



Dispense Record

Structured Document Template

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Draft for Comment

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1 Introduction

This document is a Structured Document Template (SDT) that specifies the content of a dispense record that can be created by an electronic dispensing system (EDS) that is used by a community pharmacy.

Essential information about Structured Document Templates can be found in *NEHTA Data Specification and Structured Document Template Guide for Use* [NEHT2009b].

This release is intended to inform and seek feedback from prospective software system designers and their clinical consultants. The content of this release is not suitable for implementation in live clinical systems.

The National Clinical Terminology and Information Service (NCTIS) values your questions, comments and suggestions about this document. Please direct your questions or feedback to <clinicalinfo@nehta.gov.au>.

1.1 Document Purpose

This SDT is a specification for a Prescribing Exchange Service Dispense Record (PES-DR) that is complementary to the SDT for an ePrescription. Its content is based on requirements described in four documents:

- *ETP Business Process and Requirements Specification – Release 1* [NEHT2009d];
- *ETP Technical Requirements Specification – Release 1* [NEHT2009g];
- *ETP Logical Information Model – Release 1* [NEHT2009e];
- *ETP Technical Architecture – Release 1* [NEHT2009f].

The development of this specification was influenced primarily by the *ETP Logical Information Model – Release 1* [NEHT2009e] with the remaining documents used as secondary references.

The content of the SDT will form the basis of mapping to the Clinical Document Architecture (CDA) standard adopted in Australia for transmission of electronic clinical documents. These mappings will form the primary content of the *PES-DR SDT Release 1 Implementation Guide*. The SDT can also, on a stakeholder needs basis, be used to map to other electronic message standards such as HL7 v2.x. Background information on the HL7 clinical document architecture (CDA) can be found at the HL7 web site [HL72008].

It is intended that this specification will aid software developers to implement information systems that record the dispense outcomes of the ePrescriptions.

1.2 Intended Audience

This document is intended to be read and understood by:

1. IT-aware clinicians who wish to evaluate the clinical suitability of NEHTA-endorsed standards.
2. Software development teams:
 - a. To plan, architect or implement:
 - clinical applications, infrastructure components or messaging interfaces
 - the facilitation of semantic interoperability
 - To support NEHTA-defined terminology in:
 - clinical and messaging interfaces

- generating value domains for data elements
 - creating or receiving electronic information exchanges containing clinical content
 - writing queries over clinical Electronic Health Record (EHR) data
 - implementing data constraint checks
 - designing term mappings
3. Researchers who wish to explore certain aspects of NEHTA-endorsed standards

This document is reasonably technical in nature and so it is advisable that the readers of it are familiar with the language of health data specifications and have some familiarity with health information standards and specifications such as HL7 CDA and [\[AS2007\]](#).

1.3 Background

In overview, the key features of the solution proposed for Electronic Transfer of Prescriptions (ETP) Release 1 are:

- An Electronic Prescribing System (EPS) used by a General Practitioner will create an electronic version of a prescription, an ePrescription, containing at least one prescribed item and related dosage and dispensing instructions.

As stated in the requirements document (ETP Logical Information Model (LIM) Release 1) for ETP Release 1 [\[NEHT2009e\]](#):

“An electronic prescription is a record that fulfils the requirements of National, State or Territory legislation. An electronic prescription used to request pharmaceutical benefits must fulfil the requirements of Regulation 5 and be prepared in accordance with Regulation 19 of the National Health (Pharmaceutical Benefits) Regulations 1960”.

- The subject of care (also known as the patient) will be provided with a paper copy of that ePrescription.
- That ePrescription will be transmitted to and stored in, one Prescription Exchange Service (PES) – a web-based service operated by a PES provider. The PES will be accessible by any Electronic Dispensing System (EDS) in use in community pharmacy.
- The subject of care will present at a community pharmacy of their choice with the paper prescription which the healthcare provider at that pharmacy will use as the basis of identifying and retrieving the related ePrescription from the PES.
- Dispensing events takes place which may entail a number of tasks including further interaction between the dispenser and the subject of care, between the dispenser and the prescriber or other authorities such as the Pharmaceuticals Benefits Scheme.
- At the conclusion of the dispensing event, an electronic dispense record, called the PES-DR, containing information pertinent to that event is created and stored in the PES.

As stated in the requirements document (ETP Logical Information Model (LIM) Release 1) for ETP Release 1 [\[NEHT2009e\]](#):

“The Dispense Record is the encapsulation of all activity associated with the dispensing of a single ePrescription Item within a single dispensing event. More specifically, a Dispense Record instance may exist for each ePrescription Item. A single Dispense Event may be associated with many Dispense Records, each of which encapsulates the dispensing information associated with a single ePrescription Item.”

In ETP Release 1, each PES-DR is a record of a dispensing outcome against one prescribed item that is associated with an ePrescription in the PES.

By nature of this relationship, it is essential that the reader of this document is familiar with the NEHTA publication *ePrescription Structured Document Template (SDT) Release 1* [[NEHT2009j](#)], which defines its structure and the scope of its content.

1.4 Document Map

[Figure 1](#) below identifies documents prepared for ETP Release 1 and indicates their relationship to each other.

