Health & Care Information Model:

nl.zorg.MedicationUse-v3.0

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1. nl.zorg.MedicationUse-v3.0

DCM::CoderList	Kerngroep Registratie aan de Bron
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DCM::ContactInformation.Name	*
DCM::ContactInformation.Telecom	
DCM::ContentAuthorList	Projectgroep Generieke Overdrachtsgegevens & Kerngroep Registratie aan de Bron
DCM::CreationDate	19-12-2013
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DCM::Id	2.16.840.1.113883.2.4.3.11.60.40.3.9.2
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1.1 Revision History

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Incl. algemene wijzigingsverzoeken:
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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

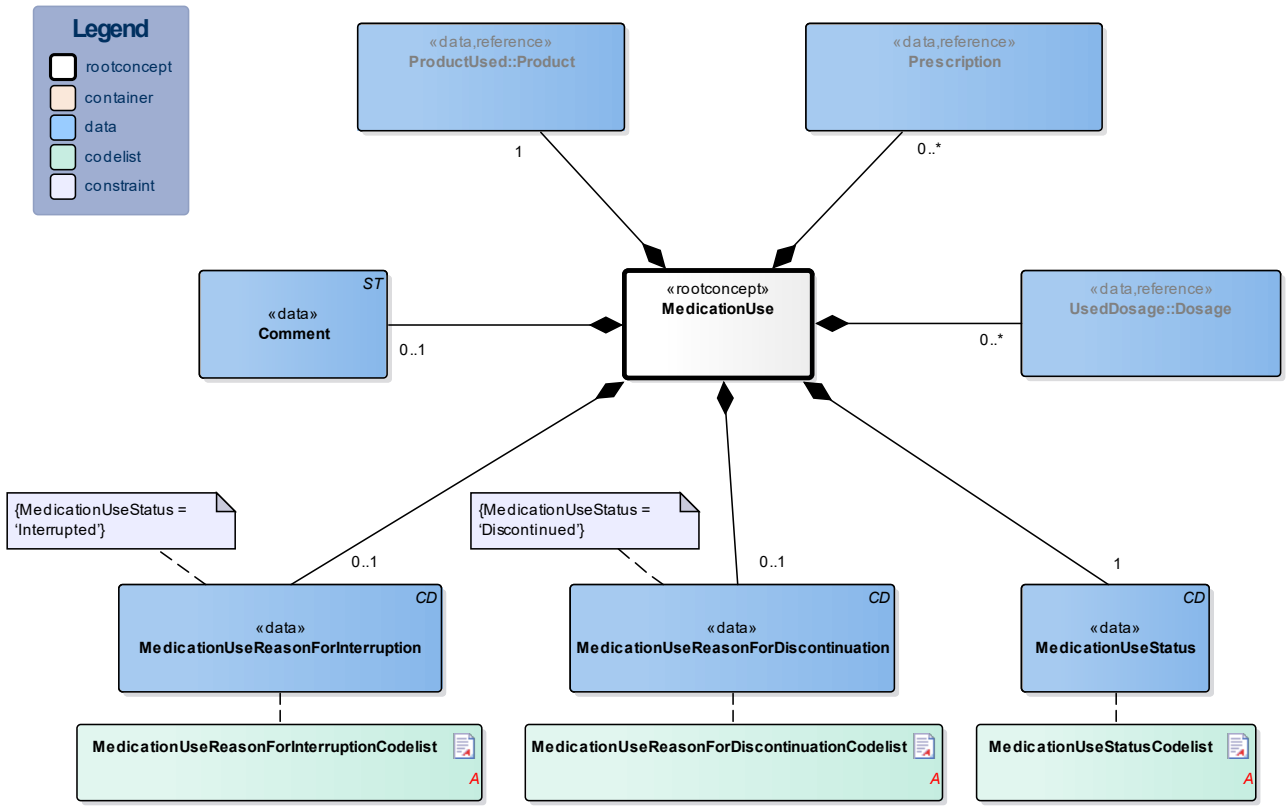
Recording medication information is a very important part of continuity in healthcare. It concerns the core of patient safety. Healthcare professionals in the collaborative branch must always have access to an up-to-date medication overview. Applying the information model will usually involve:

- 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»	MedicationUse
Definitie	Root concept of the MedicationUse information model. This root concept contains all data elements of the MedicationUse information model.
Datatype	
DCM::ConceptId	NL-CM:9.2.1
Opties	

«data»	ProductUsed::Product
Definitie	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::ConceptId	NL-CM:9.2.2	
DCM::ReferencedConceptId	NL-CM:9.5.6	Dit is een verwijzing naar concept Product in information model MedicatieVoorschrift.
Opties		

