actief	Hoofdpijn

GebruiksProduct	GebruiksDoserings				MedicatieGebruikStatus	Voorschrift
ProductNaam	StartDatum	EindDatum	Keerdosis Toedieningsschema	ToedieningsWeg		Reden van Voorschrijven
						Probleem
Pantoprazol injpdr 40mg fl	11-09-2012 17:21		1x/dag(8u) 40mg (=1st)	iv	Actief	Ulcusprofylaxe

GebruiksProduct	GebruiksDoserings				MedicatieGebruikStatus	Voorschrift
ProductNaam	StartDatum	EindDatum	Keerdosis Toedieningsschema	ToedieningsWeg		Reden van Voorschrijven
						Probleem
Dalteparine 2500 injvst 12.500 ie/ml wwsp 0,2ml	19-09-2012		1x/dag(18u) 2500ie(=0,2ml)	Subcutaan	Actief	Thromboseprofylaxe

1.9 Instructions

1.10 Interpretation

1.11 Care Process

1.12 Example of the Instrument

1.13 Constraints

1.14 Issues

1.15 References

1. GROOT, E. (2011) *Dataset medicatieproces 2011*. [Online] Den Haag: Nictiz. Beschikbaar op: http://www.nictiz.nl/module/360/590/Dataset_Medicatieproces_2011.xlsx [Geraadpleegd: 23 juli 2014].

2. *HL7v3-implementatiehandleiding medicatieproces versie 6.1.0.0*. [Online] Den Haag: Nictiz. Beschikbaar

op:

http://www.nictiz.nl/uploaded/FILES/html_cabinet/live/Zorgtoepassing/Medicatieproces/AORTA_Mp_IH_Medicatieproces_HL7.htm [Geraadpleegd: 23 juli 2014].

3. *Dossier Medicatieoverzicht*. [Online] Beschikbaar op: [Oria.nl](http://oria.nl). [Geraadpleegd: 23 juli 2014].

4. *G-standaard documentatie*. [Online] Beschikbaar op: <http://www.z-index.nl/> [Geraadpleegd: 23 juli 2014].

1.16 Functional Model

1.17 Traceability to other Standards

1.18 Disclaimer

This Health and Care Information Model (a.k.a Clinical Building Block) has been made in collaboration with several different parties in healthcare. These parties asked Nictiz to manage good maintenance and development of the information models. Hereafter, these parties and Nictiz are referred to as the collaborating parties. The collaborating parties paid utmost attention to the reliability and topicality of the data in these Health and Care Information Models. Omissions and inaccuracies may however occur. The collaborating parties are not liable for any damages resulting from omissions or inaccuracies in the information provided, nor are they liable for damages resulting from problems caused by or inherent to distributing information on the internet, such as malfunctions, interruptions, errors or delays in information or services provide by the parties to you or by you to the parties via a website or via e-mail, or any other digital means. The collaborating parties will also not accept liability for any damages resulting from the use of data, advice or ideas provided by or on behalf of the parties by means of this Health and Care Information Model. The parties will not accept any liability for the content of information in this Health and Care Information Model to which or from which a hyperlink is referred. In the event of contradictions in mentioned Health and Care Information Model documents and files, the most recent and highest version of the listed order in the revisions will indicate the priority of the documents in question. If information included in the digital version of this Health and Care Information Model is also distributed in writing, the written version will be leading in case of textual differences. This will apply if both have the same version number and date. A definitive version has priority over a draft version. A revised version has priority over previous versions.

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