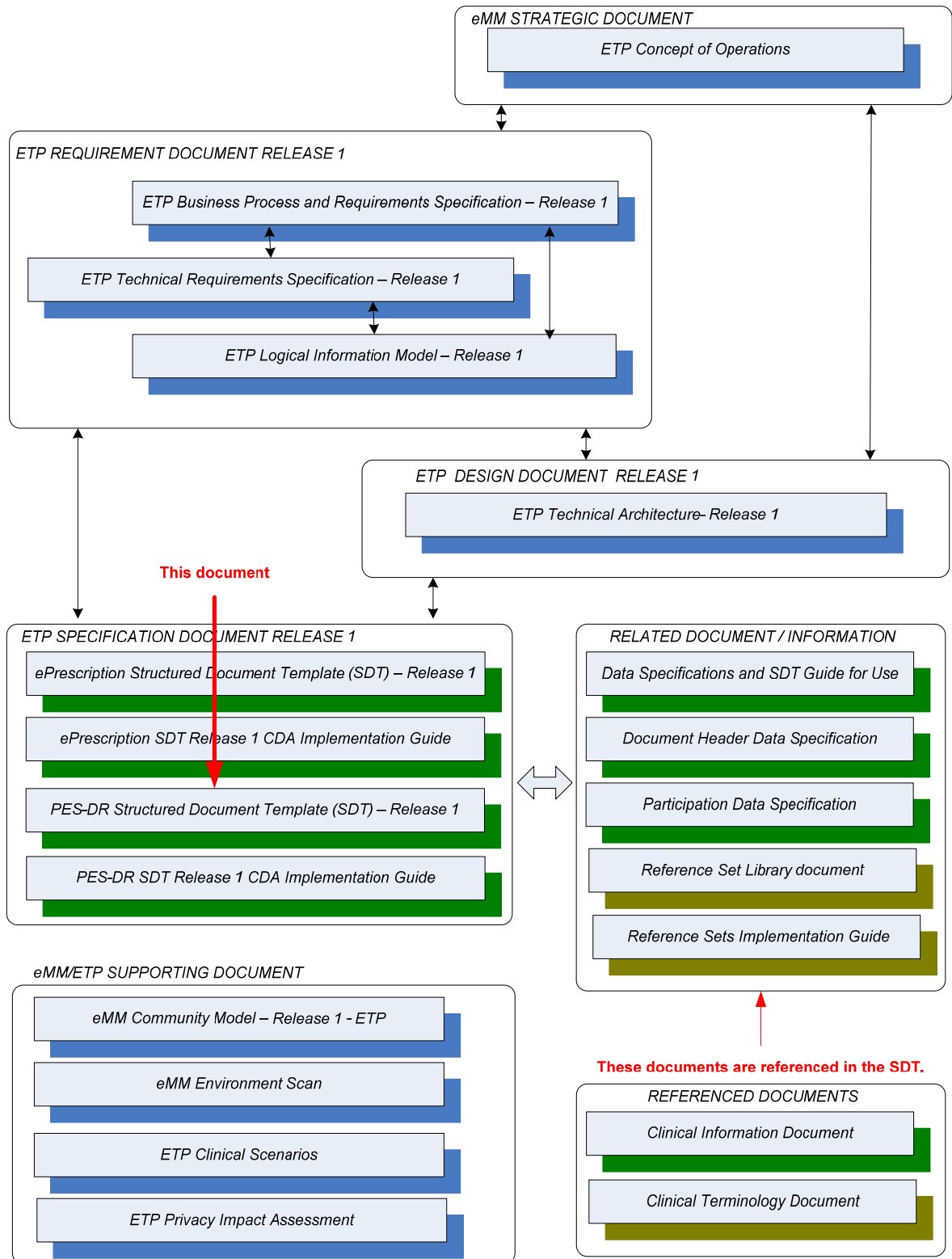


Figure 1: Document Map

This specification is indicated in Figure 1, in the group of documents labelled ETP SPECIFICATION DOCUMENT RELEASE 1. The complementary *PES-DR SDT Release 1 CDA Implementation Guide* is also indicated in this same group. The development of this latter document may require some refinement to this SDT – refinements that align with the detail of the standard for Clinical Data Architecture.

1.4.1 Related Documents

Related documents are also indicated in this document map. Amongst these are documents that are common to all SDTs, which provide information that will contribute to understanding the content in this SDT. These common documents are as follows:

- *Data Specifications – Guide for Use* [NEHT2009b] – which describes the generic data structures, data types, keywords and icons used within this Structured Document Template.
- *Document Header Data Specification* [NEHT2009a] – which contains the full specification of the standardised header used across all NEHTA Structured Document Templates. The major constructs are based on the concept of 'Participation' – modelled fully in the Participation Data Specification referenced below.
- *Participation Data Specification* [NEHT2009c] – which contains the full specification of the standardised header used across all NEHTA Structured Document Templates.

Participation is defined in the HL7 Reference Information Model (RIM) [HL72009] specification as "An association between an Act and a Role. The Entity playing the Role is the actor."

The association between an Act and a Role is called a Participation in the RIM and, each A has one or many Participations. Each instance of a Participation expresses an aspect of context for an Act in terms of either who performed it, or for whom it was done, or where it was done etc. (Please refer to the HL7 RIM specification [HL72009] for more details).

1.4.2 Reference Sets

Additionally, implementation of an operational ETP solution requires specification of Reference Sets for defining specific codes. Publications relevant to this subject matter are:

- *Reference Set Library* [NEHT2009i]. This is a register of reference sets developed for use by the SNOMED CT-AU[®] community of practice.¹ It contains information about the development and author/s of the reference sets. (See the Australian Medicines Terminology (AMT) page [NEHT2009k] on the NEHTA web site for more information.)
- *Reference Sets Implementation Guide* [NEHT2009h]. This provides basic information and guidance for the implementation of terminology reference sets.

1.5 Document Scope

For the required data elements of a PES-DR, this SDT includes their organisation (grouping), definition, datatype and constraints (including occurrence frequency, value domain and conditions of use).

The dispense records covered by this document are for recording the outcomes of community pharmacy dispensing against the following types of prescription:

- PBS/RPBS prescriptions;
- PBS/RPBS authority prescriptions; and
- Non-PBS prescriptions (private prescriptions).

These types of prescription are described in the Glossary [NEHT2008].

¹ SNOMED CT is a registered trademark of the International Health Terminology Standards Development Organisation.

The following is a summary of the organisation and scope of the content in this document.

The data organisation and details of a PES-DR for ETP Release 1 are presented as header information and dispense record detail. The former identifies the subject of care of the dispense record, the healthcare provider organisation (pharmacy) where the dispense act occurred, identity of the person within the provider organisation that authored the record and, control data.

The latter includes the identity of the prescribed item upon which the dispense act was based as well as the identity and details of the therapeutic product that was dispensed. This detail supports recording of brand substitution.

For each of the data groups and data elements specified for a dispense record, a detailed definition is provided.

(Note: the equivalent details for the header are included in *Document Header Data Specification* [NEHT2009a]).

Two UML diagrams are included, one that models the information Classes that make up the Header of a PES-DR and the other that models the information Classes that make up the details of a dispense record. These models are a commonly-used method for representing data structures and content; they are full representation of the data hierarchies presented in the SDT. Their inclusion offers an alternative means by which the reader can gain an understanding of the organisation and detail of a PES-DR record as specified in this SDT.

1.6 PES-DR Life Cycle

A PES-DR is created by an EDS as the record of dispensing of a prescribed item associated with an ePrescription.

During dispensing, the dispenser supplies a therapeutic good, for the use of a subject of care. As far as possible, the dispenser ensures that the subject of care receives the correct therapeutic good in the correct strength, dose form and quantity and that the product is appropriately packed and labelled such that the subject of care, or their carer, understands the directions for the safe and effective use of the therapeutic good.

Multiple dispenses (repeats) could take place against a single prescribed item and each is recorded as a PES-DR with reference to the source ePrescription.

Deviations from what was prescribed may also occur, such as brand substitution and accompanying dosage instructions.

For details on the lifecycle of a PES-DR please refer to the *ETP Business Process and Requirements Specification – Release 1* [NEHT2009d].

