

# **Health & Care Information Model:**

## **nl.zorg.Admission-v2.0**

Status: Final

Release status: Prepublished

# Content

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# 1. nl.zorg.Admission-v2.0

DCM::CoderList	Zib-centrum
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DCM::ContactInformation.Name	*
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DCM::ContentAuthorList	*
DCM::CreationDate	1-12-2021
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DCM::EndorsingAuthority.Address	
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DCM::Id	2.16.840.1.113883.2.4.3.11.60.40.3.15.4
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## 1.1 Revision History

Publicatieversie 1.0 (10-06-2022)

Publicatieversie 2.0 (15-10-2023)

Bevat: ZIB-1773, ZIB-1824.

## 1.2 Concept

The stay of a patient or client in a healthcare facility in the context of a (partial) admission or emergency room visit. A (partial) admission is the entire or partial stay of a patient or client in a department equipped for nursing in a health care institution, for example, an inpatient ward, day care unit, emergency care, or observatory. This HCIM therefore applies to a whole admission, part of an admission, or emergency room visit in both past and present.

## 1.3 Mindmap

## 1.4 Purpose

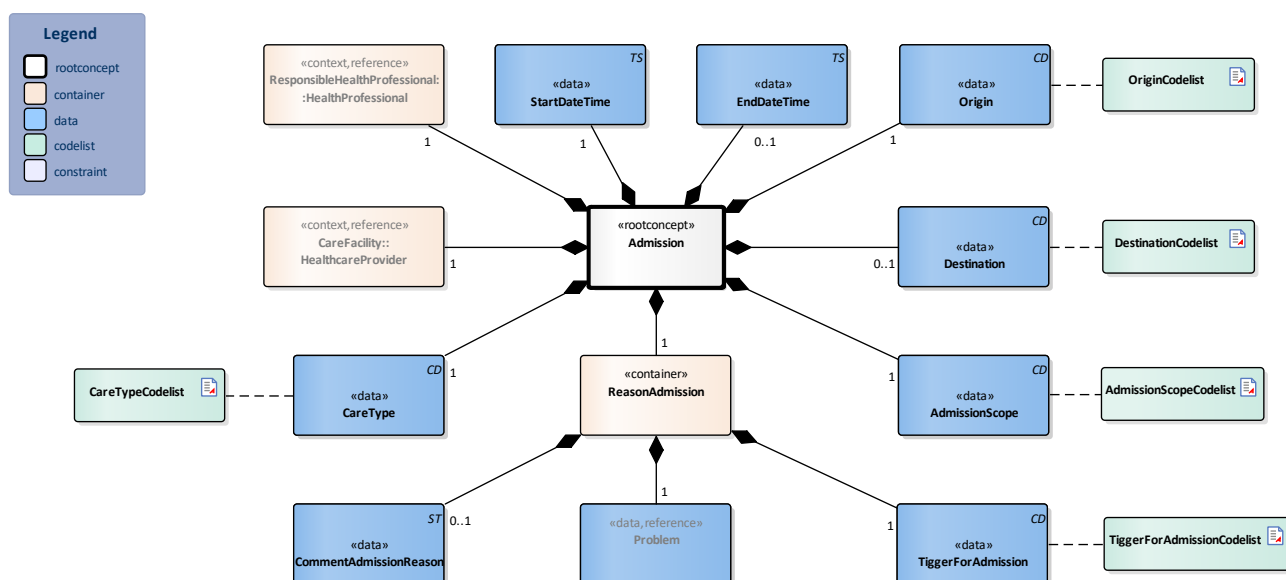
Admissions or emergency room visits occur in a healthcare facility for the purpose of treating, observing or examining a patient or client.

## 1.5 Patient Population

## 1.6 Evidence Base

The codelists for Origin and Destination generally correspond to the 'Landelijke Basisregistratie Ziekenhuiszorg' (National Basic Registration Hospital Care)

## 1.7 Information Model



«rootconcept»	Admission	
Definitie	Root concept of the Admission information model.This root concept contains all data elements of the Admission information model.	
Datatype		
DCM::ConceptId	NL-CM:15.4.1	
Opties		

«data»	CareType	
Definitie	The type of care that has been or will be provided to the patient during the (partial) admission. This is related, among other things, to the severity category of the care.	
Datatype	CD	
DCM::ConceptId	NL-CM:15.4.2	
DCM::ValueSet	CareTypeCodelist	OID: 2.16.840.1.113883.2.4.3.11.60.40.2.15.4.5
Opties		

«data»	StartDateTime	
Definitie	Date and time when the (partial) admission will start or was started.	
Datatype	TS	
DCM::ConceptId	NL-CM:15.4.3	
Opties		

«data»	EndDateTime	
Definitie	Date and time on which the (partial) admission ended. For a future or ongoing admission, the end date can be empty.	
Datatype	TS	
DCM::ConceptId	NL-CM:15.4.4	
Opties		

«container»	ReasonAdmission	
Definitie	Container of the ReasonAdmission concept.This container contains all data elements of the ReasonAdmission concept.	