«data»	Prescription	
Definitie	The agreement or order for the use of medication.	
Datatype		
DCM::ConceptId	NL-CM:9.2.3	
DCM::ReferencedConceptId	NL-CM:9.5.1	Dit is een verwijzing naar concept MedicatieVoorschrift in information model MedicatieVoorschrift.
Opties		

«data»	UsedDosage::Dosage	
Definitie	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. 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.	
Datatype		
DCM::ConceptId	NL-CM:9.2.4	
DCM::ExampleValue	4x/dag 1 tablet via de mond voor de maaltijd en voor het slapen gaan.	
DCM::ReferencedConceptId	NL-CM:9.5.4	Dit is een verwijzing naar concept Dosering in information model MedicatieVoorschrift.
Opties		

«data»	MedicationUseStatus
Definitie	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.). When documenting this, the following interpretations are used: • 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. • 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::ConceptId	NL-CM:9.2.5	
DCM::ExampleValue	Actief	
DCM::ValueSet	MedicationUseStatusCodelist	OID: 2.16.840.1.113883.2.4.3.11.60.40.2.9.2.1
Opties		

«data»	MedicationUseReasonForDiscontinuation	
Definitie	Reason why the use of a certain medicine was discontinued.	
Datatype	CD	
DCM::ConceptId	NL-CM:9.2.6	
DCM::ValueSet	MedicationUseReasonForDiscontinuationCodelist	OID: 2.16.840.1.113883.2.4.3.11.60.40.2.9.2.2
Opties		

«data»	MedicationUseReasonForInterruption	
Definitie	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::ConceptId	NL-CM:9.2.7	
DCM::ValueSet	MedicationUseReasonForInterruptionCodelist	OID: 2.16.840.1.113883.2.4.3.11.60.40.2.9.2.3
Opties		

«data»	Comment
Definitie	Comments on the medication use.
Datatype	ST
DCM::ConceptId	NL-CM:9.2.8
Opties	

«document»	MedicationUseStatusCodelist	
Definitie		
Datatype		
DCM::ValueSetId	2.16.840.1.113883.2.4.3.11.60.40.2.9.2.1	
Opties		

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	2.16.840.1.113883.5.14	Actief
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»	MedicationUseReasonForDiscontinuationCodelist	
Definitie		
Datatype		
DCM::ValueSetId	2.16.840.1.113883.2.4.3.11.60.40.2.9.2.2	
Opties		

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»	MedicationUseReasonForInterruptionCodelist	
Definitie		
Datatype		
DCM::ValueSetId	2.16.840.1.113883.2.4.3.11.60.40.2.9.2.3	
Opties		

MedicatieGebruikRedenVanOnderbrekenCodelijst			OID: 2.16.840.1.113883.2.4.3.11.60.40.2.9.2.3	
Concept Name	**Concept Code**	**Code System Name**	**Code System OID**	**Description**
Drug level too high	DRUGHIGH	ActReason	2.16.840.1.113883.5.8	Te hoge geneesmiddel spiegel

Lab interference issues	LABINT	Act Reason	2.16.840.1.113883.5.8	Interferentie met gepland labonderzoek
Patient is pregnant/breast feeding	PREG	Act Reason	2.16.840.1.113883.5.8	Patiënt is zwangerschap of geeft borstvoeding
Patient not-available	NON-AVAIL	Act Reason	2.16.840.1.113883.5.8	Patiënt is niet beschikbaar
Response to monitoring	MONIT	Act Reason	2.16.840.1.113883.5.8	Reactie op monitoring
Drug interacts with another drug	SDDI	Act Reason	2.16.840.1.113883.5.8	Interactie met ander medicament
Duplicate therapy	SDUPTHER	Act Reason	2.16.840.1.113883.5.8	Een andere therapie maakt het gebruik tijdelijk overbodig
Patient scheduled for surgery	SURG	Act Reason	2.16.840.1.113883.5.8	Patient is ingepland voor een ingreep
Waiting for old drug to washout	WASHOUT	Act Reason	2.16.840.1.113883.5.8	Tijdelijk onderbreken tot ander geneesmiddel geen werking meer uitoefent

1.8 Example Instances

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

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

GebruiksProduct	GebruiksDosering				MedicatieGebruikStatus	Voorschrift
ProductNaam	StartDatum	EindDatum	Keerdosis | Toedieningsschema	Toedienings Weg		Reden van Voorschrijven
						Probleem
Dalteparine 2500 injvlst 12.500 ie/ml wwsp 0,2ml	19-09-2012		1x/dag(18u) 2500ie(=0,2ml)	Subcutaan	Actief	Thrombose-profylaxe

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. [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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