2 PES-Dispense Record Header

This section identifies those data elements that comprise a standard Dispense Record electronic document 'header' that is created by a computer application used by the dispenser (an Electronic Dispensing System or EDS). The header is designed to define the context of the dispensing event as well as control information of the document itself.

The data hierarchy below provides a logical representation of the data elements that make up the header. This data hierarchy is not intended to represent how the data contents are visually displayed in a PES-DR authoring or reviewing Electronic Dispensing System.











Within this SDT, information components that are in upper case are sections or data groups, while information components in title case are individual data elements.

Definitions of the data types, obligations and all icons used in this SDT can be found in the *NEHTA Data Specification and Structured Document Templates Guide for Use* [NEHT2009b].

The document header is generic to all Structured Document Templates and is defined in detail in the *Document Header Data Specification* [NEHT2009a]. Specific constraints, related to the use of the header in a dispense record, are explained in sections 2.1 and 2.2 of this section.

Individual data elements associated with the Participation data group are not displayed in the data hierarchy, this is to improve its readability. The data elements of the Participation data group and their hierarchical structure can be found in the related document *Data Specification – Participation* [NEHT2009c].

	DISPENSE RECORD HEADER		
	HEALTH EVENT CONTEXT		!
	SUBJECT OF CARE		!
	FACILITY		!
	HEALTH EVENT IDENTIFICATION		0
	ID	Health Event Identifier	!
		DateTime Health Event Started	!
	DOCUMENT CONTEXT		!
	DOCUMENT CONTROL		!
	ID	Document Instance Identifier	!
	ID	Document Set Identifier	!
	123	Version Number	!
	ID	Document Originating System Identifier	!

 DISPENSE RECORD HEADER				
		T ₀₁₀	Business Document Type	!
		123	Business Document Type Version Number	!
		12	Date/Time Attested	!
		T ₀₁₀	Document Status	!
		T ₀₁₀	Language (default to en-AU)	!
		DOCUMENT AUTHOR		!
		DOCUMENT RECIPIENT DETAIL		! ↻
		T ₀₁₀	Document Recipient Type	!
		DOCUMENT RECIPIENT		!

2.1 HEALTH EVENT CONTEXT

Usage

Conditions of Use	<p>This includes a reuse of HEALTH EVENT CONTEXT.</p> <p>On this reuse, the following constraints apply:</p> <ul style="list-style-type: none"> HEALTH EVENT IDENTIFICATION: Occurrence changes from Multiple to Single Health Event Identifier: Obligation changes from Optional to Essential Date/Time Clinical Process Ended: Occurrence changes from Single to Zero
--------------------------	--

Data Element	Use in Dispense record
SUBJECT OF CARE	The person the dispense record is for.
FACILITY	The organisation that the dispenser is working for when they write the dispense record.
Health Event Identifier	This is used to tie a prescription and dispense record together.
Date/Time Health Event Started	The date (and optionally time) when the dispense record is signed.

2.2 DOCUMENT CONTEXT

Usage







Conditions of Use	<p>This includes a reuse of DOCUMENT CONTEXT.</p> <p>On this reuse, the following constraints apply:</p> <ul style="list-style-type: none"> Confidentiality Indicator: Occurrence changes from Single to Zero DOCUMENT AUTHORISER/APPROVER: Occurrence changes from Single to Zero
--------------------------	--








Data Element	Use in Dispense record
Document Instance Identifier	Unique identifier of an instance of the document being created. The value is globally unique and generally not for human consumption.
Document Set Identifier	The Dispense Record Identifier.
Version Number	The identifier of a document within a document set, used to version successive replacement documents. There is no concept of major and minor versions.
Document Originating System Identifier	Unique identifier of the system used to create the document.
Business Document Type	The value is 'Dispense'.
Business Document Type Version Number	The value is '1.0'.
DateTime Attested	The date (and optionally time) when the dispense record is signed.
Document Status	'Final' for the first dispense record, 'Withdrawn' for the document that cancels a dispense record.
Language	The value defaults to 'en-AU'.
DOCUMENT AUTHOR	The dispenser.
Document Recipient Type	The value is 'Primary'.
DOCUMENT RECIPIENT	The organisation that owns the Prescription Exchange System that the dispense record is sent to.

3 Dispense Record Detail

This section describes the structure and data elements that make up the body of a PES-DR. It contains information regarding the prescribed item(s) dispensed for the subject of care, instructions on how those items should be administered and instructions for dispensing the items, as represented in the data hierarchy below.

The definition of each data element of the body is presented in Section 4 below.

	DISPENSE RECORD DETAIL		
	DISPENSE		!
	Dispense Act DateTime		!
ID	Dispense Record Identifier		!
	DISPENSER		!
ID	Prescription Identifier		!
	DISPENSED ITEM		!
	ID	Prescribed Item Instance Identifier	!
	ID	Repeat Authorisation Identifier	0
	✓x	Item Successfully Dispensed	!
	✓x	Brand Substitution Occurred	!
	123	Number of this Dispense	!
	123	Number of this Repeat	!
	✓x	Dispense Deferred	!
	123	Maximum Number of Repeats	!
	T	Label Instruction	0
	T/T ₀₁₀	Claim Category Type	0
		PBS/RPBS ITEM CODE DETAIL	0
	ID	PBS/RPBS Item Code	!

	DISPENSE RECORD DETAIL				
			T/T ₀₁₀	Manufacturer Code	!
			DISPENSED ITEM NOTE DETAIL		o ↻
			T	Dispensed Item Note	!
			DateTime Dispensed Item Note Created		!
			DISPENSED ITEM NOTE AUTHOR		o
			ITEM DETAIL		!
			T/T ₀₁₀	Item Description	!
			Medication Duration		o
			T	Quantity of Medication	o
			DOSAGE		o
			T	Dose Instruction	!

The definition of each data element of the body is presented in Section 4 below.

4 Data Specifications

This section provides a definition of each data group or data element that forms the body of the dispense record. The layout of the definition is as published in the *NEHTA Data Specification and Structured Document Templates Guide for Use* [[NEHT2009b](#)].