<b>Datatype</b>		
<b>DCM::ConceptId</b>	NL-CM:15.4.5	
<b>Opties</b>		

<b>«data»</b>	<b>Problem</b>	
<b>Definitie</b>	The main problem to which the (partial) admission relates.	
<b>Datatype</b>		
<b>DCM::ConceptId</b>	NL-CM:15.4.6	
<b>DCM::ReferencedConceptId</b>	NL-CM:5.1.1	This is a reference to the rootconcept of information model Problem.
<b>Opties</b>		

<b>«data»</b>	<b>TiggerForAdmission</b>	
<b>Definitie</b>	The specific reason for the admission in relation to the diagnosis and/or treatment of the problem.	
<b>Datatype</b>	CD	
<b>DCM::ConceptId</b>	NL-CM:15.4.7	
<b>DCM::DefinitionCode</b>	SNOMED CT: 59021000146108 Reason for admission	
<b>DCM::ValueSet</b>	TiggerForAdmissionCodelist	OID: 2.16.840.1.113883.2.4.3.11.60.40.2.15.4.1
<b>Opties</b>		

<b>«data»</b>	<b>CommentAdmissionReason</b>	
<b>Definitie</b>	Comment on the reason for the (partial) admission, insofar as this cannot be sufficiently expressed in the other elements.	
<b>Datatype</b>	ST	
<b>DCM::ConceptId</b>	NL-CM:15.4.8	
<b>DCM::DefinitionCode</b>	LOINC: 48767-8 Annotation comment [Interpretation] Narrative	
<b>Opties</b>		

<b>«data»</b>	<b>Origin</b>	
<b>Definitie</b>	Location where the patient comes from prior to the (partial) admission. This will mainly be used at the start of hospitalisation.	
<b>Datatype</b>	CD	
<b>DCM::ConceptId</b>	NL-CM:15.4.9	
<b>DCM::ValueSet</b>	OriginCodelist	OID: 2.16.840.1.113883.2.4.3.11.60.40.2.15.4.3
<b>Opties</b>		

<b>«data»</b>	<b>Destination</b>	
<b>Definitie</b>	Location where the patient will go after the (partial) admission. This will mainly be used at the end of hospitalization.	
<b>Datatype</b>	CD	
<b>DCM::ConceptId</b>	NL-CM:15.4.10	
<b>DCM::ValueSet</b>	DestinationCodelist	OID: 2.16.840.1.113883.2.4.3.11.60.40.2.15.4.2
<b>Opties</b>		

<b>«data»</b>	<b>AdmissionScope</b>	
<b>Definitie</b>	AdmissionScope indicates whether it is a overall admission or a partial admission.	

<b>Datatype</b>	CD	
<b>DCM::ConceptId</b>	NL-CM:15.4.11	
<b>DCM::ValueSet</b>	AdmissionScopeCodelist	OID: 2.16.840.1.113883.2.4.3.11.60.40.2.15.4.4
<b>Opties</b>		

<b>«context»</b>	<b>ResponsibleHealthProfessional::HealthProfessional</b>	
<b>Definitie</b>	The health professional who is responsible during the (partial) admission. The information about the health professional can also include the specialism and role of the health professional.	
<b>Datatype</b>		
<b>DCM::ConceptId</b>	NL-CM:15.4.12	
<b>DCM::ReferencedConceptId</b>	NL-CM:17.1.1	This is a reference to the rootconcept of information model HealthProfessional.
<b>Opties</b>		

<b>«context»</b>	<b>CareFacility::HealthcareProvider</b>	
<b>Definitie</b>	The physical location of the healthcare provider where the (partial) admission has taken place or will take place.	
<b>Datatype</b>		
<b>DCM::ConceptId</b>	NL-CM:15.4.13	
<b>DCM::ReferencedConceptId</b>	NL-CM:17.2.1	This is a reference to the rootconcept of information model HealthcareProvider.
<b>Opties</b>		