4.1 DISPENSE

Identification



Name	DISPENSE
Metadata Type	Data Group
Identifier	To Be Allocated
Version	3.0

Definition


Definition	Information pertaining to the process of an authorised dispenser dealing out and making ready for supply a therapeutic good that requires a prescription, for the use of a subject of care.
Source	Based on <i>NEHTA Medication Data Specifications Version 1.0 - 22/08/2006</i> [NEHT2006]
Synonymous Names	
Notes	<p>It is intended that this process ensures as far as possible that the patient receives the correct therapeutic product in the correct strength, dose form and quantity and that the product is appropriately packed and labelled such that the patient or carer understands the directions for the safe and effective use of the therapeutic product. (AS4700.3-2007 Interim Australian Standard Implementation of Health Level Seven (HL7) Version 2.5 Part 3: Electronic messages for exchange of information on drug prescription) [AS2007]</p> <p>For the purposes of this SDT, this is the record of dispensing (or attempting to dispense) a single prescribed item against an ePrescription conducted within a community pharmacy.</p> <p>The ePrescription is retrieved from the Prescription Exchange Service (PES). The record of dispensing is sent to the PES from the Electronic Dispensing System (EDS) when dispensing (or attempted dispensing) of an ePrescription is recorded.</p> <p>NOTE: Dispensing does not include supply. Dispensing occurs when the item is made available for the subject of care. Supply occurs when the subject of care accepts the item.</p> <p>NOTE: A dispense act may be completed with no item being dispensed and still require the creation of a dispense record to record the fact.</p>

Relationships

Children

Type	Name	Obligation	Condition	Occurrence
	Dispense Act DateTime	Essential		Single
ID	Dispense Record Identifier	Essential		Single
ID	DISPENSER	Essential		Single
ID	Prescription Identifier	Essential		Single
	DISPENSED ITEM	Essential		Single

Parent

Type	Name	Obligation	Condition	Occurrence
	Dispense Record Detail	Essential		Single

4.2 Dispense Act DateTime

Identification



Name	Dispense Act DateTime
Metadata Type	Data Element
Identifier	To Be Allocated

Definition

Definition	Date (and optionally time) when an authorised pharmacist or dispenser dispensed (or attempted to dispense) a prescribed item.
Source	Based on <i>NEHTA Medication Data Specifications</i> Version 1.0 - 22/08/2006
Synonymous Names	
Notes	NOTE: A dispense act may be completed with no item being dispensed and still require a the creation of a dispense record to record the fact.
Datatype	DateTime

Usage

Examples	See: <i>Data Specifications – Guide for Use</i> [NEHT2009b].
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Relationships

Parent

Type	Name	Obligation	Condition	Occurrence
	DISPENSE	Essential		Single

4.3 Dispense Record Identifier

Identification



Name	Dispense Record Identifier
Metadata Type	Data Element
Identifier	To Be Allocated

Definition

Definition	A number generated by an EPS (Electronic Dispensing System) to uniquely identify an instance of a dispense record.
Source	NEHTA
Synonymous Names	
Notes	This represents the unique identifier assigned by the Electronic Dispensing System desktop software and as such, the number is unique ONLY to the EDS that issues it. This is the same as Document Set Identifier .
Datatype	UniqueIdentifier

Usage

Examples	
-----------------	--


Relationships

Parent

Type	Name	Obligation	Condition	Occurrence
	DISPENSE	Essential		Single

4.4 DISPENSER

Identification

 Name	DISPENSER
Metadata Type	Data Group
Identifier	To Be Allocated
Version	2.0

Definition


Definition	The healthcare provider who made the therapeutic good available.
Source	NEHTA
Synonymous Names	
Notes	This will be the same as the DOCUMENT AUTHOR .

Usage

Conditions of Use	This is a reuse of the PARTICIPATION BY HEALTHCARE PROVIDER (PERSON) data group. On this reuse, no additional constraints apply.
--------------------------	---

Relationships

Parent

Type	Name	Obligation	Condition	Occurrence
	DISPENSE	Essential		Single

4.5 Prescription Identifier

Identification

ID

Name	Prescription Identifier
Metadata Type	Data Element
Identifier	To Be Allocated

Definition


Definition	A number generated by an EPS (Electronic Prescribing System) to uniquely identify a prescription.
Source	NEHTA
Synonymous Names	
Notes	This identifies the prescription against which the dispensing was made. This may include an identifier which is only unique to the EPS, or it may also include identification of the EPS.
Datatype	UniqueIdentifier

Usage

Examples	
-----------------	--

Relationships

Parent

Type	Name	Obligation	Condition	Occurrence
	DISPENSE	Essential		Single

4.6 DISPENSED ITEM

Identification






Name	DISPENSED ITEM
Metadata Type	Data Group
Identifier	To Be Allocated

Definition


Definition	Administrative, regulatory, therapeutic good and dosage information about a single dispensed item.
Source	NEHTA
Synonymous Names	
Notes	<p>This includes information about the dispensing as well as about the item dispensed.</p> <p>The dispensed item types within the scope of ETP Release 1 ePrescription implementation are the following:</p> <ul style="list-style-type: none"> • An item on the PBS/RPBS • An item on the PBS/RPBS requiring authority • A non-PBS item (medication or other prescribed item not covered by PBS benefits)

Relationships

Children

Type	Name	Obligation	Condition	Occurrence
ID	Prescribed Item Instance Identifier	Essential		Single
ID	Repeat Authorisation Identifier	Optional		Single
✓x	Item Successfully Dispensed	Essential		Single
✓x	Brand Substitution Occurred	Essential		Single
1 ₂ 3	Number of this Dispense	Essential		Single
1 ₂ 3	Number of this Repeat	Essential		Single
✓x	Dispense Deferred	Essential		Single
1 ₂ 3	Maximum Number of Repeats	Essential		Single
T	Label Instruction	Optional		Single
T/T ₀₁₀	Claim Category Type	Optional		Single
	PBS/RPBS ITEM CODE DETAIL	Optional		Single
	DISPENSED ITEM NOTE DETAIL	Optional		Multiple
	ITEM DETAIL	Essential		Single

Parent

Type	Name	Obligation	Condition	Occurrence
	DISPENSE	Essential		Single

4.7 Prescribed Item Instance Identifier

Identification

ID

Name	Prescribed Item Instance Identifier
Metadata Type	Data Element
Identifier	To Be Allocated

Definition


Definition	A number generated by an EPS (Electronic Prescribing System) to uniquely identify information about a therapeutic good that is included within a prescription.
Source	NEHTA
Synonymous Names	
Notes	This identifies the item within the prescription against which the dispensing was made. This may be an integer, or may include an identifier which is only unique to the EPS, or it may also include identification of the EPS.
Datatype	UniqueIdentifier

Usage

Examples	No example available for this data element.
-----------------	---

Relationships

Parent

Type	Name	Obligation	Condition	Occurrence
	DISPENSED ITEM	Essential		Single

4.8 Repeat Authorisation Identifier

Identification

ID

Name	Repeat Authorisation Identifier
Metadata Type	Data Element
Identifier	To be allocated

Definition


Definition	A number generated by an EDS (Electronic Dispensing System) to uniquely identify the repeat authorisation prescription that is linked with the dispensed Prescribed Item.
Source	NEHTA
Synonymous Names	
Notes	When a prescription with remaining repeats is filled, a repeat authorisation for the next dispensing is created at the time of dispensing. This is the identifier for that repeat authorisation.
Datatype	UniqueIdentifier

Usage

Examples	No example available for this data element.
-----------------	---

Relationships

Parent

Type	Name	Obligation	Condition	Occurrence
	DISPENSED ITEM	Optional		Single

4.9 Item Successfully Dispensed

Identification



Name	Item Successfully Dispensed
Metadata Type	Data Element
Identifier	To be allocated

Definition

Definition	An indicator that specifies whether dispensing of a prescribed item has actually occurred.
Source	NEHTA
Synonymous Names	
Notes	<p>In the dispense-supply processes, the dispensing event may or may not actually occur. If dispensing does not actually occur, this failure to actually dispense may be substantiated with an associated annotation.</p> <p>The prescribed medication may or may not be dispensed depending on whether the prescribed medication is available, or brand substitution is not allowed as specified in the prescription; or whether it is clinically safe to dispense (e.g. pharmacist identifies a potential drug-drug interaction or drug-condition interaction risk that was not identified by the prescribing clinician).</p>
Datatype	Boolean

Relationships

Parent

Type	Name	Obligation	Condition	Occurrence
	DISPENSED ITEM	Essential		Single

4.10 Brand Substitution Occurred

Identification



Name	Brand Substitution Occurred
Metadata Type	Data Element
Identifier	DE-10107

Definition

Definition	Indicates whether or not the substitution of a prescribed medication with a different brand name of the same medication occurred when the medication was dispensed/supplied.
Source	NEHTA
Synonymous Names	
Notes	Substitution may be permitted where the alternative medication is expected to be therapeutically equivalent without differences in clinical effect. This data element is only relevant to PBS and RPBS prescriptions.
Datatype	Boolean

Relationships

Parent

Type	Name	Obligation	Condition	Occurrence
	DISPENSED ITEM	Essential		Single

4.11 Number of this Dispense

Identification

123

Name	Number of this Dispense
Metadata Type	Data Element
Identifier	To Be Allocated

Definition


Definition	A numeric value that represents the dispense number or sequence that has been reached for a prescribed item. This count includes the first dispense.
Source	NEHTA
Synonymous Names	Dispense Instance Id
Notes	<p>Each prescribed item logically possesses a pre-determined number of times (i.e. 1 through N) that it may be dispensed. At the time of a dispensing act, this number is known and the dispensing activity is bound to this particular number.</p> <p>An item may be dispensed until the maximum number of repeats is reached. This integer indicates which dispensing of the item is being attempted by the dispense act that this dispense record documents.</p> <p>The value is one more than the number of times the prescribed item has successfully been dispensed prior to this dispensing.</p> <p>The value increments by one each time dispensing is completed.</p> <p>The value is one more than Number of This Repeat.</p>
Datatype	Integer

Usage

Examples	<ul style="list-style-type: none"> • 1 • 2
-----------------	--

Relationships

Parent

Type	Name	Obligation	Condition	Occurrence
	DISPENSED ITEM	Essential		Single

4.12 Number of this Repeat

Identification

123

Name	Number of this Repeat
Metadata Type	Data Element
Identifier	DE-10169

Definition


Definition	A numeric value that represents the repeated dispense number or sequence that has been reached for a prescribed item with repeat dispense instruction. This count excludes the first dispense which is not counted as a repeat.
Source	NEHTA
Synonymous Names	
Notes	The value is one less than Number of This Dispense.
Datatype	Integer

Usage

Examples	<ul style="list-style-type: none"> • 0 • 2
-----------------	--

Relationships

Parent

Type	Name	Obligation	Condition	Occurrence
	DISPENSED ITEM	Essential		Single

4.13 Dispense Deferred

Identification



Name	Dispense Deferred
Metadata Type	Data Element
Identifier	To be allocated

Definition

Definition	Indicates whether or not the dispensing of the prescribed item has been deferred.
Source	NEHTA
Synonymous Names	
Notes	Deferral of dispense usually occurs when there is more than one item on a prescription and one or more of the items do not require dispensing at the time the required item is dispensed.
Datatype	Boolean

Relationships

Parent

Type	Name	Obligation	Condition	Occurrence
	DISPENSED ITEM	Essential		Single

4.14 Maximum Number of Repeats

Identification

123

Name	Maximum Number of Repeats
Metadata Type	Data Element
Identifier	DE-10169

Definition


Definition	The number of times the supply of the prescribed item may be repeated under the terms of this prescription.
Source	NEHTA
Synonymous Names	
Notes	
Datatype	Integer

Usage

Examples	<ul style="list-style-type: none"> • 2 • 4
-----------------	--

Relationships

Parent

Type	Name	Obligation	Condition	Occurrence
	DISPENSED ITEM	Essential		Single

4.15 Label Instruction

Identification

T	Name	Label Instruction
	Metadata Type	Data Element
	Identifier	To be allocated

Definition


Definition	Dispenser instructions to the subject of care concerning the therapeutic good.
Source	NEHTA
Synonymous Names	
Notes	<p>Instructions may include such things as :</p> <ul style="list-style-type: none"> • storage instructions and conditions • special or cautionary directions associated with preparation or administration of dosages • action to be taken if a dose is missed • relevant drug/drug, drug/food, drug/alcohol interaction • directions for the correct use of medicine <p>Such directions will usually be printed on a label and attached to the dispensed container.</p> <p>These directions may be a recapitulation or further refinement of instructions specified by the Prescriber originally manifested in the Prescription's Prescribed Item Note.</p>
Datatype	Text

Usage

Examples	
-----------------	--

Relationships

Parent

Type	Name	Obligation	Condition	Occurrence
	DISPENSED ITEM	Optional		Single

4.16 Claim Category Type

Identification

T/T₀₁₀

Name	Claim Category Type
Metadata Type	Data Element
Identifier	To Be Allocated

Definition


Definition	Indicates the category of pharmaceutical benefits applicable to the item being dispensed.
Source	NEHTA
Synonymous Names	
Notes	<p>The primary purpose of this data element is to enable the determination of the source of any applicable financial subsidy for the item.</p> <p>Note: Claim Category Type only relates to Dispense Records of successful dispense events.</p> <p>Note: This data element is relevant only for PBS and RPBS items.</p>
Datatype	CodeableText
Value Domain	Not specified – Use existing code sets until NEHTA determines a suitable common reference set.