<b>«document»</b>	<b>TiggerForAdmissionCodelist</b>	
<b>Definitie</b>		
<b>Datatype</b>		
<b>DCM::ValueSetBinding</b>	Extensible	
<b>DCM::ValueSetId</b>	2.16.840.1.113883.2.4.3.11.60.40.2.15.4.1	
<b>HCIM::ValueSetLanguage</b>	--	
<b>Opties</b>		

<b>AanleidingOpnameCodelijst</b>			<b>OID: 2.16.840.1.113883.2.4.3.11.60.40.2.15.4.1</b>	
Concept Name	Concept Code	Coding Syst. Name	Coding System OID	Description
Procedure	71388002	SNOMED CT	2.16.840.1.113883.6.96	Uitvoeren verrichting
Administration of medication	18629005	SNOMED CT	2.16.840.1.113883.6.96	Medicatie-toediening
Observation regime	225308005	SNOMED CT	2.16.840.1.113883.6.96	Observatie
Rehabilitation therapy	52052004	SNOMED CT	2.16.840.1.113883.6.96	Revalidatie
Safety procedure	370886002	SNOMED CT	2.16.840.1.113883.6.96	Veiligheid patiënt en/of omgeving
Respite care of patient	105386004	SNOMED CT	2.16.840.1.113883.6.96	Respijtzorg
Encounter for acute problem	180201000146103	SNOMED CT	2.16.840.1.113883.6.96	Contact vanwege acuut probleem

<b>«document»</b>	<b>DestinationCodelist</b>	
<b>Definitie</b>		
<b>Datatype</b>		
<b>DCM::ValueSetBinding</b>	Extensible	
<b>DCM::ValueSetId</b>	2.16.840.1.113883.2.4.3.11.60.40.2.15.4.2	

<b>HCIM::ValueSetLanguage</b>	--			
<b>Opties</b>				
<b>BestemmingCodelijst</b>		<b>OID: 2.16.840.1.113883.2.4.3.11.60.40.2.15.4.2</b>		
Concept Name	Concept Code	Coding Syst. Name	Coding System OID	Description
Home	264362003	SNOMED CT	2.16.840.1.113883.6.96	Eigen woonomgeving, niet zijnde een instelling
Left against medical advice	445060000	SNOMED CT	2.16.840.1.113883.6.96	Tegen advies in vertrokken [DEPRECATED]
Rehabilitation hospital	80522000	SNOMED CT	2.16.840.1.113883.6.96	Instelling voor revalidatie
Long term care facility	42665001	SNOMED CT	2.16.840.1.113883.6.96	Instelling voor verpleging/verzorging
Psychiatric hospital	62480006	SNOMED CT	2.16.840.1.113883.6.96	GGZ instelling
Hospital	22232009	SNOMED CT	2.16.840.1.113883.6.96	Ander ziekenhuis
Died in hospital	183676005	SNOMED CT	2.16.840.1.113883.6.96	Overleden [DEPRECATED]
Morgue	225737007	SNOMED CT	2.16.840.1.113883.6.96	Mortuarium
Hospice	284546000	SNOMED CT	2.16.840.1.113883.6.96	Hospice
Hospital abroad	155621000146109	SNOMED CT	2.16.840.1.113883.6.96	Ziekenhuis buitenland
Site of care	43741000	SNOMED CT	2.16.840.1.113883.6.96	Instelling (anders)
Discharge to other location within hospital premises	115841000146105	SNOMED CT	2.16.840.1.113883.6.96	Afdeling binnen zelfde instelling

<b>«document»</b>	<b>OriginCodelist</b>			
<b>Definitie</b>				
<b>Datatype</b>				
<b>DCM::ValueSetBinding</b>	Extensible			
<b>DCM::ValueSetId</b>	2.16.840.1.113883.2.4.3.11.60.40.2.15.4.3			
<b>HCIM::ValueSetLanguage</b>	--			
<b>Opties</b>				
<b>HerkomstCodelijst</b>		<b>OID: 2.16.840.1.113883.2.4.3.11.60.40.2.15.4.3</b>		
Concept Name	Concept Code	Coding Syst. Name	Coding System OID	Description
Home	264362003	SNOMED CT	2.16.840.1.113883.6.96	Eigen woonomgeving, niet zijnde een instelling
Rehabilitation hospital	80522000	SNOMED CT	2.16.840.1.113883.6.96	Instelling voor revalidatie
Long term care facility	42665001	SNOMED CT	2.16.840.1.113883.6.96	Instelling voor verpleging/verzorging
Psychiatric hospital	62480006	SNOMED CT	2.16.840.1.113883.6.96	GGZ instelling
Hospital	22232009	SNOMED CT	2.16.840.1.113883.6.96	Ander ziekenhuis
Newborn nursery unit	427695007	SNOMED CT	2.16.840.1.113883.6.96	In dit ziekenhuis geboren
Liveborn born in hospital	442311008	SNOMED CT	2.16.840.1.113883.6.96	In dit ziekenhuis geboren [DEPRECATED]
Hospice	284546000	SNOMED CT	2.16.840.1.113883.6.96	Hospice
Hospital abroad	155621000146109	SNOMED CT	2.16.840.1.113883.6.96	Ziekenhuis buitenland
Site of care	43741000	SNOMED CT	2.16.840.1.113883.6.96	Instelling (anders)