Usage

Examples	<ul style="list-style-type: none"> • 1 – for general benefits • C1 – for concessional and Safety Net Concession Card benefits • E1 – for Safety Net Entitlement Card benefits • R1 – for RPBS benefits
-----------------	--


Relationships

Parent

Type	Name	Obligation	Condition	Occurrence
	DISPENSED ITEM	Optional		Single

4.17 PBS/RPBS ITEM CODE DETAIL

Identification

 Name	PBS/RPBS ITEM CODE DETAIL
Metadata Type	Data Group
Identifier	To Be Allocated

Definition


Definition	A collection of data elements that identify a therapeutic good listed within the Pharmaceutical Benefit Scheme (PBS) or the Repatriation Pharmaceutical Benefits Scheme (RPBS).
Source	NEHTA
Synonymous Names	PBS Item Code Detail RPBS Item Code Detail
Notes	This is only relevant to PBS and RPBS items. Note: There can be multiple different codes used for the same item but for different indications e.g. Gabapentin 300mg capsules has the PBS code of 1834M within the PBS (indicated for epilepsy) and the code of 4592Q within the RPBS (indicated for neuropathic pain).

Relationships

Children

Type	Name	Obligation	Condition	Occurrence
ID	PBS/RPBS Item Code	Essential		Single
T/T₀₁₀	Manufacturer Code	Essential		Single

Parent

Type	Name	Obligation	Condition	Occurrence
	DISPENSED ITEM	Optional		Single

4.18 PBS/RPBS Item Code

Identification

ID	Name	PBS/RPBS Item Code
	Metadata Type	Data Element
	Identifier	To Be Allocated

Definition


Definition	Identifier assigned by Medicare Australia to therapeutic goods listed in the Pharmaceutical Benefit Scheme (PBS) or the Repatriation Pharmaceutical Benefits Scheme (RPBS).
Source	NEHTA
Synonymous Names	PBS Item Code RPBS Item Code
Notes	
Datatype	UniqueIdentifier
Value Domain	The code set is determined by Medicare Australia.

Usage

Examples	4411E
-----------------	-------

Relationships

Parent

Type	Name	Obligation	Condition	Occurrence
	PBS/RPBS ITEM CODE DETAIL	Essential		Single

4.19 Manufacturer Code

Identification

T/T₀₁₀

Name	Manufacturer Code
Metadata Type	Data Element
Identifier	To Be Allocated

Definition


Definition	<p>A code assigned by Medicare Australia, for use within the Schedule of Pharmaceutical Benefits, to identify either:</p> <ul style="list-style-type: none"> a party (organisation or person) who imports, or arranges the importation of, the goods into Australia; or a party (organisation or person) who, in Australia, manufactures the goods, or arranges for another person to manufacture the goods, for supply (whether in Australia or elsewhere).
Source	NEHTA
Synonymous Names	<p>PBS Item Manufacturer Code</p> <p>Manufacturer Code</p>
Notes	This is distinct from the Sponsor ID used in the Australian Register of Therapeutic Goods (ARTG).
Datatype	CodeableText
Value Domain	The code set is determined by Medicare Australia.

Usage

Examples	PF
-----------------	----

Relationships

Parent

Type	Name	Obligation	Condition	Occurrence
	PBS/RPBS ITEM CODE DETAIL	Essential		Single

4.20 DISPENSED ITEM NOTE DETAIL

Identification



Name	DISPENSED ITEM NOTE DETAIL
Metadata Type	Data Group
Identifier	To Be Allocated
Version	V1.0

Definition



Definition	Supplementary information about the dispensed item, which is not captured by other information structures contained in the Dispense Record.
Source	NEHTA
Synonymous Names	Clinical Note Annotation
Notes	<p>Uses of this may include:</p> <ul style="list-style-type: none"> • Unsuccessful Dispense: The dispensing provider's justification for not dispensing the medication that has been prescribed for the subject of care. • Deferred Dispense. • Cancelled / Reversed Dispense. • Decrease in the number of repeats. • Decrease in medication quantity. • Record of dialogue between the prescriber the dispenser and associated outcomes.

Usage


Conditions of Use	<p>This is a reuse of the SUPPLEMENTARY INFORMATION data group.</p> <p>On this reuse, the following constraints apply:</p> <ul style="list-style-type: none"> • Supplementary Information Recipient: Occurrence changes from Multiple to Zero. • Supplementary Information Note: Is renamed to Dispense Item Note, Obligation changes from Optional to Essential. • DateTime Note Created: Is renamed to DateTime Dispense Item Note Created, Obligation changes from Optional to Essential. • Supplementary Information Author: Is renamed Dispense Item Note Author, Occurrence changes from Multiple to Single.
--------------------------	--

Relationships

Children

Type	Name	Obligation	Condition	Occurrence
T	Dispensed Item Note	Essential		Single
	DateTime Dispensed Item Note Created	Essential		Single
	DISPENSED ITEM NOTE AUTHOR	Optional		Single

Parent

Type	Name	Obligation	Condition	Occurrence
	DISPENSED ITEM	Optional		Multiple

4.21 Dispensed Item Note

Identification

T

Name	Dispensed Item Note
Metadata Type	Data Element
Identifier	DE-20175

Definition


Definition	Supplementary note regarding the item being prescribed which the prescriber deems to be clinically relevant.
Source	NEHTA
Synonymous Names	Advice to Subject of Care
Notes	The note may contain descriptive information related to the dispensing event, process or item.
Datatype	Text

Usage

Examples	<ul style="list-style-type: none"> • Rang the doctor about dose. Confirmed dose. • Reverse dispense - patient has failed to pick up the medication after 2 months of the dispense • Unsuccessful dispense – patient has drug/drug interaction between his current regime of beta-blockers with the prescription for clonidine
-----------------	--

Relationships

Parent

Type	Name	Obligation	Condition	Occurrence
	DISPENSED ITEM NOTE DETAIL	Essential		Single

4.22 DateTime Dispensed Item Note Created

Identification



Name	DateTime Dispensed Item Note Created
Metadata Type	Data Element
Identifier	To Be Allocated

Definition

Definition	The date (and optionally time) that the Supplementary or additional information about the Dispense was written.
Source	NEHTA
Synonymous Names	
Notes	
Datatype	DateTime

Usage

Examples	See: <i>Data Specifications – Guide for Use</i> [NEHT2009b]
-----------------	---

Relationships

Parent

Type	Name	Obligation	Condition	Occurrence
	DISPENSED ITEM NOTE DETAIL	Essential		Single

4.23 DISPENSED ITEM NOTE AUTHOR

Identification



Name	DISPENSED ITEM NOTE AUTHOR
Metadata Type	Data Group
Identifier	To Be Allocated
Version	2.0

Definition

Definition	The healthcare provider who wrote the note against the dispensed item.
Source	NEHTA
Synonymous Names	
Notes	The author must be a pharmacist. This will typically be the same as the DOCUMENT AUTHOR .

Usage

Conditions of Use	This is a reuse of the PARTICIPATION BY HEALTHCARE PROVIDER (PERSON) data group. On this reuse, no additional constraints apply.
--------------------------	---

Relationships

Parent

Type	Name	Obligation	Condition	Occurrence
	DISPENSED ITEM NOTE DETAIL	Optional		Single

4.24 ITEM DETAIL

Identification

Name	ITEM DETAIL
Metadata Type	Data Group
Identifier	DG-10120
Version	3.0

Definition



Definition	Information, including dosage instruction, about a single, unique therapeutic good that is issued to a subject of care.
Source	NEHTA
Synonymous Names	Medication Item Dispensed Medication Item
Notes	It is intended to enable correct dispensing of the item to the subject of care. Details of the item include a description, duration and quantity of the medication and the dosage which should be administered.

Usage


Conditions of Use	<p>This is a reuse of the ITEM DETAIL data group.</p> <p>On this reuse, the following constraints apply:</p> <ul style="list-style-type: none"> • Item Status: Occurrence changes from Single to Zero • Reason for Medication: Occurrence changes from Single to Zero • Delivery Compliance Aid Description: Occurrence changes from Single to Zero • Cautionary Advice: Occurrence changes from Single to Zero • QUANTITY OF MEDICATION DETAIL: Occurrence changes from Single to Zero • CHANGE DETAIL: Occurrence changes from Single to Zero • MEDICATION ITEM AUTHORISER: Occurrence changes from Single to Zero • Additional Comments: Occurrence changes from Single to Zero
--------------------------	--

Relationships

Children

Type	Name	Obligation	Condition	Occurrence
T / T _{o1o}	Item Description	Essential		Single
	Medication Duration	Optional		Single
T	Quantity of Medication	Optional		Single
	DOSAGE	Optional		Single

Parent

Type	Name	Obligation	Condition	Occurrence
	DISPENSED ITEM	Essential		Single

4.25 Item Description

Identification

T/T₀₁₀

Name	Item Description
Metadata Type	Data Element
Identifier	DE-10194

Definition


Definition	The description of the therapeutic good as described by the dispenser or catalogue of dispensable items.
Source	NEHTA
Synonymous Names	Drug Medication
Notes	This data element is designed to carry a term from a terminology with a description of the dispensed item. The description should include the name of the item and for a medicinal item, may also contain the active ingredients, strength, form, pack size as part of the term (if applicable). In the Australian Medicines Terminology (AMT), this is done by binding to a MPUU, MPP, TPUU, TPP or CTPP concept. The concept reference set specifying the list of permissible values is not yet available.
Datatype	CodeableText
Value Domain	Not specified – Use existing code sets until NEHTA determines a suitable common reference set.

Usage

Examples	<ul style="list-style-type: none"> paracetamol 500mg + codeine phosphate 30 mg tablet (MPUU – Medicinal Product Unit of Use) paracetamol 500mg + codeine phosphate 30 mg tablet, 20 (MPP – Medicinal Product Pack) Panadeine Forte tablet: uncoated, 20 tablets (TPP – Trade Product Pack) Panadeine Forte (paracetamol 500 mg + codeine phosphate 30mg) tablet: uncoated, 1 tablet (TPUU – Trade Product Unit of Use) Panadeine Forte tablet: uncoated, 20 tablets, blister pack (CTPP – Containered trade product pack) Bandage compression 10 cm x 3.5 m bandage: high stretch, 1 bandage (MPP – Medicinal Product Pack)
-----------------	---

Relationships

Parent

Type	Name	Obligation	Condition	Occurrence
	ITEM DETAIL	Essential		Single

4.26 Medication Duration

Identifications



Name	Medication Duration
Metadata Type	Data Element
Identifier	DE-10143

Definition


Definition	The length of time the course of medication has continued since it first commenced and should be continued by the subject of care.
Source	NEHTA
Synonymous Names	
Notes	<p>This relates to the entire course of medication, not just the course which is the subject of the current prescription, and may therefore have a start date prior to the current prescription date if this is a repeat prescription.</p> <p>Capture of this data element may be helpful in the following circumstances:</p> <ul style="list-style-type: none"> • Some medications may recommend that subjects of care on long term therapy should be reviewed on a regular basis to assess for any change in risk/benefit balance. • Some drugs may recommend a maximum length of time for which they should be continuously taken. • Legislation mandates that certain drugs (drugs of dependency) can only be made available for continuous use for a prescribed maximum period. <p>The period of time may be expressed as a duration (e.g. 2 months) or as a time interval with a start and/or end date.</p>
Datatype	TimeInterval

Usage

Examples	<ul style="list-style-type: none"> • 2005 – 12/5/2008 • 3 months
-----------------	--

Relationships

Parent

Type	Name	Obligation	Condition	Occurrence
	ITEM DETAIL	Optional		Single

4.27 Quantity of Medication

Identification

T

Name	Quantity of Medication
Metadata Type	Data Element
Identifier	DE-10145

Definition


Definition	A statement of the total number of doses or physical amount of the therapeutic good that is intended for the subject of care.
Source	NEHTA
Synonymous Names	Quantity of Medication Dispensed
Notes	
Datatype	Text

Usage

Examples	<ul style="list-style-type: none"> • If dispensing 2 packs of 20 tablets '40 tablets' • If dispensing 1 box of 10 vials of an injection – e.g. Injection 600 micrograms in 1 mL 10 Injection '10 vials'
-----------------	---

Relationships

Parent

Type	Name	Obligation	Condition	Occurrence
	ITEM DETAIL	Optional		Single

4.28 DOSAGE

Identification



Name	DOSAGE
Metadata Type	Data Group
Identifier	DG-16007

Definition

Definition	Details of the amount of therapeutic substance/medicine to be administered to the patient at one time or during one continuous time interval.
Source	NEHTA
Notes	<p>This data group is used to provide details of dose instructions for medication administration. Instruction on use/administration of non-medication items can be recorded in text in the data element named 'Dispensed Item Note'.</p> <p>The dosage data group in this release of the SDT is designed to support text based dosage instructions. Clinical input is being sought to modify the data group in order to support atomic model for complex dosing instructions such as variable and alternate dosing and multi-component medicines. This is an evolving process.</p> <p>In the meantime, implementers may be interested in reading information on the NHS Dose Syntax Model. [NHS2009]. That model, whilst different to this data group, provides many similarities.</p>