Accident and Emergency department	225728007	SNOMED CT	2.16.840.1.113883.6.96	SEH
Outpatient environment	440655000	SNOMED CT	2.16.840.1.113883.6.96	Poliklinische afdeling
Discharge to other location within hospital premises	115841000146105	SNOMED CT	2.16.840.1.113883.6.96	Afdeling binnen zelfde instelling
Incident site	702869004	SNOMED CT	2.16.840.1.113883.6.96	Locatie van incident

«document»	AdmissionScopeCodelist			
Definitie				
Datatype				
DCM::ValueSetBinding	Extensible			
DCM::ValueSetId	2.16.840.1.113883.2.4.3.11.60.40.2.15.4.4			
HCIM::ValueSetLanguage	--			
Opties				
OpnameScopeCodelijst		OID: 2.16.840.1.113883.2.4.3.11.60.40.2.15.4.4		
Concept Name	Concept Code	Coding Syst. Name	Coding System OID	Description
Total admission	TA	OpnameScope	2.16.840.1.113883.2.4.3.11.60.40.4.29.1	Gehele opname
Admission part	PA	OpnameScope	2.16.840.1.113883.2.4.3.11.60.40.4.29.1	Opnamedeel

«document»		CareTypeCodelist		
Definitie				
Datatype				
DCM::ValueSetBinding		Extensible		
DCM::ValueSetId		2.16.840.1.113883.2.4.3.11.60.40.2.15.4.5		
HCIM::ValueSetLanguage		--		
Opties				
ZorgTypeCodelijst			OID: 2.16.840.1.113883.2.4.3.11.60.40.2.15.4.5	
Concept Name	Concept Code	Coding Syst. Name	Coding System OID	Description
Regular nursing care	180121000146103	SNOMED CT	2.16.840.1.113883.6.96	Reguliere verpleging
Medium care	180141000146109	SNOMED CT	2.16.840.1.113883.6.96	Verlenen van 'medium care' aan patiënt
High care	180151000146107	SNOMED CT	2.16.840.1.113883.6.96	Verlenen van 'high care' aan patiënt
Intensive care	180131000146101	SNOMED CT	2.16.840.1.113883.6.96	IC-zorg [DEPRECATED]
Care of intensive care unit patient	133903000	SNOMED CT	2.16.840.1.113883.6.96	Verlenen van zorg aan patient op intensivacareafdeling
Care of accident and emergency unit patient	290191000146103	SNOMED CT	2.16.840.1.113883.6.96	Verlenen van zorg aan patiënt op spoedeisende hulp



	Legend
Definitie	
Datatype	
Opties	

## 1.8 Example Instances

Herkomst	Begin Datum Tijd	<u>RedenOpname</u>		Verantwoordelijk Behandelaar	<u>ZorgType</u>	Zorginstelling
		Probleem	Aanleiding Opname	Zorgverlener Naam		Zorgaanbieder Naam
Eigen woonomgeving	16-05-2022	Gebroken been	Uitvoeren verrichting	J.H.R. Peters	Reguliere verpleging	Universitair Medisch Centrum Groningen

## 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. Landelijke Basisregistratie Ziekenhuiszorg [Online] Beschikbaar op: [https://www.dhd.nl/klanten/klantenservice/handleidingen\\_formulieren/Documents/Handleiding%20LBZ.pdf](https://www.dhd.nl/klanten/klantenservice/handleidingen_formulieren/Documents/Handleiding%20LBZ.pdf) [Geraadpleegd: 29 juni2017].

## 1.16 Functional Model

## 1.17 Traceability to other Standards

## 1.18 Disclaimer

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