Relationships

Children

Type	Name	Obligation	Condition	Occurrence
T	Dose Instruction	Essential		Single

Parent

Type	Name	Obligation	Condition	Occurrence
	ITEM DETAIL	Optional		Single

4.29 Dose Instruction

Identification

T

Name	Dose Instruction
Metadata Type	Data Element
Identifier	DE-16008

Definition


Definition	A description of the dose quantity, frequency and route instruction that determines how the therapeutic substance is intended to be correctly administered to/taken by the patient.
Source	NEHTA
Synonymous Names	Dosage instruction
Notes	<p>It should be ensured that the instructions for the Subject of Care are as specific as possible. For example, 'Take as directed', can be confusing and dangerous to the Subject of Care and is illegal in some states. [MA2009b]</p> <p>Scope:</p> <p>This must include the dose quantity, frequency and any additional instructions required to safely describe the appropriate dosage. This should also include the administration schedule.</p>
Datatype	Text

Usage

Examples	<ul style="list-style-type: none"> One tablet twice a day every 12 hours, before or with the first mouthful of food. Apply thin layer to affected area 3-4 times daily; reassess after 7 days if no response.
-----------------	---

Relationships

Parent

Type	Name	Obligation	Condition	Occurrence
	DOSAGE	Essential		Single

5 UML Class Diagram

The overall structure of all structured document templates is described in *NEHTA Data Specification and Structured Document Templates Guide for Use* [[NEHT2009b](#)].

This section contains a UML 2.0 class diagram of a possible implementation of the detail part of the structured document template.

Class diagrams for the standard document header are found in *Document Header Data Specification* [[NEHT2009a](#)]. Class diagrams for participation are found in *Participation Data Specification* [[NEHT2009c](#)].

The diagram represents the data elements with their names, data types, multiplicities and groupings into data groups. Data elements are modelled as attributes and data groups as classes. Participation data groups are modelled with all of their attributes suppressed; this is to simplify the diagram.

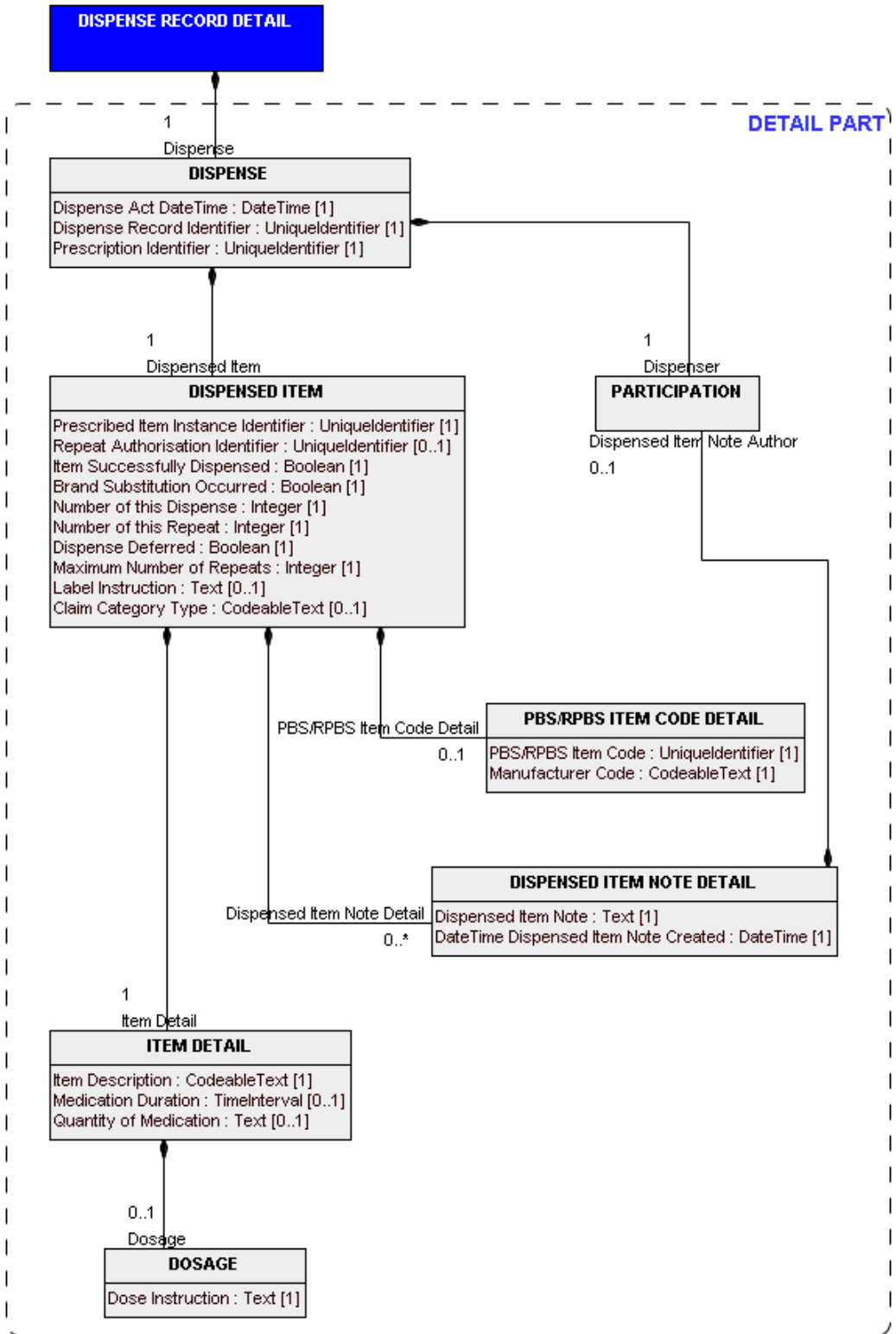


Figure 2 UML Class Diagram of a Possible Implementation of Dispense Record Detail Part

6 Reference List

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7 Appendix A. Known Issues

This appendix lists known issues for this document. The identified issues will be addressed in subsequent releases.

Reference	Description
PES-Dispense Record Header, Dispense Record Detail	The uses of the participation data groups SUBJECT OF CARE, FACILITY, DOCUMENT AUTHOR, DOCUMENT RECIPIENT and DISPENSED ITEM NOTE AUTHOR needs to be added.
DISPENSED ITEM NOTE DETAIL	All multiple occurring data groups and data elements are implicitly ordered (see Guide for Use [NEHT2009b] , page 15). As such it is the responsibility of the sender to insert the items into the document in the correct order and the receiver to extract them in the correct order. However, we are concerned that this mechanism may not have sufficient clinical safety in the case of the NOTES data group. Consequently we are investigating changes to the mechanism to further reduce the risk that items in lists may be ordered incorrectly.

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